

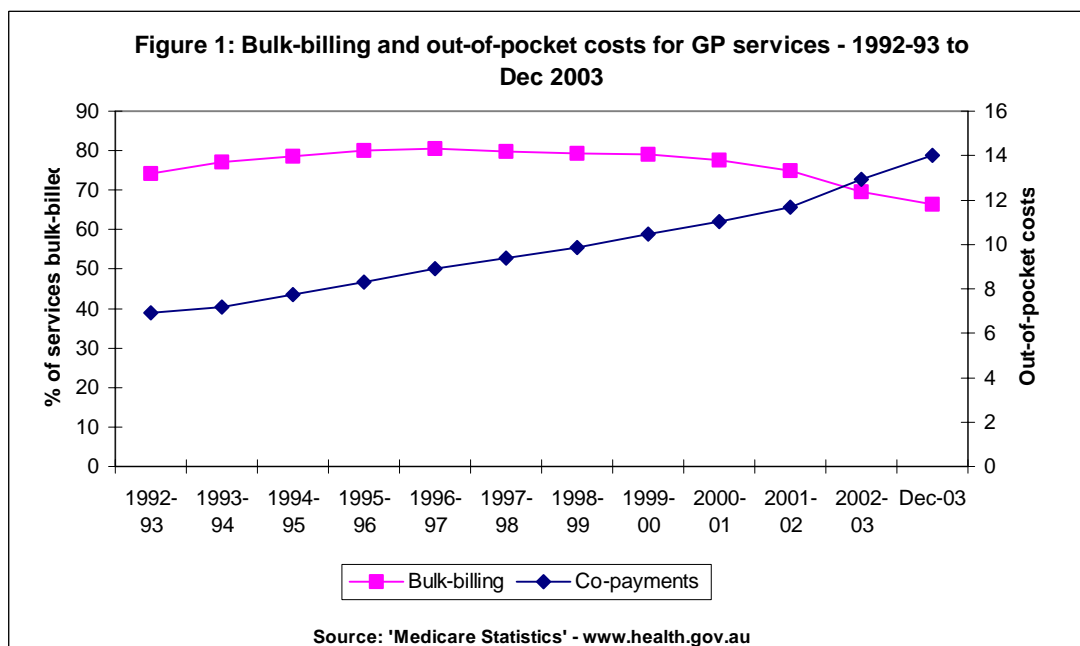
From A Fairer Medicare to Medicare Plus: What are the Implications for the Future of Bulk-billing and Medicare?

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The recent passing by the Senate of the Commonwealth government's Medicare Plus package, followed a year-long debate about the future of Medicare. During this period a Senate Select Committee on Medicare was established to examine the government's first package, A Fairer Medicare, and then reconvened to consider its second package, Medicare Plus. This article examines both packages and explores the impact that Medicare Plus will have, if any, on the rate of bulk-billing and patient out-of-pocket costs for general practitioner services throughout Australia and asks whether 'Medicare Plus' will strengthen or undermine Medicare.

The Decline in Bulk-billing by General Practitioners

The decline in bulk-billing and rise in out-of-pocket costs for general practitioner services in recent years has led to a significant focus on health policy, and specifically Medicare. Bulk-billing rose from 74.2% in 1992-93 to a peak of 80.6% in 1996-97 (see figure 1) before falling to 66.5% in December 2003 (Commonwealth Department of Health & Ageing, 2004a). During this same period, out-of-pocket costs for general practitioner services have risen from an average of \$6.90 to \$14.03 (Commonwealth Department of Health & Ageing, 2004b).



The rate of bulk-billing is far from evenly spread throughout Australia. In the year ending 2002-03, 76.6% of services were bulk-billed in New South Wales, 66.3% in Victoria and 66.1% in Western Australia. By contrast, the bulk-billing rate was 54.7% in Tasmania and only 38.5% in the Australian Capital Territory (Commonwealth Department of Health & Ageing, 2004c). A breakdown of bulk-billing rates by federal electorate for the December 2003 quarter further highlights this uneven spread. In the electorate of Fowler, located in South-west Sydney, for example, 97.5% of general practitioner services were bulk-billed compared to a bulk-billing rate of only 29.8% in the electorate of Indi, located in rural Victoria (Commonwealth Department of Health & Ageing, 2004d).

