**Submission to the**

# Senate Select Committee on Medicare

ANGLICARE
TASMANIA

**July 2003**

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## 1. INTRODUCTION

### 1.1 A profile of Anglicare Tasmania

Poverty in Tasmania is an entrenched and long-term problem. Research conducted in this State has consistently shown high levels of hardship and exclusion. Anglicare Tasmania firmly believes that social policy changes can modify and ameliorate the effect of poverty on low-income households.

Anglicare Tasmania is the largest state-wide community service organisation in Tasmania. It operates under the auspices of the Anglican Church and is part of Anglicare Australia. Anglicare has offices in Hobart, Glenorchy, Launceston, Devonport and Burnie and provides a range of community services throughout Tasmania including many outreach services to rural areas.

In operation since 1983, Anglicare employs over 300 staff and has developed strong networks and relationships with peak bodies, ministerial advisory committees, local inter-agency networks, other community service agencies, Commonwealth and State governments and the broader community.

In 1995 Anglicare established a Social Action and Research Centre (SARC) which engages in research and policy development. SARC's role is to engage in social action, policy development, advocacy and public debate based on appropriate research. Its focus is Tasmanians living in poverty. It has published research on the participation of children from low income households in the state school system, models of credit and grant schemes to assist people on low incomes, the problems facing people on low incomes in the private rental market, the cost of living in Tasmania, the State concessions system, and the issues confronting the Tasmanian labour market. The recommendations from these reports have led directly to positive intervention by the Tasmanian State Government in areas most affecting low income Tasmanians. In 2000, research was conducted into access to bulk-billing general practitioners in Tasmania. This submission draws heavily on this original research.

SARC exists to support Anglicare's mission to achieve social justice and provide the opportunity for people in need to reach fullness of life. SARC's work is informed by the direct experience and involvement Anglicare has developed through its community service work.

Anglicare Tasmania welcomes this Senate Inquiry into Medicare. In the context of national policy debates dominated by the experiences of Sydney and Melbourne, this submission seeks to provide information about the impact of the proposed changes to Medicare on those Australians who live in regional and rural areas of Australia.

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## 1.2 This submission

Tasmania has the highest proportion of low income earners in the nation. It also has a highly dispersed population with the majority of low income earners living in outer metropolitan, regional and rural areas around the state. Historically, Tasmania has one of the poorest rates of bulk-billed services by general practitioners. For these reasons the proposed amendments to Medicare are particularly pertinent to Tasmanians.

This submission addresses the impact of the proposed changes to Medicare in the Tasmanian context. It does not attempt to address all aspects of the Government's proposed Medicare package but rather focuses on the significant implications for low income earners in Tasmania with the decline in bulk-billing and rising co-payments for GPs. It will briefly address the implications of the private health insurance rebate.

This submission draws on the research conducted in the State by Anglicare. Importantly, within a Tasmanian context, Anglicare submits that the proposed package does not provide adequate incentives to increase either the numbers of GPs outside major metropolitan areas or the rates of bulk-billing in areas of significant disadvantage. Rather, the proposed amendments could have the opposite effect. As this submission demonstrates, rather than making 'A Fairer Medicare', these proposals would effectively destroy the universality of Medicare, creating a tiered health system in which many low income earners will potentially have less access to quality health care than they have currently, while many others will be paying higher costs.

## 2. BACKGROUND: THE TASMANIAN CONTEXT

An affordable and accessible health system is essential to ensure good health outcomes for Tasmanians. Tasmania has had some of the worst health indicators in the nation[i] combined with the highest proportion of low income earners of any in Australia and the highest unemployment rates. The links between poverty, unemployment and poor health outcomes have been well established in the literature.[ii]

