REVIEW OF NATIONAL COMPETITION POLICY REFORMS

SUBMISSION TO THE PRODUCTIVITY COMMISSION

BY THE

Australian Medical Association

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

- *The Commission's draft report (issued in October 2004) argues that the two highest priority areas for further competition-related reforms are health and natural resource management. The Commission continues to push for a broad-ranging independent review of Australia's health system in achieving cooperative system reform to deep-seated structural problems.*

- *The AMA views some of the arguments offered in the Productivity Commission's health system analysis as superficial. The implication is that the Australian health system is highly inefficient. By any international comparison, the Australian health system is performing very well, generating a large number of high quality health services at a relatively modest share of GDP. It is certainly the case that Australian governments have failed to look after vulnerable groups (Aboriginal and Torres Strait Islander peoples experience appalling health outcomes) and that, more generally, governments have failed to understand the growing health wants and needs of an aging population, stumbling with inadequate recurrent funding, inadequate infrastructure and poor workforce planning. It does not follow that these failings can be remedied by competition-related reform of health service provision. Of course, there is scope to improve the functioning of the health system through competition-related reform. However, it is no be-all and end-all.*

- *The report acknowledges that some parts of the health sector show signs of healthy competition (medicine), while in other areas (notably pharmacy) the prime barriers to competition-related reforms are the arrangements maintained by government. In relation to the health sector, two excellent places to start would be to remove the pharmacy exemptions from NCP and to continue to wind back the regulation of private health insurance.*

- *The AMA has no expectation of any useful outcomes from some of the health system reform proposals mentioned, but not endorsed, in the draft report. For example, Scotton's budget-holding proposals presume that governments have the capacity to make very fundamental resource allocation decisions. Their track records are littered with errors and the decisions they take pay excessive regard to the needs of funders rather than the needs of patients. Similarly, area health authorities turned out to be a wasted opportunity in Australia. They have attracted all the high transaction and administrative costs without permitting any of the supply to become contestable. In short, all of the cons and none of the pros.*

- *Commonwealth/State arrangements would benefit from an overhaul. Since COAG has struggled to achieve any meaningful inter-government cooperation, a more realistic objective may be a clearer separation of roles and responsibilities so that governments are made accountable for their actions and less able to play their cost and blame shifting games. The resistance to change, however, is no simple large system inertia. The AMA has no*

expectation of a major reallocation of responsibilities between the Federal and State levels of Government.

- *Hence, the AMA sees more potential in incremental reforms. Small steps are better than none at all. The body of this submission canvasses some small steps where there is a realistic chance of making some progress. As noted above, Australia's health system performs very well on cost and quality compared with the systems in many other comparable economies. This is due, in part, to the role of the GP as the gate-keeper. Reforms which strengthen the role of the GP as gate-keeper and comprehend the importance of the central role that GPs play in the system are worthy of consideration.*

- *Many of the reform proposals involve building even bigger bureaucratic structures (for example, the Health Reform Alliance proposals for a national Health Commission or the Menadue variation of a Federal/State commission in each state). In common with the budget-holding proposals, these schemes seek to largely remove the patient from the decision-making process. In the context of a community with ever higher levels of educational attainment and real incomes, the proposal that we solve the problems by giving patients even less say than they have now is completely bizarre, unworkable and unsaleable. Market-based reforms are much more likely to improve the working of the health sector than bureaucratic solutions.*

- *The competition policy mantra is that anti-competitive behaviour is bad, impairs productivity and reduces living standards while competition fosters efficiency. The medical profession has a long and worthy tradition that scientific advances are shared with all, eg through refereed articles in professional journals. This has huge benefit to patients, for example, saving many lives when adverse side effects are discovered in treatments previously viewed as safe, and ensuring that the intellectual capital from new discoveries is spread quickly and as widely as possible. The approach of the medical profession sits in stark contrast with that of the pharmaceutical manufacturers who would argue that their industry depends upon their ability to use patent laws to ensure they benefit from their research. Given the high cost of developing new drugs, a measure of patent protection makes sense for the viability of pharmacy. It does not follow that the same regime would make sense for the practice of medicine.* ***Before doing anything, the Government needs to be certain that the further application of NCP to health (and the medical profession) must not impair cooperative activity****. For medical professionals, this is a very deep ethical issue. If scientific advances are not shared in a cooperative framework, the inevitable outcome is needless loss of life.*

- *The provision of private medical services is a highly competitive activity. The average size of a GP practice is 3 GPs while many specialists operate solo practices. The associateship model is gaining ground over the partnership model. The associateship model generates the scale efficiencies of larger practices (through the shared use of resources) but the associates each have their own business and continue to compete with each other.*

- *Medical practice has not gone the way of the big 6 legal and accounting firms where a small number of very large (sometimes transnational) firms seek to dominate. In private medical practice, the areas that most lend themselves to corporate activity are pathology and diagnostic imaging (due to the high capital expenditure requirements). For most other areas of medical practice, the big corporate model is not the "natural" model and is only likely to emerge if purchasers are given excessive power over providers, thus creating the incentive for providers to incorporate and bulk up to gain countervailing market power.*

- *There has been some corporate activity in general practice. The business strategies are, however, very diverse and it is difficult to make any generalised comments about the implications for competition. Some corporate GP players seek to be efficient facility providers and managers, and will sell a complete suite of services to GP associates (spanning the facility, staff and other business services). Other corporate GP players have wider aims, such as seeking to capture referrals for investigations to assist a parent corporation. The AMA does not perceive any urgent concerns in this area. Developments do need to be monitored and understood for what they are.*

- *In the short term, the Federal Government has a golden opportunity to show that it is serious about NCP when it negotiates the next community pharmacy agreement. The contrast between general practice and pharmacy points very starkly to the need for some new thinking.*

1: "BIG BANG" OR INCREMENTAL REFORM?

1.0.1 In this section we discuss the case for a broad-ranging independent review of Australia's health system and the implied "big bang" changes that might result, as opposed to incremental reforms.

