

Extending Fee-For-Service to Physios: A lost opportunity for equity

Tim Woodruff

After a quarter of a century recognising medical care as important in the community, and paying rebates to enable patients to see doctors, the Federal Government has finally said physiotherapy and other allied health services are important too, and agreed to fund such services.

In terms of actual services for physiotherapy, it hasn't amounted to much. There are very significant caps on treatment and very restricted access in terms of patient selection. But it's progress.

The core set of health providers now funded by the Federal Government under Medicare is finally recognising reality. Doctors working in isolation cannot give complete care in many circumstances and a team approach with varying input from a range of providers is often the best treatment.

Why has it taken so long, given that almost every politician in Canberra must have had experience directly or indirectly of the benefits of community allied health services?

The main reason, I suspect, has been cost. Often this has been hidden under the excuse of 'It's a state responsibility'. But that doesn't fit with the fact that funding for doctors in the community was taken on by the Federal Government three decades ago. It simply requires leadership or political will, as the recent commendable proposed initiatives in the mental health field demonstrate.

On the ground, of course, the recognition is well established by patients and providers. Patients ask for referrals or self-refer. Indeed, in my experience as a rheumatologist, self-referral by patients to allied health services often results in a better process of treatment with respect to musculoskeletal problems than attending a GP, although outcomes are not necessarily any different.

Having said that, it is worth pointing out that general practice is probably the most challenging and difficult field of health care. A GP has to know something about everything, enough to maintain the patient's confidence and the GP's own satisfaction and sanity, and also know when they are out of their depth in

The author, Tim Woodruff, is current national president of the Doctors Reform Society. This article is an edited version of a presentation to the Australian Physiotherapy Association National Congress 26 May 2006.

every medical field.

I would like now to return to cost as an impediment to appropriate recognition of allied health services. To do that, I will look at funding mechanisms currently in place for doctor supplied medical services in the community.

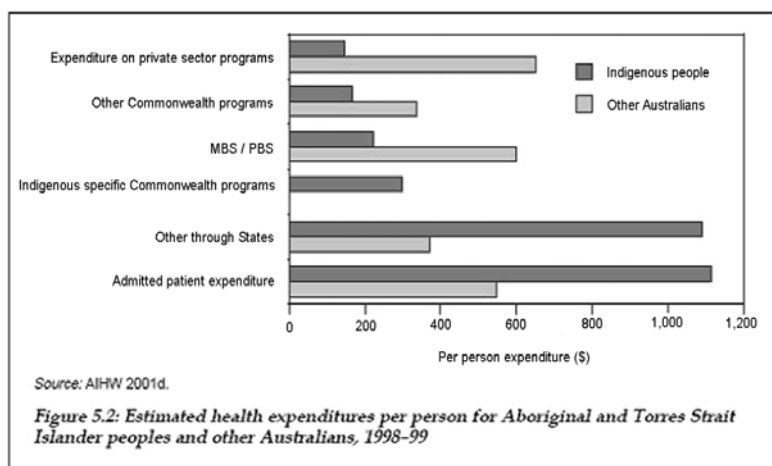
The Federal Government funds doctor services in the community through fee for service. The cost to government is a major issue for Treasury.

This fee for service mechanism needs to be considered from the perspective of two basic principles which should underpin any health service funding. These are equity and efficiency. In considering these issues, we need to look at the distribution of funds and at supplier-induced demand under a fee for service mechanism.

If we look at general Medicare funding and pharmaceutical benefit funding then we see a disturbing pattern. The most important determinant of distribution is the distribution of the health provider: the GP or the specialist. Thus, as Professor Ian Hickie of the Brain and Mind Research Institute pointed out on ABC Radio PM recently, residents of wealthy eastern Melbourne, taking in Toorak, enjoy an average Medicare rebate of \$74 a year for visits to private psychiatrists, but people in rural Western Australia get a mere 34 cents.