The National Medicare Alliance (2002) has argued that there are several reasons for the decline in bulk-billing by general practitioners. These include:

- increased general practitioner workload in rural, remote and outer metropolitan areas as doctor numbers decline;
- decreased competition (including undersupply in some areas), particularly in rural, remote and outer metropolitan areas;
- the amount doctors get back through the rebate being gradually eaten away by inflation;
- changing make up of the general practitioner workforce and preferences for shorter working hours;
- increased administration costs of running a practice;
- rising medical indemnity insurance premiums; and
- lower job satisfaction.

The relationship between the rate of bulk-billing and general practitioner numbers is also a significant factor. Although the figures in Table 1 are now two years old, they show that bulk-billing rates are highest where the supply of general practitioners is highest, and lowest where there are fewer general practitioners per 100,000 people.

Table 1: Number of general practitioners per 100,000 persons and percentage of services bulk-billed

Location	Number of general practitioners per 100,000 persons	Percentage of services bulk-billed
Capital cities	122.7	85.2
Other metropolitan areas with populations of 1000,000	108.1	79.6
Large rural areas with populations of 25,000	111.4	60.2
Small rural areas with populations between 10,000-24,999	93.6	59.4
Other rural areas with populations of 5,000+	77.3	58.7
Remote areas	66.1	56.8

Source: Australian Competition and Consumer Commission 2002, *A Fairer Medicare*

In response to community concern about the decline in bulk-billing, the government introduced A Fairer Medicare – Better Access, More Affordable on 28 April 2003. The cost of this package was estimated to be \$917 million. A Fairer Medicare sought to introduce the following measures:

- incentives for general practitioners to bulk-bill concession card holders;
- a safety net to meet 80% of concession card holder's out-of-pocket costs once those costs reached a \$500 threshold;
- private health insurance funds to offer insurance for out-of-pocket costs over \$1,000;

- an additional 234 new medical school places and 150 new general practitioner registrar positions; and
- funding to employ nurse practitioners (Commonwealth Department of Health & Ageing, 2003).

The response by consumers and professional groups to A Fairer Medicare was far from positive. While most supported initiatives such as additional medical places and practice nurses to support the work of general practitioners, community and professional groups were critical of the key element of A Fairer Medicare – incentives for general practitioners to bulk-bill concession card holders and the establishment of a safety net for concession card holders. In response, the Senate Select Committee on Medicare was established to examine A Fairer Medicare.

Senate Select Committee on Medicare

The Senate Select Committee on Medicare was established on 15 May 2003 and the public response to the work of the Committee demonstrated the importance of Medicare to the Australian population. The Committee received 226 submissions from members of the public, consumer organisations, professional groups, the Commonwealth Department of Health and Ageing, and state and territory governments. Once submissions were received, the Committee held public hearings throughout Australia.

Submissions and public hearings highlighted a range of views concerning A Fairer Medicare. The majority of those who made submissions and gave evidence to the Committee supported the need for additional medical places and nurse practitioners to assist the work of general practitioners, and this was also advocated by the Senate Select Committee on Medicare (The Senate 2003, pp. xv-xvii).

The Senate Select Committee on Medicare also examined the change in general practitioner incomes, relative to average weekly earnings and the incomes of specialists. This was raised by the Australian Council for Social Service (2003, p. 2) in its submission to the Committee when it argued:

“When measured against the income levels of the general population, general practitioner incomes are very high indeed. In 2001, Jeff Richardson of Monash University estimated that the bulk of GPs providing the bulk of services are earning taxable incomes of between \$100,000 to \$105,000 per annum (7.30 Report, 3 January 2001) compared to median household incomes of around \$40,000. However, when measured against specialists and some other professional groups, this level of income may be considered insufficient by many GPs.”