1.0.2 The Commission's draft report (issued in October 2004) argues that the two highest priority areas for further competition-related reforms are health and natural resource management. For many years, the Commission (and its predecessor bodies) has favoured a comprehensive review of Australia's health system. For example, the 1997 Industry Commission report on Private Health Insurance recommended:

> *"a broad public inquiry into Australia's health system. Such an inquiry should encompass:*
>
> - *health financing, including state/federal cost shifting incentives;*
> - *integrated health systems and coordinated care (including assessment of the role of private insurers);*
> - *the role of copayments;*
> - *competitive neutrality between players in the system (for example between public and private providers, between untaxed not-for-profit private hospitals and taxed private hospitals, and taxed and untaxed health insurance funds);*
> - *market power exerted by players in the system, including supply constraints in the medical market;*
> - *community rating, including assessment of pre-existing ailment rules;*
> - *information management in health care (such as transferable patient records and use of information in quality assurance); and*
> - *progress of protocol development.*
>
> *In the event that such a broad strategic inquiry is considered unmanageable, a number of specific inquiries could be undertaken, focussing on themes such as financing issues, quality of health care, and competitive neutrality."*

1.0.3 Seven years later, we wonder just how much these recommendations need to change. A likely inclusion would be a reference to intergenerational pressures. These were certainly emerging during the 1990s but were not in sharp focus. A 1994 EPAC report, ***Australia's Ageing Society***, took an optimistic view that the "ageing problem" was manageable. The 1996 National Commission of Audit report was less optimistic. The first ***Intergenerational Report*** (2002) broke some new ground in articulating the importance of ageing on health costs and moved the debate into a much more comprehensive framework whereas much of the earlier work reflected a narrow preoccupation with retirement incomes.

1.1 Is the health system moribund?

1.1.1 Major, broad-ranging reviews of policy are undertaken with a view to major reform. The impetus for broad-ranging reviews and major reforms come from systems that are moribund. If Governments are not prepared to contemplate major reform for whatever reason, any major review would absorb significant resources for no useful outcome. The thrust of the Commission's draft report is that there are deep-seated structural problems in the health sector and that competition-related reform will go a long way to resolving these.

1.1.2 The AMA considers some of the links made in the draft report between problems in the system and the need for competition-related reform to be tenuous, if not spurious. There

are problems in the delivery and financing of health care and not all parts of the health system are models of economic efficiency. However, by any international comparison, the Australian health system is performing very well, generating a large number of high quality health services at a relatively modest share of GDP. Through the MBS alone, more than 226 million medical services were provided to Australians in 2003-04 at an average charge of $48.57 per service. It is difficult to make any persuasive argument that the Australian health system is moribund, but the room for improvement is apparent.

1.1.3 It is certainly the case that Australian governments have:

- failed to look after vulnerable groups (Aboriginal and Torres Strait Islander peoples experience appalling health outcomes); and
- failed to understand the growing health wants and needs of an aging population, stumbling with inadequate recurrent funding, inadequate infrastructure and poor workforce planning.

1.1.4 It does not follow that these failings can be remedied by competition-related reform of health service provision. Nor does it follow that Governments will allow real competition in health when that clearly involves the operation of price and price signals. Price signals do not win votes and less desirable and less effective managed competition options have more attraction when viewed through the narrow political prism. Of course, there is scope to improve the functioning of the health system through competition-related reform. However, it is no be-all and end-all. There are wider grounds for change and broader objectives. Quality improvement is every bit as important as efficiency gains.

1.1.5 The report acknowledges that some parts of the health sector show signs of healthy competition. Private medical practice is a case in point. There are some issues in relation to the medical workforce, but it is absurd to suggest that the medical profession is to blame for every skill shortage or maldistribution. Responsibility for training is shared with government and likewise the responsibility for any shortcomings is also shared between governments and the profession. Finger-pointing is a poor substitute for cooperative action to resolve the issues.

1.1.6 In other areas (notably retail pharmacy) the prime barriers to competition-related reforms are the arrangements maintained by government. These are explored further in section 5.

1.2 Directions for health care reform

1.2.1 Box 10.11 in the draft report discusses possible directions for health care reform without specifically endorsing any of them. The AMA has no expectation of any useful outcomes from some of the proposals mentioned. For example, Scotton's budget-holding proposals presume that governments have the capacity to make very fundamental resource allocation decisions. Arguably, the proposal boils down to some limited competition grafted onto the back of a command economy model. The command economy model does not work very well. The track records of governments in resource allocation decisions are poor. In the post election environment, they quickly reduce to crude rationing schemes with a big dose of provider control. The decision-making framework inevitably places a strong focus on Budget outcomes and not enough consideration is given to the needs of patients.

1.2.2 Similarly, thus far area health authorities turned out to be a wasted opportunity in Australia. They have attracted all the high transaction and administrative costs without permitting any of the supply to become genuinely contestable. Prices paid and resources allocated are dictated. The end-result is a sort of mismanaged non-competition. The

creation of area health authorities has exposed the public health system to transaction costs it once avoided without gaining the benefits of genuine competition.

1.2.3 Other participants in the debate argue that all sources of funding should be pooled. Exactly what this achieves is unclear, since once the funds are pooled they have to be allocated (unpooled) to meet various needs. The bureaucratic structures will struggle desperately to make sensible decisions on the allocation of pooled funds in the absence of market signals.

1.2.4 A number of the so-called reform proposals involve building even grander bureaucratic structures (for example, the Health Reform Alliance proposals for a national Health Commission or the Menadue variation of a Federal/State commission in each state). The Health Reform Alliance proposals are not, of course, designed to enhance competition in the health sector. But they do have a common thread with the budget-holding proposals mentioned in the draft report—these schemes seek to largely remove the patient from the decision-making process. They rely on proxy-buyers and non-market rationing of access to services. In the context of a community with ever higher levels of educational attainment and real incomes, the idea that we solve the problems by giving patients even less say than they have now is, in our view, completely bizarre, unworkable and unsaleable. When we turn over the stones, we find that the motivation for many of these proposals is control of the system, control of the money and new opportunities to shift costs. We see two queues, a very long queue of people who want to control the money and how it is spent, and a very short queue of people who want to be accountable for the outcomes.

