



AMA

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Submission
2004-05**

**AUSTRALIAN MEDICAL ASSOCIATION
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AMA FEDERAL BUDGET SUBMISSION 2004-05
REFOCUSSING ON HEALTH CARE

INTRODUCTION	2
SUMMARY	3
SAVINGS IN THE BANK, BUT WORKFORCE ON THE BLINK	3
NOT JUST GPs	5
WHY WE NEED ACTION NOW	6
PARTICIPATION IS THE KEY	7
GEOGRAPHIC IMBALANCES	7
ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH	8
PUBLIC HEALTH	8
• HEPATITIS C	8
• TOBACCO CONTROL	9
• IMMUNISATION	9
PHARMACEUTICAL BENEFITS SCHEME (PBS)	10
PRIVATE HEALTH INSURANCE	10
PUBLIC HOSPITALS	11
AGED CARE	11
DEMENTIA	12
VETERANS' MEDICAL SERVICES	12

AMA FEDERAL BUDGET SUBMISSION 2004-05

REFOCUSSING ON HEALTH CARE

INTRODUCTION

This submission is made by the Australian Medical Association (AMA), Australia's peak medical professional organisation. The AMA represents some 28,000 Australian doctors.

The AMA notes that Australia has a world-class health system built on the foundations of a highly skilled health workforce, strong health institutions and strong values which aim for quality and access for all. Australians enjoy very high disability-free life expectancy. Few other countries in the world do as well.

The AMA believes that Australians want to keep it that way. Despite an ageing population, Australia will be able to meet the expectations of its citizens of access to health care that is both affordable and high quality.

The greatest challenge now facing the Australian health system is to ensure an adequate skilled workforce. The GP shortage has been belatedly recognised, but the shortages are by no means limited to GPs, nor for that matter to doctors.

Government policies of previous years have severely limited the growth of the medical workforce. Unquestionably, this has produced Budget savings over and above those achieved by holding down rebates in real terms. For general practice alone, we estimate that workforce limiting measures cut rebates by \$450m in 2002-03 alone and by a cumulative \$1.4 billion since 1995-96. For specialists, the impact of workforce restrictions is estimated at \$100m in 2002-03 alone and by a cumulative \$300m since 1995-96.

The severe limits on the medical workforce mean that many Australians no longer have access to appropriate and timely primary and tertiary care. It is time for the Federal Government to refocus on its role in health care, and to take decisions based not only on the cost to the taxpayer, but also the wider economic and social benefits of good health care. It is time for the Federal Government to give back to the health system the \$500 to \$600m p.a. in Budget savings that have been achieved through undue limits on the workforce.

The AMA does not suggest that Government expenditure is the answer to every problem. Australia has achieved excellent results in health care because of effective partnerships and complementary efforts by the public and private sectors in both the provision and the funding of health care. Since the partnerships have worked, it makes absolute sense to keep them going. We urge the Government, in formulating the 2004-05 Federal Budget, to refocus on health care, to reconsider both its total spending commitments and its priorities.



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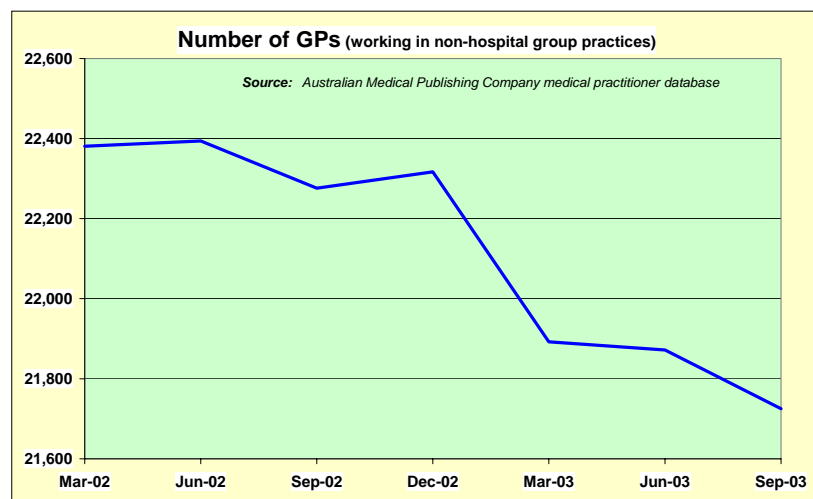
SUMMARY