In addition, enough patients in eastern Melbourne are prepared to pay an additional \$100 per hour copayment. The chances of that regularly happening in remote or rural Western Australia are remote, and this mechanism of funding therefore also contributes to the maldistribution of providers.

More generally, if we look at Medicare rebates and PBS rebates, we see a similar pattern of maldistribution. Figures from



the Australian Institute of Health and Welfare show Medical Benefits and PBS funding for Aborigines at \$200 per person per year compared to \$600 for non-Aborigines (see figure 5.2 from AIHW previous page) [1].

The inefficiency of that situation is highlighted by the fact that hospital spending on Aborigines more than makes up for the shortfall, treating them when they are very unwell rather than providing early preventive care. The inequity of the system is stark.

Now let's look at the Medicare Safety Net with its rapidly rusting "iron clad guarantee". When patients see a GP, or specialist, or have pathology or radiology in the community (not in hospital), they pay whatever copayment is required. When the total amount of those copayments reaches \$1000, or \$500 for card holders, then for any further copayments Medicare will pay 80% of the amount.

A strong link to socioeconomic status is revealed by figures on how this money was distributed by electorate during 2005 [2]. Bradfield in Sydney is the Australian electorate with the highest socio-economic rating. Fowler in outer western Sydney is at the bottom.

In Bradfield the safety net paid out \$56.26 per person. In Fowler the figure was \$7.82. Another comparison is between the number four on the socio-economic rating list, Wentworth, and the second lowest, Lingiari in outback Northern Territory. Those figures are \$62.66 and \$1.60 respectively.

Lingiari's low payments could be due to an absence of providers, but those for Fowler in western Sydney are less easily

explained in this way.

People living in the richest 25 per cent of electorates received an average safety net payment of \$28.01 in 2005. Those in the poorest 25 per cent, received \$8.86.

Most of this safety net money goes to pay specialist bills because specialists charge the biggest copayments. One could argue that in poorer electorates, patients see specialists in public hospitals but the enormity of the difference suggests that this Federal money is not being distributed according to need, but according to factors like provider availability, GP referral patterns, patient demand or a mixture of these. Medical need does not rate.

The next issue of concern about how doctors are funded centres around potential perverse incentives of fee for service payments.

In a paper in the Medical Journal of Australia in 2000, Professor Jeff Richardson demonstrated that if you were admitted to a private hospital in Victoria with a heart attack, you were twice as likely to have coronary angiography than if you were admitted to a public hospital [3]. If you were a private patient in a public hospital, you were still one and a half times more likely to have angiography than if you were a public patient.

Further information from this study is summarised in the table below. These findings must be due to under-servicing of public patients or over-servicing of private patients or both; and the reality is almost certainly that it is both.

Another example is a randomised controlled trial in which doc-

Ratio of Rates of Angiography and Coronary Artery Revascularisation Procedures in Private Versus Public Hospitals				
	Rate Ratio (95% confidence interval)*			
	Angioplasty	Angioplasty/Stent	CABG	Any CARP
Public patients in public hospitals	1.00	1.00	1.00	1.00
Private patient in public hospitals	1.43	1.09	0.90	1.00
Private hospital patients	2.17	3.05	1.95	2.87

Rates are for all Victorian residents aged 15-85 years admitted to Victorian acute care hospitals with acute myocardial infarction July 1995-Dec 1997, adjusted for age group, sex and half-year of initial admission.
 * Rate ratios are calculated using the Cox proportional hazards model.
 CABG = Coronary Artery Bypass Grafting CARP = Coronary Artery Revascularisation Procedure

tors at a university hospital outpatient clinic in North America were allocated to receive income by salary or by fee for service [4]. It was found that the fee for service doctors scheduled 30% more return visits than their salaried colleagues. Paying doctors per service encourages extra services—and these might not merely be unnecessary and expensive, they can sometimes be actively harmful.

This effect involves the theory of supplier-induced demand. It firstly requires fee for service payments and secondly needs an excess of suppliers.