1.3 Federal/State issues

1.3.1 There are many in the community who would agree that Commonwealth/State arrangements would benefit from an overhaul. This ranks as one of the areas with the greatest potential to benefit from "big bang" reform. Since COAG has failed most miserably to achieve any meaningful inter-government cooperation, the best way ahead may be a clearer separation of roles and responsibilities so that governments are made accountable for their actions and less able to play their cost and blame shifting games. The resistance to change, however, is no simple large system inertia. The current system allows both levels of government to avoid accountability and that appeals strongly to politicians of all persuasions. ***The AMA has no expectation of a major reallocation of responsibilities between the Federal and State levels of Government***.

1.3.2 The matters requiring alteration to Commonwealth/State responsibilities have been identified for more than 10 years and very little progress has been made in affecting change. There is insufficient political will to make the changes and it is foolish to think that at some future point there will be.

1.4 Radical or incremental reform?

1.4.1 To sum up, the AMA can see no prospect of radical reform in the Commonwealth/ State area and little or no potential in the other reform proposals which are on the table. The evidence suggests that government timidity rules out more extensive market-based reforms (making supply markets truly contestable, taking genuine steps to ensure competitive neutrality). Hence, the AMA sees more potential in incremental reforms. ***Small steps are better than no steps at all***.

1.4.2 As noted in paragraph 1.1.2, Australia's health system performs very well on cost and quality compared with the systems in many other comparable economies. This is due, in part, to the role of the GP as the gate-keeper to the other parts of the health system and

the counsellor to the patient. It is often argued at the theoretical level that health markets are characterised by imbalance of information between patients and providers. GPs can make a very material contribution to the quality of choices made by patients. In terms of incremental changes which are realistically achievable, measures which strengthen the role of the GP as gate-keeper and comprehend the importance of the central role that GPs play in the health system should be the primary consideration.

1.4.3 Turning to reforms that are more strongly competition-related, two excellent places to start would be to remove the retail pharmacy exemptions from NCP (see section 5) and to continue to wind back the regulation of private health insurance (see following).

1.5 Private health insurance

1.5.1 The way we finance health care is a matter of national choice. Australians have never chosen to pay the taxes that would be necessary for health care to be funded fully through the tax system. Taxpayer funding of all health service expenditure has hovered around 70% for many years. The appetite of taxpayers for higher taxation appears to be waning. Therefore, private health insurance is here to stay. The role it will play in health financing is more likely to increase, rather than decrease, as the cost burdens of health care for an ageing population mount and intergenerational inequities increase. Therefore, it will become an imperative that the functioning of the private health insurance system be improved.

1.5.2 The private health insurance industry would itself benefit if there were more competition between insurers. Private health insurance has suffered from an almost pathological over-regulation. In recent years, there have been some moves to reduce the regulation. There is potential to take that process further. The emphasis in the past has been on regulating what private funds can and cannot do. The cost of compliance with this regulation is significant. Health insurance is a complex product, and the efficiency of the insurance market has been dogged by poor patient/contributor knowledge. The emphasis in regulatory efforts needs to switch from regulating what the funds can offer to regulating the information they provide to patients/contributors. An informed market, built on high quality accessible information, is much more likely to be an efficient market than a poorly informed market. It follows that measures to improve the flow of information to consumers should be accompanied by measures to ensure genuine portability between funds. A reduction in the volume of regulation will help make private health insurance markets more open to being contested by new players.

1.5.3 The Federal Government needs to deregulate private health insurance in the following areas:

- Removal of government power to approve or vary premium increases;
- Simplification of contractual arrangements between funds and providers;
- Survey existing and possible future health funds to establish critical deregulation measures which would encourage market entry;
- Improved portability arrangements between funds; and
- Greater competitive neutrality in health financing.

2: SUSTAINING COOPERATIVE ACTIONS

2.0.1 The competition policy mantra is that anti-competitive behaviour is bad, impairs productivity and reduces living standards. Conversely, competition improves productivity and fosters efficiency. There is some risk, however, that policy makers may confuse anti-competitive actions with cooperative actions.

2.0.2 The medical profession has a long and worthy tradition that scientific advances are shared with all. This sharing of information occurs on many levels, to name a few:

- collegiate working arrangements including opportunities to work overseas to study new treatments and procedures *in situ*;
- scientific conferences; and
- refereed articles in professional journals.

2.0.3 The end result is that intellectual capital from new discoveries is socialised, spread quickly and as widely as possible. The sharing of information has huge benefit to patients. For example, the discovery of adverse side effects from treatments previously viewed as safe will result in new protocols to reduce the risks. This can save many lives.

2.0.4 The cooperative activities of the medical profession sit in stark contrast with that of the competitive behaviour seen in many other sectors as well as other parts of the health sector. As a rule of thumb, those who generate new intellectual capital will do all that they can to protect their discovery with patents and other measures so as to benefit financially from it. Pharmaceutical manufacturers would argue that their industry depends upon their ability to use patient laws to ensure they can recover the high costs of their research and product development. Given the high cost of developing new drugs, a measure of patient protection make sense for the viability of pharmacy. The medical profession would not seek to impose its cooperative approach on the pharmacy manufacturers. Equally, it does not wish to see an end to the cooperation between doctors because that would make no sense at all for the practice of medicine.