### 2.1 High proportion of low income earners

Tasmania's chronically high level of unemployment has been accompanied by a correspondingly high rate of long-term unemployment and reliance on social security payments. In 2001, almost 40% of Tasmanians relied on Commonwealth Government pensions and benefits as their main source of income. This figure vastly exceeds the national average of 28% and even dramatically exceeds the second most reliant state, South Australia at 30.8%.[iii] Currently, Tasmania's unemployment rate is 8.3% compared to a national unemployment rate of 6.1%. Centrelink statistics for December 2002 show that 58% of Tasmanians receiving Newstart Allowance have been on the benefit for a year or more and almost 40% of Newstart Allowees have been in receipt of the benefit for two years or more. The extent of further, hidden unemployment is partially revealed by the participation rate, which in Tasmania, at 58%, is the lowest in the country compared with a national average of 63.8%.[iv]

### 2.2 Increasing numbers of the 'working poor'

According to recent ABS data analysed in recent Anglicare research, casual workers comprise 25% of the Tasmanian labour force, and more than 40% of these workers would prefer to be working more hours.[v] The income for many families in this group is slightly above eligibility limit for Health Care Concession Cards, which makes them particularly vulnerable to the proposed changes to Medicare.

The nature of casual work means that many employees have variable earnings. For some, their hours of work vary from week to week while others pick up occasional or seasonal stints of casual employment. Although there is some flexibility for earnings variation while still qualifying for a Health Care Card, there are many individuals whose income over an eight week period may push them just above the Health Care Card eligibility levels. Because the income level to qualify for a Health Care Card is lower than the income level to retain the card, once an individual loses their card due to an irregular or sporadic increase in income, it may be some time before their income is sufficiently low to re-qualify for the card. The potential loss of

a Health Care Card is already a disincentive to taking up additional work. Any further increase in the cost of GP services for non-concession card holders would create an even greater incentive for low income earners to ensure that their earnings remained below the threshold level. Clearly this would be a perverse and unintended negative outcome flowing from the proposed changes.

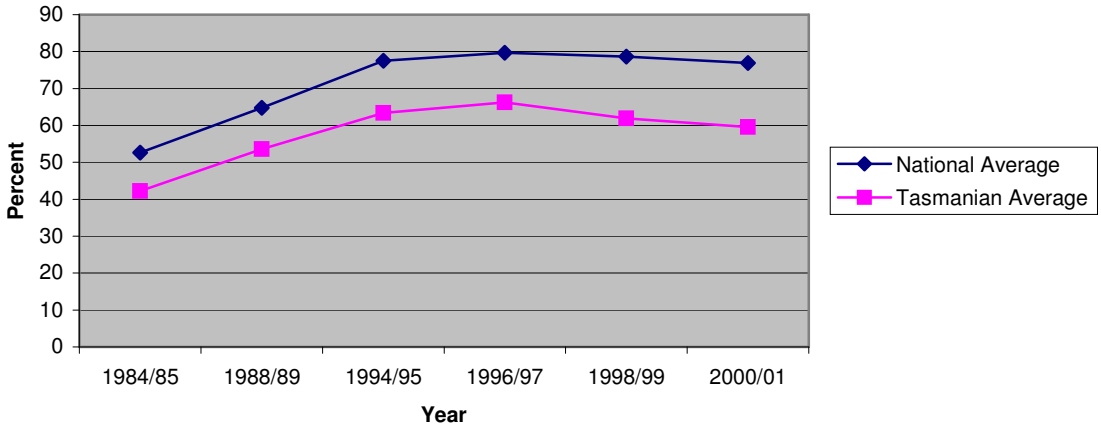
Under the proposed package, this group will not gain any advantage offered by the 'free care' option for concessional patients and will be the most financially disadvantaged by the up-front charges and increasing co-payments which are the likely outcome of these measures. In Tasmania GPs with practices located in areas of high social disadvantage are most likely to have a concentration of patients who are either concessional or low income. As is demonstrated later in this submission, in Section 3.2, the proposed incentives are not adequate to fully rebate the costs of patient consultations, forcing GPs to either not participate in the 'free care' option or to compensate the bulk-billing component of their practice by increasing co-payment charges to non-concessional patients. Clearly the low income earners, categorized as 'working poor' will be hit hardest in this scenario.