The AMA believes that there is an opportunity, in the year 2004-05, for the Federal Government to provide significant social and economic benefits to the Australian people through some strategic additional investment in health care. This would involve:

- 1) refocussing on health care, giving back some of the savings achieved in recent years as a result of limitations on the growth of the medical workforce and increasing Federal spending on health as a percentage of GDP to address both the:
 - increasingly severe health workforce shortages; and
 - rising costs associated with an ageing population and new safe & effective health technologies;
- 2) giving serious consideration to short-term measures to encourage doctors to participate in the medical workforce to help relieve the current shortages—this needs to reach out to those who have withdrawn from the workforce in despair and those considering early retirement;
- 3) rethinking health spending priorities to ensure access and affordability of health care to disadvantaged groups such as indigenous people, aged, low income and people living in outer urban and rural areas;
- 4) increasing spending on preventative health as an investment in reducing health costs in future years; and
- 5) commissioning a comprehensive review of the Pharmaceutical Benefits Scheme (a White Paper).

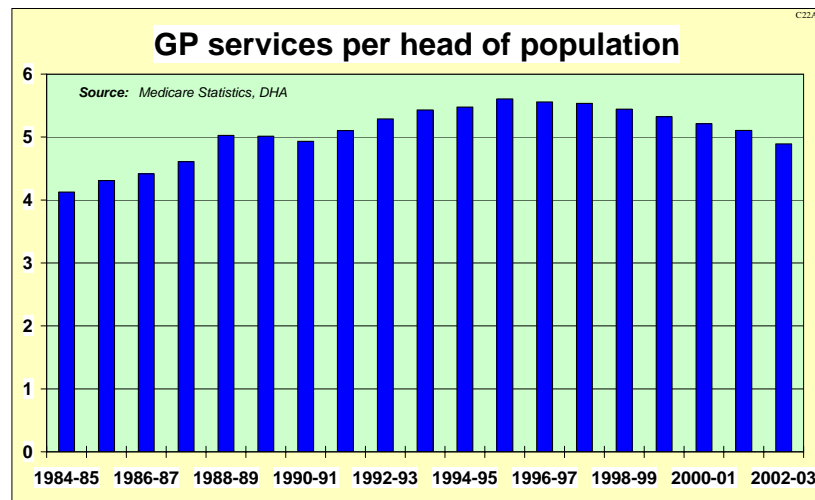
SAVINGS IN THE BANK, BUT WORKFORCE ON THE BLINK

Growth in the medical workforce has been tightly constrained by successive governments over many years. Apart from an insufficient input of new doctors, there have been increasing losses from the workforce reflecting the medical indemnity crisis, red tape and concerns over remuneration. The GP workforce is ageing and no longer “replacing itself”. Our data indicate a loss of some 700 GPs from the workforce over the past seven quarters. Not all can be explained by retirements.



The Access Economics study of the GP workforce estimated the shortfall at 1,200 to 2,000 GPs in the year 2000. The AMA estimates that the shortage has increased in the meantime to around 3,000 full-time GPs.

Lack of access to GPs can be clearly seen in the per capita access to GP consultations. There has been a significant fall since the peak in 1995-96.



A shortage of GPs translates into a reduction in GP benefits paid, although there may be some offsetting costs generated in the health system as patients seek alternative avenues to obtain care including public hospital accident and emergency services. All else equal, if per capita utilisation in 2002-03 had better reflected the primary care needs of the population, the additional benefit outlay in that year would have been \$450 million. The total Budget savings from tightly restricting the GP workforce since 1995-96 have been \$1.4 billion. This is the amount that now needs to be reinvested by the Government in workforce measures.