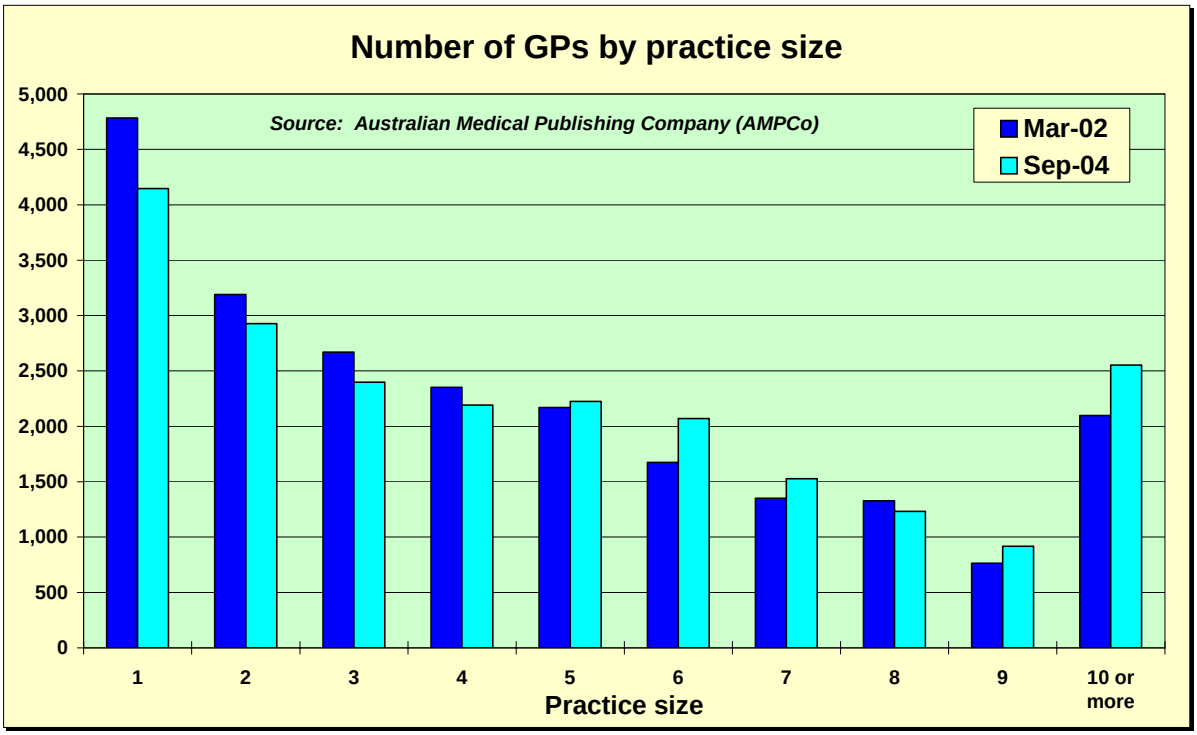
2.0.5 Therefore, before doing anything, the Government needs to be certain that the application of NCP to the medical profession will not impair cooperative activity. ***This is a very deep ethical issue for the medical profession. If scientific advances in the practice of medicine are not shared freely in a cooperative framework, the inevitable outcome is needless loss of life and impairment of health outcomes.***

3: PRIVATE MEDICAL PRACTICE

3.0.1 The provision of private medical services is a highly competitive activity. Private medical practice is characterised by a very large number of providers.

3.1 General Practice

3.1.1 The average size of a GP practice is 3 GPs. Practice size has been increasing over time, with a reduction in the number of practices with one to four doctors. The evidence suggests that there is potential for scale efficiencies up to about 6 to 8 doctors, but after that the outcomes are uncertain. In some geographical areas, population density is so low that there is never any prospect of 6 to 8 doctor practices. Therefore, it needs to be understood that the provision of primary care services in these areas will cost more than in densely populated urban areas.



3.1.2 General practice is highly competitive. GP workforce issues are addressed further in section 4.1.

3.2 Partner or Associate?

3.2.1 For GPs in particular (but for other specialties also), there is a choice to be made between being a partner in a GP practice or an associate. A partnership is a single business unit. Associates each have and operate their own solo practice but purchase business services from a common provider which may be an independent corporate facility provider, a GP owner-operator or a jointly owned medical service company. The associateship model generates the scale efficiencies of a large practice without some of the legal complications of a partnership (for example, fraud or malpractice by one of the partners may have consequences for the other partners). ***Associates continue to compete with each other even though they are accessing shared resources.*** They can also cooperate (as can

partners) to provide a better service to patients (for example, providing cover for others on leave or after hours). Evidence from the field is the associateship model is gaining ground over the partnership model.

3.3 Surgeons and consultant physicians

3.3.1 For surgeons and consultant physicians, solo practice probably remains the predominant business structure. For example, a survey of ophthalmologists (in press) indicates that there are more operating a solo practice than there are as partners or associates in a group practice. That said, the sharing of rooms with other specialists (not necessarily of the same sub-speciality) is quite commonly undertaken to keep practice costs low and this can be done formally (through a group practice) or informally.

3.3.2 Private medical specialist practice is also a highly competitive activity. Private medical specialists typically compete not only for private patients but also for VMO contracts in public hospitals. In this latter role, they also compete against salaried staff specialists (although the latter tend to be protected by their staff permanency).

3.3.3 The prime focus for competition among specialists is quality rather than price. This reflects the expected market response to patient wants and needs. A patient having a major operation considers a good outcome above all else. The quality of the procedure and the after-care is of paramount importance. Workforce issues are addressed further in section 4.2.

3.4 Pathology and Diagnostic Imaging

3.4.1 In private medical practice, the areas that most lend themselves to large-scale corporate activity are pathology and diagnostic imaging (due to the high capital expenditure requirements). This is the only area of private medical practice which has evolved along the lines of the “big n” model common in legal practice and accounting. Australia has some very large corporate players in these areas (a number of them listed on the stock exchange).

3.4.2 Competition between these corporations is vibrant.

3.5 Corporatisation

3.5.1 In the legal and accounting professions, there has been a substantial concentration of activity with a small number of very large (sometimes transprofessional, sometimes transnational) firms. We refer to this as the “big n” syndrome. These firms have expanded their fields of work beyond the old bounds of the professions to include a very wide range of business consultancy services.