This means it currently doesn't apply to general practice in most of Australia because of the gross workforce shortages. But once national workforce numbers in any profession are adequate across Australia, there are inevitably areas where there is supplier excess, and supplier-induced demand will occur.

For this to happen, the supplier has to convince people of the value of a product. In the health care system, convincing people of the value of a product is relatively easy. There is a huge information inequality between patients and their health care providers, whether they be doctors, physios, or any other. Even with today's increasingly aware and questioning patients, most patients are in no position to decide whether the advice of the provider is best practice.

Patients remain disempowered, setting up the situation for supplier-induced demand. But what is it about the suppliers, the doctors, physios, and other allied health professionals which allows this to happen? Are we greedy entrepreneurs?

There are clearly examples of such behaviour, sometimes leading to de-registration, but the evidence for supplier-induced demand is not pointing at a few errant providers practicing at the edges.

The figures discussed previously and demonstrated in other studies point to an alternative reason to explain supplier-induced demand.

We professionals are trained to do things, to use whatever skills we have to improve the health of our patients. For us to decide what to do we rely on what we have been taught and on evidence. Unfortunately, the level of evidence on which we rely is low.

As a consultant physician, the mainstay of my treatment is drugs. In the area of drugs, it's relatively easy to perform a proper randomised trial, and money to sup-

port such trials is offered by the drug industry.

Nonetheless, the quality of data even under these circumstances is inadequate to be more than a guide to me in treating individual patients, many of whom would never make it into a trial because they're too old, or too sick, or that don't have the condition in a sufficiently typical form to warrant inclusion.

When it comes to procedural interventions, the difficulties of getting data are multiplied. How difficult is it to get a double blind randomised controlled trial of a surgical procedure, or indeed, many physiotherapy interventions? Who will fund the innovative attempts to get useful data about such interventions, given that 80% of clinical trials are funded by drug companies?

So what is the doctor to do when faced with a clinical problem? Essentially we extrapolate from whatever good evidence there is, and we use our own, and our colleagues' experience, and this combines with our personalities, ranging from the cautious and perhaps timid, to the confident and perhaps arrogant. What happens?

The table below, titled "Supplier Induced Demand", indicates the variation in rates of different procedures across different areas in Victoria [5]. It demonstrates, for example, that for a well-established, potentially disastrous procedure like laminectomy, the variation between areas is very low.

But for a procedure regarded as minimally invasive like colonoscopy, the variation across the state is huge. What are the indications for performing a colonoscopy? Clearly, when

confronted by an individual patient, doctors come up with all sorts of indications which their almost identically trained colleagues would not accept. This relative ignorance of what is best sets the scene for supplier induced demand.

Thus, although unethical behaviour and greed may drive the extremes of supplier-induced demands, one doesn't have to accept that as the main reason for the different behaviours in fee for service vs salaried practice.

In salaried practice, peer supervision can play a part in limiting the extrapolation, as can budgetary and time constraints.

Whatever the reason, most health economists and governments have believed that supplier induced demand was a problem. Treasurers were worried. So what

Supplier Induced Demand	
Procedure	Variance Ex(Variance)
Coronary Angiography	13.4
Coronary Revasc Procedure	5.4
Cataract Extraction	15.4
Tonsils and Adenoids	7.5
Myringotomy	11.7
Carpal Tunnel Release	8.4
Vertebral Discectomy	2.1
Decompression Laminectomy	1.9
Total Hip Replacement	3.8
Hysterectomy	6.4
Prostatectomy	3.9
Colonoscopy	45.3
Cholecystectomy	5.3
Exploratory Laparotomy	1.7
Appendicectomy	5.9

Standardised Rate Ratios for Various Operations in Statistical Local Areas in Victoria, Compared to the Rate Ratios for All Victoria.

has been done and can be done?

Firstly, governments decreased the number of providers relative to need. With no supplier excess, there is no chance of inducing demand, but there is even more likelihood of maldistribution of doctors.