### 2.3 Decline in bulk –billing general practitioner practices in Tasmania[vi]

Anglicare welcomes the initiatives in the package to increase the size of the medical workforce, particularly in outer metropolitan and rural areas. Like all states, Tasmania has had difficulty in recruiting doctors to rural postings. Generally Tasmania has slightly fewer GPs for its population size than the national average with a population of 1325 per GP compared to the national average of 1290 people per GP.[vii]

Similarly, Anglicare also welcomes any initiatives to encourage an increase in bulk-billing practices. The percentage of services bulk-billed by Tasmanian GPs has historically been lower than the national average (see Figure 1). Tasmania has been well behind the other states on this measure since the Health Insurance Commission began collecting this statistic in 1984. From 1997/98 to 1999/2000 Tasmania dropped below the Australian Capital Territory to have the lowest percentage of GP services bulk-billed of any state or territory in Australia. The percentage in 2002 is 58.3%.[viii]

**Figure 1. Graph Showing Percentage of GP Services Bulk-Billed**




Source: Health Insurance Commission Annual Reports, 1984 – 2001

## 2.4 Affordability of health care

Affordability of health care has been identified as a critical issue for low income earners in Tasmania. The Tasmanian Healthy Communities Survey conducted in 1998-99 demonstrates clearly that people restricted their use of health care because of financial difficulties. The survey found that 31% of adult Tasmanians experienced difficulty in meeting their financial needs in the last 12 months. Of this group 31% (24,168 Tasmanians) reported that they did not seek health care because of these financial constraints. Further, 29% reported that financial difficulties meant that they did not purchase prescriptions ordered by their GP. [ix]

Anglicare's research similarly found that access to health care was a particularly serious concern for low income Tasmanians who lived in an area where they were unable to easily access a doctor who bulk-billed. The following comments illustrate the concerns identified by participants in a statewide consultation with low income earners:

"*I can't afford to go to the doctor and if I do go I can't afford the medicine. Both my daughter and I need to go but we can't. There's no money until next Thursday. I owe the Northern Suburbs Medical Centre $9 for the last bill and I haven't got it. If you can't pay the bill the doctors charge an account fee and the bill increases.*" (Launceston Participant).

"*My sister had severe stomach pains and went to the Royal [Hobart Hospital], we waited two hours and they turned her away because they said she should see her GP. She didn't have any money to go to a doctor. She had to wait two days for her [Centrelink] payment before she could go to the doctor. I would have given her the money to go if I had it but there is no spare money.*" (Clarendon Vale Participant).

"*I can't afford to go to the doctors. The gap is $10. I can't afford to take my kids to the doctor*." (Launceston Participant).

"*My son is asthmatic. He's out of ventolin. I can't afford to go to the doctor for a script. He's got a cold and I don't know what will happen tonight." (*Launceston Participant).

"*It sucks that the doctors down here don't bulk-bill. If you're quite ill and you have to go every day its $3-4 per day. Either you can't afford to go or you owe so much that you're embarrassed to go*." (Circular Head Participant).

"*If you go to the doctors you have got to pay a gap which can be up to $10, depending on who you see. It's $50 to $100 for a specialist. All doctors should bulk-bill people on low incomes. We don't go to doctors and our kids don't because we can't afford it. Doctors bills have gone up but the Medicare subsidy hasn't. What are they doing? Are they using the poor to make themselves rich*?" (Launceston Participant).

The experiences of the communities without a bulk-billing doctor were in stark contrast to those who were able to access a GP who bulk-billed low income earners. When asked what worked well in their community to help people on low incomes live a decent life, many participants mentioned local doctors who bulk-billed.

"*Our GP has been here for many years. She's here because she wants to be here. She bulk-bills low income earners – she is under incredible stress but she does a great job*." (St Helens Participant).