3.5.2 With the exception of pathology and diagnostic imaging, the “big n” syndrome has not emerged as the predominant business structure for private medical practice. We suspect that the “big n” model is not the natural model because private medical practices are providing personal, not corporate, services and the services provided by medical professionals are more highly differentiated.

3.5.3 We cannot say, however, that the corporate model will not make more inroads. If purchasers are given excessive power over providers, this would certainly provide an incentive for providers to incorporate and bulk up to gain countervailing market power.

3.5.4 There has been some corporate activity in general practice although it is more often along the lines of providing a facility and less often along the lines of providing a full primary

care service. The business strategies are, however, very diverse and it is difficult to make any generalised comments about the implications for competition. It is clear that the prime strategy of some corporate players is to be efficient facility providers and managers. These corporations will sell a complete suite of services to GP associates (spanning the facility, staff and other business services). Other corporate players have wider aims, such as seeking to capture referrals for investigations (pathology and/or diagnostic imaging) to improve the market share of a parent corporation.

3.5.5 The growth in corporate general practice appears to have peaked now following a period of growth in the late nineties.

3.5.6 There is a broad and normal distribution of medical charges in each specialty reflecting a healthy state of competition amongst doctors. The situation is somewhat different for the relatively small number of privately insured inpatient medical services (< 20 million out of > 220 million services) for reasons mainly to do with the activities of the private health insurers.

3.6 Conclusions re private medical practice

3.6.1 The AMA does not perceive any current or future developments which require further competition reform in private medical practice. Developments do need to be understood for what they are and they need to be monitored. Private medical practice is, by and large, efficient and competitive.

4: MEDICAL WORKFORCE

4.0.1 Australia has no proud record of medical workforce planning. Instead, there is a long history of overshooting in both directions—first too many—then too few. Workforce issues were typically crisis-driven and managed within the context of infrequent public inquiries which in turn, were in all directions. The following points summarise three major reports of the 1970 and 1980s:

- 1971: the ***Karmel Inquiry***[1] recommended a large expansion of medical education;
- 1980: the ***Jamieson Committee***[2] (with a brief focussed on public hospitals) made no fewer than 14 proposals on workforce and personnel practice issues including recommending a reduction in medical school intakes and specialist vocational training places; and
- 1988: the ***Doherty Report***[3] made a host of recommendations, including tightening access of overseas trained doctors, but ultimately sat on the fence on the question of too many or too few doctors.

4.0.2 One important recommendation of the Doherty Report was the creation of a Medical Workforce Review Committee to analyse data and review workforce issues. This resulted in the formation of the Australian Medical Workforce Advisory Committee (AMWAC) in the mid-1990s. Since the creation of AMWAC and the invaluable supporting work by the Australian Institute of Health and Welfare (AIHW), Australia has come a long way in medical workforce planning. It still has a long way to go.

4.0.3 It is imperative in understanding medical workforce issues to comprehend that there is no free market in medical training places. The hands of government are everywhere, controlling medical school undergraduate intakes, controlling access to Medicare provider numbers, controlling hospital-based postgraduate training places (Registrars), and controlling entry of overseas-trained and temporary resident doctors. Much of this control arise because of the powerful role of government as an influential funder of universities and teaching hospitals.

4.0.4 Medical colleges also have a role to play in post-graduate medical training in setting standards, examining and in some cases, accrediting training positions. From time to time, governments seek to blame the medical colleges for any problems in doctor supply. This finger pointing is not at all unexpected. Politicians, government departments and agencies do not like being made accountable for their actions and scapegoats are always needed. But the fact remains that medical workforce is a shared responsibility between the medical profession and governments and when workforce problems arise, the responsibility for that is also shared. The challenge for the future is to grow out of the finger-pointing and to develop stronger cooperation between all the stakeholders.

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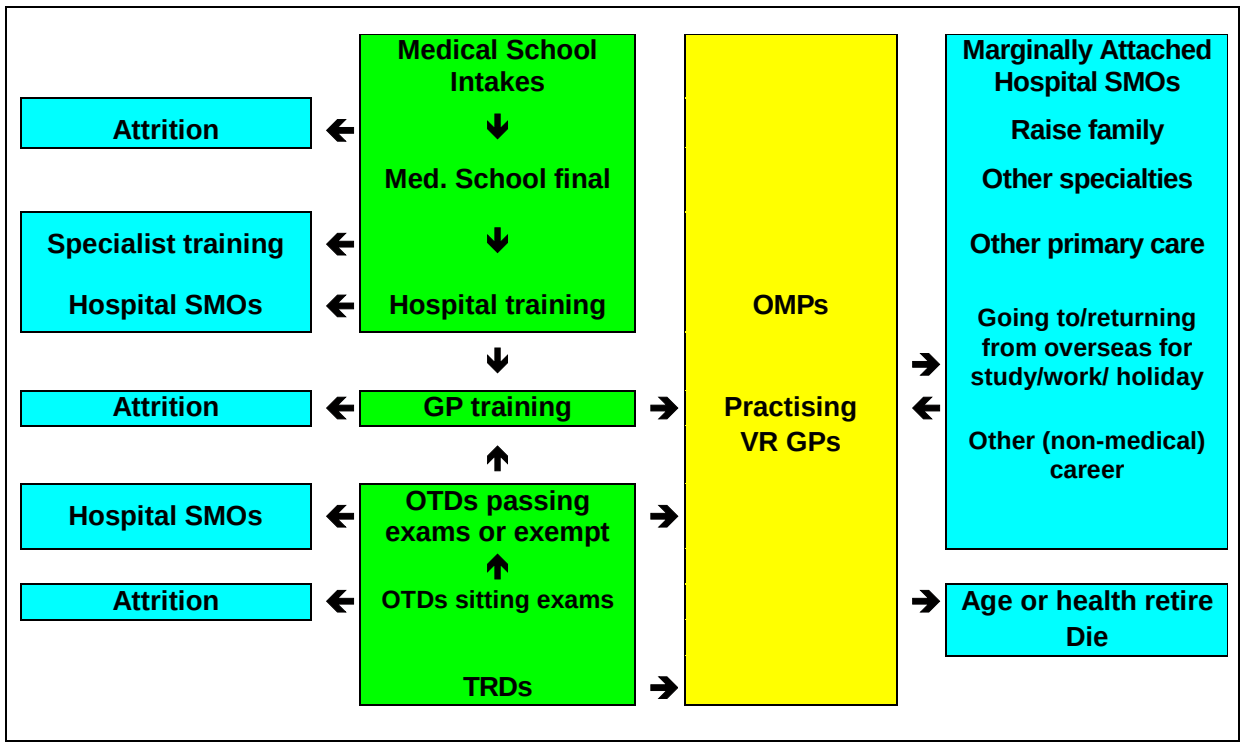
1 Peter Karmel (chairman). Expansion of medical education. Report of the Committee on Medical Schools to the Australian Universities Commission. AGPS. Canberra. 1971.