The importance of this issue was further recognised when the Senate Select Committee commissioned the Australian Institute for Primary Care to examine A Fairer Medicare and the Opposition’s alternative package. Analysing average weekly ordinary earnings (AWOTE) data, the Australian Institute for Primary Care found that, while general practitioner incomes are substantially higher than that of AWOTE, there had been a decline in general practitioner incomes relative to AWOTE in the period from 1993-2003. The Institute found that relative general practitioner incomes had fallen from 5.2 times average weekly earnings in 1993 to 4.7 times average weekly earnings in 2003 (Australian Institute for Primary Care, 2003, pp. 19-20).

The Australian Institute for Primary Care argued that the relative decline in general practitioner incomes was a significant reason for the decline in bulk-billing as general practitioners increased patient out-of-pocket costs as a way to restore their relative income level (Australian Institute for Primary Care 2003, p. 3). The Australian Institute for Primary Care (2003, p. 4) further argued:

“...Trend data indicate that bulk-billing rates were relatively stable when Commonwealth expenditure per FTE [full-time equivalent] general practitioner was around 5.2 times

average weekly earnings. Over time, as the value of FTE general practitioner Commonwealth expenditure has declined as a proportion of AWOTE, bulk-billing rates have declined and out-of-pocket costs have increased. Current general practitioner behaviour could be interpreted as attempting to restore past relativities."

Not only have general practitioner incomes fallen relative to AWOTE, there has also been a significant decline in general practitioner incomes relative to specialist's incomes. According to Ford and Livingstone (2004, p. 12):

"...Health Insurance Commission data relating to the billings of general practitioners and surgeons for the period 1997-98 to 2001-02 ... demonstrate that general practitioners' billings declined by more than 7.8% relative to their surgical colleagues... We believe that like any other group in the community, general practitioners keep a watchful eye on the relative financial wellbeing and will respond to signals about their relative ranking in the income stakes. Thus, in any situation where there is a discretion to charge someone more, this option will be taken up."

The report by the Australian Institute for Primary Care and other evidence received, led to the Senate rejecting A Fairer Medicare. According to the Committee:

"At a philosophical level, the government package amounts to a decisive step away from the principle of universality that has underpinned Medicare since its inception. The Committee does not accept the government's argument that, because everyone continues to be eligible to be bulk-billed and receives the same rebate, universality is preserved... At a practical level, the policy is focusing on 'guaranteeing' bulk-billing of concessional patients in a way that is quite simply unnecessary, since the majority of these people are in all likelihood already bulk-billed. The Committee is inclined to agree that the package essentially focuses on a solution to a problem that does not exist" (The Senate 2003, p. xiii).

Medicare Plus

The rejection by the Senate of A Fairer Medicare led to the government proposing an amended package, Medicare Plus. At a cost of \$2.85 billion Medicare Plus kept a number of initiatives from A Fairer Medicare, such as nurse practitioners, and introduced a number of new initiatives such as:

1. A two-tiered safety net for out-of-pocket expenses for medical services out of hospital.

This is perhaps the most contentious of the changes in Medicare Plus. The safety net will meet 80% of out-of-pocket expenses for medical services provided out of hospital for:

- families who receive Family Tax Benefit (A) – once an annual threshold of \$300 is reached;
- Concession Card Holders – once an annual threshold of \$300 is reached for individuals and families; and
- all other individuals and families – once an annual threshold of \$700 is reached for individuals and families (Commonwealth Department of Health & Ageing, 2004e).

2. Incentives to lift the rate of bulk-billing in rural, regional and remote Australia and Tasmania.

According to the Commonwealth Department of Health & Ageing (2004e) "general practitioners in regional, rural and remote Australia and in all of Tasmania who bulk bill concession card holders and children under 16 will benefit from a ... bulk billing incentive payment ... [of] \$7.50".