The supply of GPs has been restricted over the years by the following government policies:

- **Restricting GP training places:** By 1995, the Labor government had restricted GP training places to 400 p.a. (from 800 p.a. a few years earlier). This was subsequently increased to 450 p.a. in 2000. The Government's Fairer Medicare Package seeks to further increase the numbers to 600 p.a., still well below the levels of the early 1990s, but it will be a struggle to get the extra 150 until the output of graduates increases some years hence.
- **Restricting medical undergraduate places:** The Federal Government has always kept a tight rein on the number of funded medical school undergraduate places and these places have not kept pace with demand from general practice or the specialties. For example, in 1985, there were 1,356 medical course graduates while in 1999, 2000 and 2001 respectively there were 1,256, 1,195 and 1,203.
- **Restricting access to Medicare provider numbers:** The Coalition Government introduced provider number legislation in 1996, preventing newly qualified doctors accessing Medicare until they have completed their vocational registration training.
- **Cutting GP rebates in real terms:** Between 1991 and 1998 the Medical Benefits Schedule rebate for a Level B consultation, the most used GP service, increased from \$20.00 to \$21.30, a \$1.30 increase for almost the whole decade. While GP rebates rose more rapidly from 1998 to 2003, low rebates continue to adversely affect the viability of General Practice.

- **Restricting entry of overseas trained doctors:** At various times in the 1990s, the Government moved to tightly restrict entry of overseas trained doctors (OTDs), while positions for temporary resident doctors (TRDs) are limited by area of need rules. Under the General Skilled Migration Program, medical practitioners currently score no points. The current policy amounts to telling OTDs that they are not needed and not wanted.
- **Setting GP rebates too low:** Patient rebates, at 85% of an unrealistic MBS fee, do not come close to the cost of providing the service.
- **Capping GP rebates:** In 1999, the Coalition Government sought to cap GP funding through the GP MoU. This sent a strong message to GPs that the Government was not going to address their concerns.
- **Dismissing the Relative Value Study:** During 2001, the Government dismissed its own Relative Value Study which had, over a six-year period, developed strong and clear economic and commercial arguments for a major increase in the Medical Benefits Schedule for GP consultations, indeed most MBS fees.
- **Introducing intrusive remuneration mechanisms:** In 1994, the Government embarked on a series of targeted incentive schemes for GPs rather than increase rebates. As the Productivity Commission has shown, these resulted in a major increase in red tape particularly in recent years (now taking about 8 hours per week for most GPs). These schemes are resented by many doctors as being overly intrusive by Government and failing to provide substantive incentive for patient services.
- **Insisting on unfair student bonding:** The current Government proposal to require 234 prospective medical students to sign a bond to work in areas of need for 6 years after completing all undergraduate and graduate training (about 10 years) before even commencing their studies is further reinforcing the pattern of Government control which is demoralising GPs. These bonding schemes are being proposed despite compelling evidence from US and OECD studies that medical student bonding is not effective.
- **Inappropriate political focus on bulk-billing:** Coalition and ALP proposals to try to use financial pressure to force GPs to bulk bill are doing further damage to GP morale and reducing the incentive for medical graduates to pursue a career as GPs.

The “Fairer Medicare” package fails to address the majority of these issues. The extra dollar per urban service in the package has already been swallowed up by the blowout in indemnity costs.

The AMA is clear on this point—redressing the GP shortage will increase medical benefit expenditure. We contend that the GP shortage is now resulting in quite inappropriate lack of access to primary care services in significant areas. At least one fifth of the Australian population now live in areas of acute GP shortage. If this is not redressed, Australia will pay a higher price in tertiary care down the track. Immediate steps to increase participation in the GP workforce are essential to ensure that the needs and the expectations of the Australian people are met. We need the doctors “on the ground”.

NOT JUST GPs

The medical workforce shortages are not limited to the GP workforce. The Australian Medical Workforce Advisory Committee (AMWAC) has put a great deal of effort into workforce planning since its formation in 1995 and has released nearly 30 reports on individual medical specialties over the period. Shortages and prospective shortages have been identified in many specialties. There are indications, however, of slow progress in some areas due to infrastructure and funding limitations. There remains a clear difficulty in persuading State Governments to fund the needed medical and surgical registrar positions.