2 JH Jamison (chairman). Efficiency and Administration of Hospitals – Royal Commission of Inquiry. Parliamentary paper No. 20/1981. AGPS. Canberra. 1981.

3 RL Doherty (chairman). Australian Medical Education and Workforce into the 21st Century: Report of the Committee of Inquiry into Medical Education and Medical Workforce, AGPS. Canberra. 1988.

4.1 General Practice

4.1.1 In 2002, Access Economics developed a GP workforce model for the AMA. Drawing on that model, the following diagram describes GP workforce supply schematically.



4.1.2 Obviously demographic issues are important (eg, the age at which people join the workforce, when people leave the workforce due to age retirement, ill-health or death, the feminisation of the workforce). Also important are the income and lifestyle issues which determine whether people remain in GP workforce or change career, and how many hours they are prepared to work. The Federal Government has enormous influence over supply of general practitioners in Australia through policy levers:

- Medical school intakes (and by implication, outputs);
- GP postgraduate training places now managed by General Practice Education and Training (GPET) a government-owned company (the RACGP has been sidelined);
- Entry of OTDs (managed by a government agency, the Australian Medical Council);
- Entry of TRDs and management of areas of need (which provides the framework for geographically restricted provider numbers for the TRDs); and
- Control of Medicare rebates which has a powerful influence on the economics of general practice and on the incentives to provide or not to provide services.

4.1.3 The medical profession is largely excluded from any role in relation to the planning of the GP workforce.

4.1.4 The recent history of GP workforce planning is a history of policy failure. For budgetary reasons, the Federal Government restricted the supply pipeline. The government seized control by mandating post-graduate GP training (making access to provider numbers contingent upon a GP training place). The several outcomes from this include:

- the fact that GPs are now quite a lot older before they enter the GP workforce fully qualified (therefore have shorter working lives);
- little progress has been made in addressing the maldistribution (the shortages of GPs in rural and remote areas, and, increasingly, in low-income outer urban areas); and
- a significant shortfall in the number of FTE GPs relative to the wants and needs of a rapidly ageing population (there remains an overall shortfall of 2,000 to 3,000 GPs).

4.1.5 Following the release of the 2002 Access Economics GP workforce report, the AMA was successful in persuading the Government to increase GP training places. Policy is now heading in a more rational direction. It will, however, be some years before the benefit of increased undergraduate medical school places translates into more GPs on the ground. In the interim, the Government is simply robbing Peter to pay Paul (seeking to entice doctors out of salaried positions in the hospitals to fill the GP training quotas). The workforce problems have not yet been solved, but they are being relocated.

4.1.6 The AMA does not expect that the Government will resile from its very high degree of intervention in the GP education (and hence workforce supply). Medical education is expensive and managed under the strong hand of government (the expanded role for HECS notwithstanding). Therefore, it is contingent on the profession to do all it can to encourage and assist the government to lift its game and, hopefully, make fewer and smaller errors in the future.

4.2 Specialties

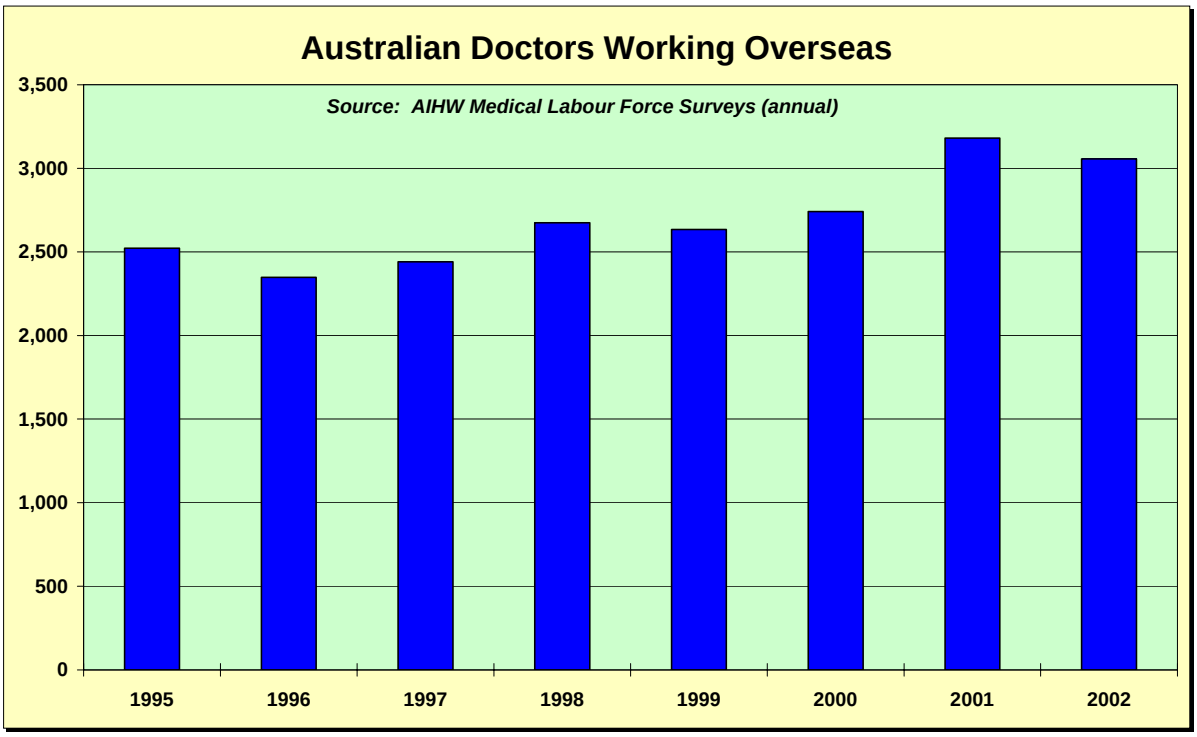
4.2.1 The situation with the medical specialities other than general practice is much less clear cut. The specialist medical colleges have more influence on the numbers in training, and therefore more responsibility for the outcomes, than the RACGP. The responsibility is, however, shared with government. There are large differences in the training programs and in the nature and extent of control exercised by the colleges. Generalisations are not only dangerous, they are also irresponsible.