"*Having a bulk-billing doctor locally means not having to worry about money before going to the doctor*." (St Helens Participant)

Anglicare's research clearly found that participants restricted their use of GPs because they were unable to afford the cost of consultations. This is consistent with international research which also shows that the rise in costs of co-payments correlates directly with a decrease in the use of services by low income earners.[x]

## 3. IMPACT OF THE PROPOSED AMENDMENTS TO MEDICARE

### 3.1 A three-tiered health system

The 'Fairer Medicare' package raises broad concerns about the dismantling of Medicare as a universal health care system. Anglicare shares the concerns identified by Professor Jeff Richardson which he summarises as:

> "Together the two key changes provide a simple structure for the progressive transfer of expenditure from public to private sectors. Non-indexation of the general rebate will coerce doctors into raising co-

> payments. This will create pressure for increased private insurance. This, in turn, will inflate fees. A three-tiered system is likely to emerge viz pensioners and card holders, the privately insured and the remainder of the population (the poorer, less educated and the less politically articulate households)." [xi]

The creation of a tiered health system will have a number of consequences on low income earners in Tasmania. Briefly summarized these consequences include the following:

- *Reduced access for low income earners to GPs in areas with an income mix*

The low number of GPs in Tasmania has already resulted in many practices around the state closing their books to new patients. One consequence of these proposals is that in a climate where demand is far outstripping supply, there will be an added incentive for practices to select new patients on the basis of their capacity to pay the 'gap' fee rather than their need for health care.

- *Increased pressure on public hospital emergency departments*

Reduced access to GPs will force low income earners to seek health care from public hospital emergency departments for minor ailments because there is no where else for them to go. The high demand of concessional patients in Tasmania together with the low supply of GPs will inevitably create higher demand on an already over-stretched public hospital system. A similar scenario has been predicted for other states.[xii]

- *Increased cost burden on the 'working poor'*

Working Australians on low incomes will be paying the same amount for health care as their wealthier counterparts, but will not have the income to pay for the private health insurance option to cover the co-payments. Increasing the range of private health insurance to include out-of-hospital health costs will inevitably result in higher health costs across the board, leaving 'working poor' families even further disadvantaged.

In the following sections, examples drawn specifically from a Tasmanian context highlight these concerns.

### 3.2 General Practice Access Scheme: A disincentive to GPs in areas of high disadvantage

On the face of it, low income earners with Health Care Concession Cards stand to benefit from the proposed changes to Medicare, if general practitioners take up the option of providing free care to health care card holders with the corresponding

direct rebate reimbursement option. However, given the widespread geographical distribution of disadvantage throughout Tasmania, general practitioners in areas of high socio-economic disadvantage in this State are offered little incentive to adopt the changes.

A local GP working in an outer metropolitan practice provided Anglicare with an example illustrating how the package would impact on practices such as hers. The practice has a mix of low income earners and pensioners, with approximately 70% concessional patients and the remainder just above the eligibility threshold. This income mix would be common for many general practices throughout Tasmania. The example provided demonstrates how the General Practice Access Scheme proposal provides incentives for general practitioners in more central, affluent areas to bulk bill, while positively financially disadvantaging practices in low income areas (See Appendix A).

As this example illustrates, under the proposed changes, a practice in an affluent area with a majority of patients able and willing to pay higher gap fees, will take in significantly more income than a practice in area of high social disadvantage for the same number of consultations. Even with existing incentive schemes and charging a minimum gap fee to non-concessional patients, it is clear that practices in these areas will be financially disadvantaged under this scheme.

This would have a number of consequences for practices in areas of high social disadvantage including:

- There would be even less incentive for doctors to work in less affluent areas because doctors are usually paid a percentage of gross fees charge; and
- The only means for practices to increase their income to cover expenses and adequately remunerate doctors under this model would be to see more people. An increase in the number of consultations would mean shorter consultation times leading to a poorer quality of health care or
- General practices in economically disadvantaged areas would become unviable resulting in a loss of health care from areas with the greatest need.