Secondly, the value of the rebate was allowed to fall, forcing copayments which caused patients to decrease demand. But it's worth noting that according to a survey from the Commonwealth Fund, 34% of sick Australians in the community indicated access problems due to cost over the last 2 years.

Thus, these approaches lead to inequity as the poor are disproportionately affected by copayments, and to inefficiency because those patients who do limit their demands on services cannot determine accurately which services they should limit.

The third approach has been to increase the non-fee for service component of doctors' incomes, moves which can be used to improve quality of care and limit supplier induced demand. The Federal Government is to be congratulated for pursuing this approach, despite the enormous implementation problems. Currently, 10-30% of GP income is non-fee for service.

Lastly, there is salaried remuneration. This can successfully address both problems of distribution and of supplier induced demand.

It is obvious that the current system of funding doctors in the community leaves much to be desired. It promotes both inequity and inefficiency, because doctors are human. I have no reason to suspect that physiotherapists or other health professionals are any different.

Although fee for service funding under Medicare is an improvement on almost no funding for allied health services, it is not the best option. In 1974, when universal health insurance under Medibank was introduced against huge resistance from the AMA, putting doctors on salaries was politically impossible. Little had changed a decade later when universal insurance was reintroduced under Medicare.

For some patients, there are definite gains if physiotherapy and other allied health workers are funded through Medicare on a fee for service basis, but we can do so much better in terms of both equity and efficiency. This is an opportunity, now that allied health is recognised, to move to needs-based funding and away from fee for service to salaried service, not just for allied health practitioners but for doctors as well. Otherwise it is a lost opportunity and in a decade the funding of allied health will serve as another model demonstrating the inequities and inefficiencies of fee for service funding.

Finally, I'd like to comment on the funding and organisation of primary health care. The concept of integrated primary health care has the full support of the Doctors Reform Society.

This should be part of needs-based funding, with an emphasis on salaried rather than fee for service remuneration. We already have a model of integrated primary health care which, though far from perfect, could be expanded and improved if there was the political will.

Victoria has about fifty community health centres. They are relics of the original centres set up under Gough Whitlam when Medibank, (the original Medicare) was introduced in 1974.

The centres vary considerably in size and therefore in the services they provide. At least ten have general practitioners, almost all on salaries, with funding for salaries coming from the commonwealth from fee for service Medicare payments.

The centres are not outposts of hospitals, running to a hospital agenda; nor are they run by state or federal governments, or controlled by GPs. But they are far from perfect with 20-50 different sources of funding and varied eligibility criteria limiting integration. Governance is through a Board of Governors, half appointed by State Government to ensure that there is an appropriate mix of expertise, and half voted in from the local community.

The average recurrent cost of such centres is about \$2 million per year, excluding fee for service funding for doctors. For \$600 million, which is the cost of removing support for private health insurance for ancillaries such as physio, dental treatment, gym shoes, relaxation tapes and the like, the government could fund 300 such centres, with or without GPs. This would be one centre per 80,000 people.

Those figures were calculated at a time when there was no budget surplus, but in these times of huge budget surpluses, we could have one such centre for every 20,000 people for a cost of \$2.4 billion. That is about a third of the cost of the tax cuts from the last budget. Such spending could therefore set the scene for an efficient basis to distribute needs-based funding to the community whilst avoiding the potential for supplier-induced demand.

Needs-based funding and integrated primary care need to happen. The dual targets of equity and efficiency will not be achieved without a move away from fee for service to salaried health care providers.

References

- [1] Australia's Health 2002. Australian Institute of Health and Welfare
- [2] *The Age Opinion* March 17, 2006. C Livingstone
- [3] Coronary angiography and coronary artery revascularisation rates in public and private hospital patients after acute myocardial infarction. Robertson IK, Richardson JR. *Med J Aust* 2000 Sep 18;173(6):291-5
- [4] Phelps C 1997, *Health Economics*, Second Edition, Addison-Wesley.
- [5] Supply and Demand for Medical Care: Or, Is the Health Care Market Perverse? Working paper 123, 1999, Centre for Health Economics. Richardson J