4.2.2 The key development over the past decade is the opening up of specialist college processes to wider scrutiny, primarily through AMWAC processes and more recently through the Australian Competition and Consumer Commission (ACCC). This development may have caused some discomfort from time to time. However, the AMA sees the inevitability that it will continue. There are many stakeholders with a legitimate interest in training numbers and the only sensible way through is the recognition of these legitimate interests, a high quality dialogue based on good information and analysis, and cooperation by all concerned.

4.2.3 For its part, the Government needs to understand the full framework of determinants of medical workforce supply. This undoubtedly includes remuneration. There are some areas of medical specialty where the remuneration is so poor as a result of inappropriately low MBS rebates that there is simply no incentive for anyone to commit to the long years of training. Geriatrics is one example. Right now, Australia is setting itself up for very serious sub-specialty workforce shortages as a result of misguided public policy.

4.2.4 Finally, there is scant appreciation by policy makers that the medical workforce is becoming an international workforce notwithstanding barriers to entry in the recognition of overseas qualifications. Australian medical education is highly regarded overseas and there is more freedom of movement for Australian doctors working overseas than for overseas trained doctors working in Australia. Australia competes for overseas trained doctors against countries with greater needs and deeper pockets. Policy makers have too glibly

assumed that any shortfall in Australian-trained specialists can be made up by importing doctors from overseas. There needs to be a sharper appreciation of the demand for Australian-trained doctors from overseas. AIHW data a recent upsurge in the number of Australian doctors working abroad.



5: RETAIL PHARMACY

5.0.1 The Federal Government has a splendid opportunity to show its colours on National Competition Policy when it renegotiates the Community Pharmacy Agreement.

5.1 Policy framework

5.1.1 The Pharmaceutical Benefits Scheme (PBS) plays an important role in making medicines accessible to Australians. Medicines are playing an increasingly important role in health outcomes (in cure, management and prevention). Pharmacy is a key partner in the delivery of medicines. The AMA supports good public policy in relation to medicines and pharmacy. Pharmacists are valued partners in the delivery of health care. Good policy will encompass the continued viability of community pharmacy and provide the incentives for cost-effective dispensing.

5.1.2 The AMA has an increasing concern that current policy (as expressed in the third pharmacy agreement) is not producing the desired outcomes for the wider community or for the Federal Budget. If the fourth community pharmacy agreement simply runs in the tracks of those before, it will validate a series of National Competition Policy (NCP) exemptions which are denied to other parts of the health sector, namely: the right to bargain collectively, the right to local monopolies (through the geographic restrictions on the location of pharmacies) and the right to restriction on ownership of pharmacies.

5.1.3 Arguably, the outcomes of this do not auger well for the future viability of community pharmacy. The NCP exemptions have boosted pharmacist incomes and artificially inflated the market value of a pharmacy. Goodwill running to seven figures is not at all uncommon. In short, the NCP exemptions work to the benefit of existing owners and against the interests of future owners. It is increasingly expensive, and difficult, for younger pharmacists to get a start in business.

5.1.4 The AMA also has concerns about other aspects of the remuneration of pharmacists. The third community pharmacy agreement has delivered large windfall gains to pharmacy ($180m over the first four years of the five-year agreement). These windfall gains are attributable in virtually their entirety to the mark-up component of pharmacy remuneration. ***It is time to rethink the mark-up arrangement***, not only because of its excessive generosity to pharmacy but also because it is distorting dispensing behaviour and impairing cost-effective access to generic medicines.

5.1.5 Distribution of medicines under the PBS is expensive (in 2003-04, distribution costs were 28.5% of the total cost of the PBS to the community and 33.9% of the budget cost to the Government). Given the budgetary pressures for a moderation in the growth of PBS expenditure, an efficient and cost-effective distribution system is a necessity, not an optional luxury. ***Ultimately, every dollar overspent on distribution is a dollar underspent on medicines.***

5.1.6 ***The indexation of remuneration to pharmacy is now very seriously out-of-kilter with the rates of indexation applied to other Federal health programs.*** At the time the third community pharmacy agreement was entered into, the forward estimates anticipated that the average dispensing fee would rise by 1.9% p.a. In the first four years of the agreement, the average dispensing fee rose in fact by 3.2% p.a. In comparison, the annual (1 November) indexation of MBS fees is very modest indeed at 1.47% in 1999, 1.22% in 2000, 2.75% in 2001, 1.66% in 2002 and 1.57% in 2003 (on average, 1.73%).