### 3.3 Co-payment increases as a result of proposed initiatives

Another potential effect of this package is that it actually creates increased pressure on GPs to end bulk-billing for general patients ie non-concessional patients. There is no evidence or even rationale within this package to support the Government's claim that "from February 2004, up-front costs for non-concessional patients visiting participating general practices will be significantly reduced". The package offers incentives for GPs to provide 'free care' to concession cardholders, principally through the option of direct rebate reimbursement. However, there is no incentive for GPs to restrict the co-payment fee charged to non-concessional patients. Nor are there regulatory controls offered to limit the co-payment charges. The average co-

payment for GP consultations has risen from $6.90 in 1992-93 to an average of $13.05 in March 2003.[xiii] It is argued that this is evidence of the inadequacy of the current Medicare rebate.

If, as suggested in the previous example, the incentives to bulk-bill concessional patients are not adequate to meet the consultation costs, this package will have the effect of actively promoting an increase in the amount of 'gap' fees charged to cover costs. Arguably, for practices to remain financially viable GPs will be forced to increase the charges for fee paying patients where there is the option of doing so. In the worst case scenario, this could result in a reduction of general practitioners in areas of high disadvantage. This will be particularly disadvantageous to low income earners whose income is just over the Health Care Concession Card eligibility limit. As outlined in previously in this submission, the up-front or 'gap' charge is a major disincentive to low income earners visiting their GPs.

### 3.4 Private health insurance and the 30% rebate

The extension of private health insurance for out-of-hospital out-of-pocket expenses is another component of the package which raises concerns for low income earners. Clearly low income earners are the most vulnerable in a health system which is becoming increasingly privatized and open to market forces. As a group low income earners are less able to afford the cost of private health insurance or, if compelled to take up the option due to particular circumstances, they are highly likely to experience significant financial disadvantage as a result of allocating this amount from a very limited budget. Others have noted that the 30% rebate for private health insurance holders currently benefits higher income earners over low income earners. The case which highlights this most graphically is that of dental care, an area which is particularly pertinent to Tasmania.

Funding to the public dental health system was drastically cut when the Federal government abolished the Commonwealth Dental Health Program in 1996, saving $100 million annually from a scheme which provided dental health care to low income earners throughout Australia.[xiv] As John Spencer from the Dental Statistics and Research Unit, Australian Institute of Health and Welfare, observes the current 30% rebate costs between $316 -345 million a year to subsidise the dental care of people with private health insurance. In other words, three times the amount of dental health funding has been removed from the public dental health system and redirected to those middle and high income earners who can afford to pay private health insurance and who were already seeing private dentists on a regular basis.

In Tasmania the issue of dental health is a critical one and the loss of funding from the public dental health care sector impacts severely on those in greatest need. Tasmanian adults have the worst dental health in the nation with the highest percentage of edentulous (complete loss of natural teeth) adults per capita with 15.3% of the adult population, compared to the national average of 9.7%. The State

also has the highest percentage of persons wearing a denture in the nation, with 11.2% in the 25 – 44 year category, which is almost double the national average.[xv]

The extremely poor dental health status of Tasmanians can be explained by a number of factors:

- the extraordinarily long waiting times for general dental care;
- due to delays, dental problems deteriorate from restorative treatments to acute surgical ones;
- people are forced to substitute emergency care for basic dental care
- very low numbers of dentists in the State and difficulties recruiting dentists into the public dental system.[xvi]

Drawing on this example, Anglicare argues that the dental health needs of low income Australians would be better met if those funds went directly into the public health system, which includes better, more accessible dental health care. Some estimates suggest that an additional 1.5 million cases could be treated annually if current government subsidies to the private health sector were redirected to public hospitals.[xvii]

Therefore as a general point, Anglicare argues that the extension of the private health insurance rebate to cover out-of- hospital costs will only serve to further redirect resources away from universal health care through adequately resourced GP services and the public health system and away from those in the community in greatest need.