Ominously, in its 2001-02 annual report, AMWAC reported that:

“In addition, for the first time, AMWAC has seen a number of physician specialties that have failed to attract sufficient interest from trainees (gastroenterology, geriatric medicine, haematological oncology, medical oncology and thoracic medicine). There is a concern that this is an emerging trend and in turn this further underscores the more general concern about workforce supply.”

In short, there are not enough graduates and others to fill the training places. Therefore, both the Federal and State Governments will need to steer a different policy course if more severe specialist workforce shortages are to be avoided down the track.

Specialist shortages are looming. The Royal Australasian College of Surgeons recently released a report on the surgical workforce in Australia and New Zealand commissioned from Professor Bob Birrell. Birrell concluded that the Australian surgical workforce needed to grow by 50% by the year 2020 to meet:

- demographic change (growth in and ageing of the population which alone creates a need for 36% more surgeons); and
- the real growth in service use prompted by increased affordability and new technology.

The AMA estimates that over and above the \$450m p.a. (\$1.4 billion in total since 1995-96) stripped from GP rebates, a further \$100m p.a. (\$300m in total since 1995-96) has been stripped from specialist rebates by restricting the overall growth of the specialist medical workforce. While the specialist workforce shortage would appear, on the face of it, to be less severe than the GP shortage, there is no room for complacency given the looming extra needs of the ageing population.

WHY WE NEED ACTION NOW

The Government has announced measures to increase both medical school intakes and GP training places, and has indicated that it will stand by these measures even if the Senate seeks to block the “A Fairer Medicare” package. These decisions are sensible, welcome and are supported by the medical profession, although the ill-considered unfunded bonding scheme is a negative.

An international review of the effectiveness of medical workforce measures conducted by the OECD in 2003 found that medical student bonding has not generally proven effective in influencing the distribution of the medical workforce. Another study in the USA in 2003 of its national medical bonded scholarship scheme found bonding students to be ineffective in retaining doctors in areas of need and destructive of morale.

The USA’s national scheme of reimbursing new doctors their university fees (HECS in the Australian context) was found much more effective as graduate doctors were able to make more informed career and location decisions based on their current circumstances rather than as undergraduates.

It is not enough to rev up training. If nothing else is done, the medical workforce shortage will deteriorate further in the meantime. As we have shown above, the GP workforce is now falling. The medical indemnity crisis is having a deleterious effect on both the GP and the specialist workforce. It is essential that the Government take actions with more immediate effect. We cannot afford to wait for 10 years given the pressing health needs of the population.

PARTICIPATION IS THE KEY

Participation is the key to remedying the immediate doctor shortage. Australia needs to tackle head on the reasons why doctors are leaving the workforce, and to implement the policies that will keep them engaged. If we fail to do that, we are simply inviting failure in the strategy of training more doctors. We risk spending a good deal more of the community's money on medical education, and then not reaping the reward.

The AMA is deeply concerned about the potential loss of many highly skilled and experienced senior doctors as a result of the medical indemnity crisis. The IBNR levy is having workforce-sapping repercussions at a time when we can ill afford to be losing this wealth of skill and experience.

The following steps would all have a positive effect on participation:

- the Medicare Benefits Schedule reflect actual costs;
- an increase in patient rebates that allows doctors to discount their charges to the rebate for needier patients;
- indexation of the MBS at a rate based on movements in the costs of medical practice;
- Phasing out of most GP blended payment schemes except direct area of need and rural and remote support payments;
- Major reductions in red tape;
- Support for practice nurses in all areas;
- A patient rebate that enables the GP to supervise and direct a practice nurse in the delivery of specific primary care activities;
- Non VR GPs to receive full GP rebates;
- Government Red Tape Review to analyse processes and barriers faced by overseas trained doctors wishing to practice in Australia;
- Targeted incentive schemes for areas of need and rural and remote practices;
- Retention incentives for GPs aged 55 and over who continue full-time practice;
- Scholarships for medical students in return for service in areas of need and HECS reimbursement arrangements for new doctors;
- Expansion of programs to attract rural students into medicine;
- Elective supervised GP terms for pre-vocational RMOs; and
- Improved IT support.

GEOGRAPHIC IMBALANCES

Australia has had long-standing geographic imbalances in both the GP and specialist workforces. Governments have tried many solutions, the majority of which have been supported by the medical profession. However, there is a hierarchy of problems. The geographic imbalances are much harder to resolve when the overall shortage is so large.

