



Opening the gate to healthy scepticism

The objectives of medical policymakers are not always focused on the patient, writes **Jim Butler**.

In the past five years there has been considerable discussion and policy ferment about medical workforce issues and the Medicare Benefits Schedule.

The main policy discussion has involved three possibilities for achieving greater flexibility, and less duplication, in the performance of tasks: task delegation (for example, administration of vaccines in general practice by practice nurses under the direction of GPs); task substitution (the extent to which professional groups other than medical practitioners will be subsidised directly by having their own items on the MBS); and, if other professional groups are given direct access to MBS subsidies, gatekeeping issues (whether a referral by a GP or specialist to other professionals should be required for the services of the other professionals to qualify for an MBS subsidy).

A difficulty for policymakers in this arena is deciding whether, and to what extent, existing rules and regulations governing the performance of tasks by different professional groups are primarily protecting the economic interests of those groups, as opposed to protecting consumers of health services. Undoubtedly, certification requirements and the demarcation of tasks in health protect particular groups from competition. But, like certification plates on new cars, they can also protect people from receiving poor quality products.

Consider the demarcation between the radiographer and the radiologist. Can radiographers read images to the same standard of diagnostic accuracy as radiologists? If they can, considerable cost savings could be reaped from allowing them to do so. Evidence on comparative diagnostic accuracy is needed to resolve this issue, but another question also arises: would

people accept having the reports on their images prepared by

radiographers? The message here is "proceed with caution".

Not surprisingly, some professional groups in the health sector are supportive of proposals to include their members' services directly on the MBS, preferably without gatekeeping constraints. Assurances by such groups that the quality of their services is as good as that provided by their medically qualified competitors need to be thoroughly vetted before they are embraced by the MBS as being "equal but cheaper".

Weakening the gatekeeper role of doctors also needs to be approached with caution. To be sure, for people who are referred by their GP for specialist services, the gatekeeper requirement adds the cost of a GP consultation to their overall cost of treatment. But it may also reduce the number of specialist consultations demanded by others.

GP survey data from the Bettering the Evaluation And Care of Health study in Australia for 2006-07 showed that, on average, out of every 100 encounters with a GP, 12.2 referrals for other services were given. Of these 12.2 referrals, 8.0 were to specialists and 3.1 were to allied health services. How many of the patients at these 100 encounters would have leap-frogged their GP and proceeded directly to see a specialist in the absence of the gatekeeper requirement? One suspects quite a few more.

And with specialist consultations attracting higher MBS rebates than those of GPs, these additional costs would need to be offset against the cost savings generated by removing the GP gatekeeper requirement.

While it is true that some health systems do, and some do not, have

gatekeeper provisions, there does not seem to be any movement in those that do to dismantle them. And in the US, where the gatekeeper role has been conspicuously absent, managed care organisations not uncommonly define such a role within their organisations.

The foregoing arguments suggest that task substitution and weakening gatekeeper provisions are policies that need to be considered carefully even from a narrow focus of comparative professional competencies and

balance sheet effects for any given quantity of services.

But there is an additional reason for concern where either substitute services and/or additional services not previously available are admitted to the MBS – the subsidies themselves may lead to a considerable expansion in the demand for services with

consequent fiscal implications for the national health insurance scheme in Australia.

An interesting example is the recent addition of services provided by psychologists for a range of mental illnesses to the MBS schedule. Included on the MBS since November 1, 2006, the five-year budget for Medicare funding of these services (with other MBS revisions for GPs and psychiatrists) was \$538 million. After only six months, it was clear that demand for the services of psychologists had well exceeded expectations and that the budget was inadequate.

A report from the Mental Health Council of Australia in July 2007 suggested that almost double the budgeted amount would be needed if the demand for services seen in May 2007 were maintained.

More recent data show the demand for services has increased substantially since May 2007 – and this with a gatekeeper provision in place (patients must obtain a referral from their GP to access MBS rebates for the new psychology items). Such is the demand for services that bulk-billing rates by psychologists to the end of 2007 were only about 25 per cent compared with 75 per cent to 80 per cent for GPs.

A broader perspective raises questions about the consistency of government policy that subsidises private health insurance premiums on the one hand (the 30 per cent rebate) but then introduces subsidies through the MBS for the same allied health services covered by private health insurance. A side-effect of the second policy may well be to discourage the purchase of general treatment insurance (what used to be called ancillaries cover) from private health insurers.

These policies do not appear to be consistent – unless, of course, the government has some longer term objective of removing the 30 per cent rebate for private health insurance.



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The delegation of tasks, such as having nurses give vaccines for GPs, has been on the discussion list.

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