## 4. RECOMMENDATIONS

*1. The rebate to GPs who bulk-bill all patients be increased*

To improve the access and affordability of general practice Anglicare recommends that the Medicare rebate be raised to a rate which would adequately resource GPs to increase bulk-billing. To maintain the universality of Medicare, this higher rebate should be extended to GPs who bulk bill all their patients, not concession card holders only. The higher rate should be based on an accurate assessment of the cost of a standard consultation and indexed annually.

*2. The 30% rebate for private health insurance be abolished*

National evidence indicates that Australia's public health system is experiencing increasing demand while the resources to meet the demand are diminishing. Anglicare recommends that the 30% private health insurance rebate is abolished, enabling the $2.26 billion currently paid in subsidies to be redirected to Medicare and other areas of the health system.

## Endnotes

[i] Australian Bureau of Statistics, 2001*, Australian Social Trends,* Commonwealth of Australia, Canberra, Cat. No: 4102.0

[ii] For example, Mathers, C., Vos, T. & Stevenson, C., 1999 *The burden of disease and injury in Australia* AIHW Cat No: PHE18, AGPS, Canberra; National Health Strategy 1992 *Enough to make you sick: How income and environment affect health* Research Paper No 1, AGPS Canberra

[iii] Australian Bureau of Statistics, 2001*, Australian Social Trends,* Commonwealth of Australia, Canberra, Cat. No: 4102.0

[iv] ABS unpublished 2002 *Labour Force, Selected Summary Tables, Australia, Monthly*, Table u5.Cat No; 6291.0.40.001

[v] Madden, K. 2003 *Blue Collared: The shrinking world of work in Tasmania*, Anglicare Tasmania <www.anglicare-tas.org.au>

[vi] The section on General Practice in Tasmania draws on the research undertaken by Anglicare : Madden, K. 2002 "Access to Bulk-Billing General Practitioners in Tasmania" *Australian Journal of Primary Health* 8(1): 87-90; Anglicare Tasmania 2001 *Hearing the Voices Vols: 1 & 2* Anglicare Tasmania, Hobart www.anglicare-tas.org.au

[vii] Glover, J., Harris, K. & Tennant, S. 1999 *A Social Health Atlas of Australia: Tasmania Second Edition Volume 7* Public Health Information Development Unit, University of South Australia, Adelaide

[viii] National Medicare Alliance, 2003 *A Plan to end the bulk-billing crisis* www.nma.org.au

[ix] Herbert A. & Short L. 2002 *Economic Wellbeing in Tasmania Healthy Communities Survey Report No 9*, Department of Health and Human Services, Hobart Tasmania

[x] For example see Richardson, J. 1991*The Effects of Consumer Co-payments on Health in Medical Care*, Background Paper Number 5, National Health Strategy, AGPS, Canberra.; Shi, L., Starfield, B., Kennedy, B. & Kawachi, I. 1999 Income Inequality, Primary Health Care and Health Indicators, *Journal of Family Practice*, April; 48(4): pp 275-84.; Turrell, G., Oldenburg, B., McGuffog, I. & Dent, R. 1999 *Socioeconomic determinants of health: towards a national research program and a policy intervention agenda*, Queensland University of Technology School of Public Health Centre for Public Health Research.

[xi] Richardson, J. 2003 "The Amendments to Medicare of 28 April" *Australian Financial Review* May 6, 2003

[xii] for example, Jones, C. "Hospital queues set to double" The Courier Mail 23 June 2003

[xiii] Commonwealth Department of Health and Ageing, 2003 Medicare: Average Patient Contribution per Service Table B5 cited in Health Issues Centre 2003 Senate Select Committee on Medicare

[xiv] Spencer, A.J. (2001) "What options do we have for organizing, providing and funding better public dental care?" Australian Health Policy Institute, University of Sydney

[xv] Australian Institute of Health and Welfare, Dental Statistics and Research Unit, (2001a) "Oral health and Access to Dental Care 1994-96 and 1999" Research Report, Adelaide University;: Australian Institute of Health and Welfare, Dental Statistics and Research Unit, (2001b) "Oral Health and Access to Dental Care – the gap between the 'deprived' and the 'privileged' in Australia" Research Report, Adelaide University