In recent years Federal and State Governments have tried to rely on attracting doctors from overseas to deal with areas of severe shortage. However, even with a rapid expansion of this program it has not met the need for doctors in this country either in total number or in relation to the maldistribution of doctors. The morality of attracting doctors from developing countries is highly questionable—those countries suffer very severe doctor shortages. The

market for overseas trained and temporary resident doctors is hardening as other countries with similar workforce problems provide stronger competition.

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

When it comes to health care, there are none more disadvantaged than Aboriginal and Torres Strait Islander (ATSI) people. Their health status remains appalling. They have much lower life expectancy and higher infant mortality. Age-standardised death rates are approximately three times higher than the rest of the population, with significantly higher rates of death for specific conditions, particularly chronic conditions such as diabetes. The experience of other countries such as Canada, the US and NZ indicates that it is possible to make progress. In the 20 year period between 1974 and 1994, the Maori death rate declined by 45% and the US Indigenous by 35%. Australia has no reliable data for a similar period, however no significant reduction occurred in the death rates for Aboriginal and Torres Strait Islander populations between 1985 and 1995.

It is unacceptable that Australia falls behind the rest of the developed world in making progress in this area. Therefore, as argued by the AMA's Score Card on Expenditures on Aboriginal and Torres Strait Islander Health, despite recent significant increases in spending in the area, the AMA calculates that to achieve equitable funding for Aboriginal and Torres Strait Islander health the government needs to spend at least a further \$250 million per annum. Below are some of the main areas the AMA believes these funds should be focused.

1. The **Primary Health Care Access Program** needs to be funded on a national basis;
2. A **National Training Plan** needs to be financed to produce the health and administrative personnel required to provide a high quality, accessible service. This Plan must include strategies to increase representation of Aboriginal and Torres Strait Islander people in all staff groups. The minimum increase is 3,200.
3. The AMA calls on the government to increase funding to ATSI-ACSIS for **Health Service Infrastructure**. It is unacceptable that many communities still lack functional amenities.

PUBLIC HEALTH

- **HEPATITIS C**

In the last budget Hepatitis C gets \$15 million over four years, a seemingly paltry increase on the \$12 million for the prior four years against the recent and prospective growth in the dimensions of the problem. Failure to act now on the issue has the capacity to cripple the health system in coming years if resources are not urgently allocated into both prevention and treatment programs. Doctors, patients and carers need the latest information if the Hepatitis C problem is to be contained.

Substantial increases are required for the prevention of hepatitis C, given that there has been a 45% increase in new infections in the past four years, leading to 16,000 new infections per year. With 250,000 Australians infected with the virus, which is often chronic and affects quality of life, it is also imperative that we improve access to treatment, care and support for people with hepatitis C. The AMA calls on the government to undertake a full economic analysis of the cost of hepatitis C to the Australian community and the cost of effective interventions and agree to fully fund the recommendations.

- **TOBACCO CONTROL**

Given the huge burden of disease caused by tobacco use, governments should ensure that treatment of tobacco dependency is a condition of funding for community health centres, family planning clinics, health services for Aboriginal and Torres Strait Islander peoples, maternity care services, psychiatric disability services and health services provided in correctional facilities. This should include provision of nicotine replacement products for patients at a subsidised rate.

Smoking cessation has the potential to reduce hospital readmission and lifetime use of health services therefore all hospital in-patients who smoke should also be offered treatment and referred to relevant services. The NSW Health model guidelines for all health services could provide the basis for such a system.

These measures will necessitate a significant increase in federal funding for such services as there will be an additional burden on state Quit campaigns to provide training to health professionals working in these services, and to ensure that Quitline services can accommodate those referred.

Current funding levels for tobacco control are very low. According to the VicHealth Centre for Tobacco Control the total federal expenditure on tobacco control in 2002-2003 was \$3.64m. Tobacco use is the number one cause of preventable illness, death and hospitalisation in Australia and therefore a well funded concerted national effort to improve use of cessation services could be expected to substantially reduce smoking prevalence - with consequential reductions in medical, hospital, pharmaceutical and nursing home costs in Australia. The AMA believes that an increased expenditure of \$45 million over the next three years is required.