5.2 Comparison of pharmacy with general practice

5.2.1 The table following compares the competition policy framework (and its outcomes) for pharmacists with that of GPs. The differences are stark.

	Community pharmacy	General Practice
Collective bargaining	The community pharmacy agreement is structured around a collective bargaining arrangement and there is **no opening to competitive pricing of dispensing services**.	**Not permitted.** The Government determines MBS fees and rebates unilaterally while GPs are not allowed to discuss fees, even within a practice.
Restriction on ownership	**Protected and limited to pharmacists** and, in highly restricted circumstances, friendly societies by Federal government policy.	**None.** Anyone can own a medical practice (any person, any organisation).
Restriction on location	**Strictly limited** by Federal government policy with the clear intent of protecting community pharmacy from competition.	**None.** As a general rule, once a GP has a Medicare provider number, he or she is free to practice wherever. TRDs may be subject to area-of-need limitations.
Control over workforce by the profession	**Not much.** Little ability to influence undergraduate numbers (advisory capacity only). Two states now require new graduates to meet PSA requirements for registration and it seems that others may follow suit. Therefore, rather more self-determination for the Pharmacy profession than for GPs.	**None.** The medical profession is excluded from decisions which determine the number of GPs (medical school intakes, GPET training places) and the Government intervenes in GP workforce issues (eg bonded rural scholarships) in a way that has no parallel in other professions.
Value of goodwill	**High and rising.** Goodwill of $1 million or more would seem to be commonplace	**Low and in many cases zero**. The government-contrived shortages of GPs means that any GP entering an area can simply set up shop and have a full patient workload without having to pay for goodwill. Some GPs are able to sell their practices for the cost of the equipment, others have not even been able to do that and have simply closed their doors and lost their investment in practice-specific equipment when retiring or when unable to keep their practices going due to ill-health.

5.3 Response to the counter-arguments

5.3.1 In its defence of the *status quo* for one of the NCP exemptions (the restrictions on the ownership of pharmacies), the Pharmacy Guild has submitted a report it commissioned from the Network Economics Consulting Group (NECG)[4]. Having searched the NECG report in vain for any hooks for good public policy, the AMA now makes the following responses to the arguments advanced.

[4] "*Ownership Restrictions applying to Pharmacies—Assessment of case for retaining restrictions*", Network Economics Consulting Group, July 2004.

NECG assessment	AMA response
Existing ownership arrangements facilitate higher levels of service than would prevail if ownership arrangements were deregulated (p. 27)	No evidence whatsoever is tendered in support of this contention. There is, however, evidence that the full suite of arrangements for community pharmacy support higher profitability than would be the case in competitive markets and this, in turn, is reflected in the very high goodwill value of a pharmacy. There is evidence from the UK that the quality of advice from supermarket-owned pharmacies is as good or better than that from independently owned pharmacies.
... the restrictions help to correct market failure associated with the use of medicines. In the absence of regulation, market failure may arise in the pharmacy sector as a result of ... imperfect information ... (p. 27-28)	The AMA agrees that doctors and pharmacists both play an important role in giving patients high quality information about the use of medicines. However, to imply the pharmacists will only provide high quality information if they own the pharmacy would seem to be a remarkable slur on the professionalism of pharmacists. If the argument had any sway, then it would follow that the quality of primary care would be immediately improved by regulations to restrict the ownership of GP practices to the GPs themselves. A true professional will act in a fully professional manner regardless of the nature of his or her employment or business structure.
... externalities (p. 28-32)	NECG argues that inappropriate use of medicines will generate negative externalities (higher health costs and poorer health outcomes) and that intervention (subsidy of pharmacy services) can promote appropriate use of medicines. The report fails to forge any connection between ownership restrictions and the quality of pharmacy services. Externalities apply to many aspects of health and the NECG arguments are not pharmacy specific.
... moral hazard leading to over-consumption of pharmaceutical products (p. 32-33)	The report claims that "*The provision of pharmacy services can facilitate a reduction in the negative consequences of demand-side moral hazard by helping to ensure that consumption of medicines is necessary and appropriate for the patient's medical condition*". Yet all the economic incentives, whether in relation to PBS or over-the-counter sales, are for pharmacists to sell the more expensive medicines. NECG concedes the incentive to over-dispense. Again, no link is forged between the quality of pharmacy and ownership restrictions.
... principal-agent problems (p. 34-35)	NECG misconstrues "supplier-induced demand" theories to argue that it may lead to over-prescribing of drugs (whereas proponents of SID argue that it leads to doctor over-servicing), and then goes on to make the extraordinary claim "*it is expected that most pharmacists would act ethically in the best interests of their customers*".

	But only if they own the pharmacy apparently!

The central tenet is that pharmacy services are an effective way to address market failures associated with medicine usage. However, these services tend to be under-valued by consumers and it is not easy to prevent free-riding on the provision of those services. Hence, in an unregulated market, there would be too little consumption of pharmacy services. This provides a rationale for government intervention to promote the provision and consumption of pharmacy services above levels that would otherwise prevail. This section of the report argues that the existing ownership arrangements are an effective, though not necessarily perfect, way to promote this outcome. (p. 36)	This central tenet boils down to an argument that ownership restrictions help to sustain a higher rate of return than would be expected where other players could contest the market. Were we to assume for the sake of the argument that pharmacy services do generate the high social value claimed (and yes, the medical profession does value pharmacy services) and that the subsidies to evoke a higher provision of service were fully justified, the argument still falls down because the clear international evidence is that unrestricted ownership of pharmacy does not impair the quality of pharmacy services. On the contrary, additional competition is more likely to lift quality[5].

5.4 Time for fresh thinking

5.4.1 As we noted at the start of this section, the Government now has a splendid opportunity to show that it is serious about NCP when it negotiates the next community pharmacy agreement. It is time for some fresh thinking on pharmacy.

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[5] The control of entry regulations and retail pharmacy services in the UK, Office of Fair Trading, January 2003, pp 40-46