[xvi] Cameron, P. 2002 *Access to Dental Care for Low Income Tasmanians: a Discussion Paper* Anglicare Tasmania www.anglicare-tas.org.au

[xvii] Duckett, S. & Jackson.T. 2000 "The new health insurance rebate: an inefficient way as assisting public hospitals" Medical Journal of Australia 172 : 439-442

APPENDIX A

APR-23-2003 WED 02:41 PM FROM: FAX: PAGE 1

Dr Lucy Alexander
Claremont Village Medical Centre
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PH 62 491311

22nd April 2003

Mr Chris Jones
CEO Anglicare

Dear Mr Jones

I heard your ABC radio interview this morning and am writing to explain some concerns I have about the proposed changes to Medicare. The government's claim that the changes will guarantee bulk billing for healthcare card (H.C.C.) holders are entirely false. I am an idealistic female GP in a practice in Claremont which you will well know has a mix of low income earners and pensioners. Approximately 70% of our patients have health care cards. However those who do not have a H.C.C. are usually only just above the income threshold ie; the working poor. They would have great difficulty paying a gap of $20 at the GP and then full price for medications at the chemist.

The situation is entirely different in central, higher income areas. They may have a mix for arguments sake of approx 30% HCC holders and 70% private paying patients. Those private patients are often already paying $40 - $48 per consultation ie; a gap of $20 or more.

To make a simple comparison of practice income per 100 patients seen:

**OUR PRACTICE:**

For 100 standard patients visits under the new system we would charge out = **$2965.00**
This is made up of;
70 patients x $26.05 ( the new rebate) = **$1823.50**
30 patients x $38.05 = **$1141.50**
(a $12 gap - as much as we think our paying patients can afford)

**CITY PRACTICE:** For 100 patients visits - = $4005.00
30 patients x $26.05 = $ 781.50
70 patients x 46.05 =$3223.50
(assuming they charge a $20 gap
they may charge more already)

So using this example, a practice in an affluent area will take in $4005, and a practice in an area of low income will take in $2965 for the same work.

Our concerns is this – doctors are usually paid a percentage of gross fees charged. We already have huge difficulty recruiting doctors to work in less affluent areas. This is for many reasons other than money. They usually live and educate their children centrally and not in areas such as Chigwell and Claremont.

In our practice we strive to provide an excellent standard of medical care for people in a low income area. All our doctors have specific general practice training, we are accredited,

computerised and see an average of only four patients an hour ie; we do not rush people through in order to make money. We want to stay working in our area with patients who can not afford to pay a lot more towards their health, but we will not compromise our standards. We actually ask our HCC holders to contribute $5 to the cost of their consultations already, and our paying patients pay a $10.95 gap.

| | |
|---|---|
| Ie; 30 x $36 | = $1080.00 |
| 70 x $30.05 | = $ 2103.50 |
| Total | = $ 3183.50 |

From this calculation you can see that our practice would take in less money if we change to the new system. We can not provide our current standard of care on less income. The relative value study found that the real cost of a standard consultation should be $45.00. General practice expenses are high at about 50% of income, due to rent, staff, medical equipment and computers etc. Therefore when the government says it will guarantee bulkbilling for HCC holders with this new package they are making a huge unsubstantiated assumption.

There are 2 more points I would like to make.

1. The government may actually realise that inequity exits in this proposal but may be setting us (GP's) up as greedy if we criticise it.

2. If a practice accepts the package and agrees to bulk bill HCC holders, are they going to continue to accept HCC holders as new patients or will these people find they are not "acceptable" to some practices due to decreased remuneration compared to paying patients?

Please consider these issues carefully and use your influence in debate on this matter. I would appreciate the chance to discuss any of this with you if you have time.

Yours faithfully

Dr Lucy Alexander