- **IMMUNISATION**

The AMA notes with approval that the rate of full immunisation of Australian children (according to the previous NHMRC recommended Australian Standard Vaccination Schedule) rose from 53% in 1995 to 90% in 2002. All vaccines on the recommended childhood schedule were funded by Government and available at no charge to parents. The Australian Government's commitment to high vaccination coverage was seen in the financial incentives of the Maternity Immunisation Allowance and the Child Care Benefit Allowance.

The recently approved NHMRC recommended Australian Standard Vaccination Schedule (approved September 2003) includes childhood vaccinations (pneumococcal and varicella) that are not funded by the Australian Government for all children. Parents whose children are not in one of the identified high risk groups, and who wish to have their children fully immunised, will need to pay directly for pneumococcal and varicella vaccines. There is concern that this cost will cause a lower rate of fully immunised children which will cause personal and fiscal health costs to the community.

The AMA strongly urges the Government to provide all ASVS childhood vaccinations free of charge to all Australian children. The cost (\$113 million pa) would be offset by reduced morbidity and mortality in children, in lost work days by parents and other carers and by reducing the load of infection in group settings such as child care centres.

At the very minimum the Government should extend the high risk group of children for whom free immunisations are available to include all under two year olds attending group child care centres.

PHARMACEUTICAL BENEFITS SCHEME (PBS)

The AMA has a range of concerns about the Government's proposals to increase PBS copayments by the order of 29%. By international standards, Australia is not a big spender on pharmaceuticals. Indeed, higher PBS costs may save overall health care costs through effective and early treatment.

The PBS has been one of the keys to Australia's success in delivering a very high quality health care system at moderate cost (many other OECD countries spend more than Australia's 9.3% of GDP on health care with less to show for it). While agreeing that PBS expenditure cannot continue growing indefinitely at 10% p.a. in nominal terms, the AMA supports the principles of the PBS to provide universal access to medicines for the public in an effective, efficient and equitable manner. But it is not convinced that Australia has "hit the wall" requiring savage budget measures.

From our perspective as the peak body representing the entire medical profession in Australia, the AMA regards the PBS as being:

- a cost-effective way of treating and preventing illness; and
- particularly effective in containing the costs of chronic diseases, dementia and psychiatric illness.

Last year's *Intergenerational Report* ignored future revenue streams, and had some highly contestable underlying assumptions, including that people in the paid (and thus tax paying) workforce will continue the trend of the 1980s and 1990s to early retirement, when in fact it seems that that trend has already started to plateau, with major employers including government reversing their previous policies which encouraged early retirement.

The AMA contends that there are a number of other strategies which merit serious consideration. These include:

- the role of generic pharmaceuticals;
- prescriber support through electronic software and decision support and other means;
- improved Medication Review programs and dispensing arrangements;
- consumer education; and
- the scope to improve the targeting of PBS subsidies by introducing more steps into the current crude concessional/non concessional access (poverty traps are severe for those who just miss out on concessional access).

The Government must work with stakeholders and the Australian community to find effective interventions that will maintain the integrity of the PBS (and its very significant health benefits) while managing the costs in an appropriate way. As part of this, data from the PBS and pharmaceutical research should also be made available to measure the quality use of medicines, and the contribution of pharmaceuticals to health outcomes.

PRIVATE HEALTH INSURANCE

The AMA considers that the 30% private health insurance rebate is an effective policy that encourages a very significant number of Australians to accept some financial responsibility for their own health care. As policy it represents excellent value for money to the tax-payer. Were it not for this policy, the pressure on public hospitals would be unbearable. The AMA urges the Government to be steadfast in its course in this area.

Private hospital separations have increased by 35.3% between 1997-98 and 2001-02 (from 1.79 million separations to 2.43 million) while public hospital separations have risen by 5.2% over the same period (from 3.77 million to 3.97).

The abolition of the 2nd tier default benefit for private hospitals will seriously disrupt the private hospital sector at a time when it has been expanding rapidly to cope with the increased demand generated by higher private health insurance participation. This has benefited the public hospitals considerably. Abolition of the 2nd tier default benefit will reduce the number of private beds in the long run and drive up prices, premiums and therefore expenditure on the rebate. The Government needs to reverse this decision to provide certainty and stability and to minimise its own expenditures.

PUBLIC HOSPITALS

The AMA has long had scant regard for the political games played around public hospitals. It therefore views favourably the new policy of requiring States to match the growth in Federal spending under the AHCA's in order to receive the maximum grants. Anything that reduces the cost and blame-shifting is welcome.

The AMA urges the Federal Government to rapidly progress the Commonwealth/State reform agenda identified in the Australian Health Care Agreements in the areas of the interface between hospitals and primary and aged care services, continuity between primary, community, acute, sub-acute, transition and aged care and a national system of pharmaceuticals. These matters have the potential to raise the level of care available to Australians without the need for major increases in funding. The Commonwealth must show the lead.

The AMA urges the Commonwealth, State and Territory Governments to commence research into the causes and contributing factors towards public hospital access block and emergency department overcrowding.

The AMA is very hopeful that all Australian governments will now commit to and implement the reform agenda which they have previously agreed to in principle, and which is vital if Australia's health system is to remain world class.

The AMA urges governments to co-operate on:

- improving the interface between hospitals and primary and aged care services;
- steps to improve the continuum of care for older Australians between aged care, health care, and rehabilitative care; and
- the implementation of a national pharmaceutical expenditure program during the life of the current AHCA's.

AGED CARE

Quality care for older Australians depends on the effective integration of medical, nursing, allied health, acute, rehabilitation, residential, community, and other care. Currently, health care is not effectively integrated with other aged care services.

The current situation of ineffective integration leaves consumers at a loss in moving purposefully through the system and results in unnecessary duplication and piecemeal health and aged care.

As a society, we need to develop and implement strategies to improve the continuity of care

across programs and to address any cost-shifting measures that impede quality care. The role of doctors in the health and aged care environments, and specifically the aged care/acute care/health care interface, is integral.

However, there are major disincentives which make it difficult for doctors and other health care professionals to work in the aged care sector.

These disincentives include an inequitable fee structure for doctors, inequitable wages for nurses and other care staff, the large number of non-face-to-face administrative tasks and red tape expected of GPs and care staff, the lack of integration of medical services in the aged care system, and the absence in many residential facilities of consultation rooms with adequate treatment facilities and plug-in computer facilities that would facilitate access to patient records.

The Government must urgently address the funding, staffing and visit facility issues surrounding the provision of high quality medical care in residential aged care facilities.

Specifically, the Government must urgently revise the Medicare Benefits Schedule to provide appropriate incentives for doctors to provide medical services to residents of residential aged care facilities (RACFs), recognise the complex care needs of residents and work with the sector on developing an environment which will encourage skilled workers back into the aged care sector.

DEMENTIA

The AMA calls on the Government to recognise dementia as a National Health Priority area, and to allocate \$100 million over 3 years to enable research into dementia issues and the development of strategies to address the dementia epidemic.

VETERANS' MEDICAL SERVICES

The capacity of specialist medical practitioners to continue to deliver the Government's promise to veterans by participation in the Repatriation Private Patient Scheme (RPPS) has come under significant pressure.

These pressures include the increasing age and complex health needs of veterans, the increase in the numbers of "gold card" holders, the shift of veterans' medical care from public to private hospitals and the failure of the CMBS to keep pace with the rising costs of medical practice, including the escalating cost of medical indemnity.

Hundreds of medical specialists have withdrawn from the RPPS in the past year and many more specialists have closed their books to new veteran patients. As a consequence the RPPS is becoming progressively non-viable, particularly in rural and regional areas.

\$95 million in additional funding for specialist medical fees would enable the medical profession to continue its participation in RPPS and ensure the Government's promise to veterans of private medical care remains fulfilled.

Some of this \$95 million could be found through the refocussing of benefit eligibility criteria and the improved targeting of compensation and income support payments to ensure that the original and primary intent of Australia's repatriation scheme, to recognise the war service of veterans, is retained.

—oOo—