3. Allied health and dental health services for people with chronic conditions and complex needs.

"This initiative introduces a new MBS item that can be claimed by a general practitioner for certain services provided 'for and on behalf of a the general practitioner' by an allied health provider (excluding state or Commonwealth funded allied health providers)" (Commonwealth Department of Health & Ageing, 2004e).

4. Dental Plans

In addition, Medicare Plus will bring in a further MBS item to support access for dental treatment for people with a chronic or complex health condition. It is estimated that over 69,000 dental treatment care plans will be covered by this item (Commonwealth Department of Health & Ageing, 2004e).

5. Other initiatives announced as part of Medicare Plus include:

- expanding HealthConnect/MediConnect;
- new medical school places to meet the need of rural and remote communities; and
- new criteria to determine rural, remote and metropolitan areas classification (Commonwealth Department of Health & Ageing, 2004e).

Analysis of Medicare Plus

At the beginning of this article it has been argued that the introduction of A Fairer Medicare and then Medicare Plus largely rose as a response to community concern about the decline in bulk-billing by general practitioners. With this in mind it is important to ask: What impact will Medicare Plus have on the future of bulk-billing in Australia?

Bulk-billing and Patient Out-Of-Pocket Costs

While new initiatives such as additional medical school places are welcome, there is little in the Medicare Plus package to suggest that bulk-billing will rise or that patient out-of-pocket costs will fall. The Commonwealth Department of Health and Ageing (2004e) estimates that an additional 1.8 million services will be bulk-billed each year as a result of the \$7.50 incentive for general practitioners who bulk-bill concession card holders and patients under 16 in regional, rural and remote Australia and Tasmania. The calculation of 1.8 million services is based on the number of services that are currently charged an out-of-pocket cost of less than \$7.50. As outlined previously, the average out-of-pocket cost in December 2003 throughout Australia was \$14.03 (Commonwealth Department of Health & Ageing, 2004b). Although an additional 1.8 million bulk-billed services is welcomed, its impact is unlikely to be significant in the broader context as this accounts for only 1.86% of all services provided by general practitioners for the year ending 2002-03 (Commonwealth Department of Health & Ageing, 2004f).

If general practitioners in rural, remote and regional Australia and Tasmania choose to bulk-bill concession card holders and patients under 16, then the bulk-billing rate may settle at just above 50% in these areas. Using Ford and Livingston's (2004, p. 13) analysis and assuming that "... a busy general practitioner who has 3,000 consultations a year of whom 50% are Health Care Card holders, and a further 5% of whom are non-Health Care Card entitled young people, an additional \$7.50 would earn that general practitioner an additional \$12,375 per year". As the Australian Institute for Primary Care (2003) analysis of A Fairer Medicare found, general practitioners have increased out-of-pocket costs as a way to restore their relative income levels. If general practitioners do not consider the additional income to be sufficient to restore income levels they will continue to charge out-of-pocket costs. In the past, not all general practitioners charged out-of-pocket costs as they were mindful of the financial hardship this could cause patients. There is a possibility that this will change due to the Medicare Plus safety net. It may now be easier for general practitioners to charge out-of-pocket costs to their

patients (and therefore cease bulk-billing), as they will know that their patients are now covered by the safety net once their out-of-pocket costs reach the \$300 or \$700 threshold.

Allied Health

The introduction of allied health and dental services for people with chronic conditions and complex needs under the Medicare Plus package is a welcome yet limited initiative. According to the Health Minister; "under the Enhanced Primary Care program introduced in 1999, general practitioners can involve at least two allied health professionals in developing a Multidisciplinary Care Plan for people with chronic and complex health conditions. The new item will cover up to five allied health professional consultations (at \$80 initially and \$35 subsequently) delivered under a Care Plan" (Abbott 2004).

With regard to dental care, the Commonwealth Department of Health and Ageing (2004e) estimates that 69,000 dental treatment care plans will be covered by this initiative over a three-year period. The limitation of the funding through Medicare Plus for public dental treatment can be seen in light of an examination of public dental waiting lists throughout Australia. In the first 12 months following the cessation of the Commonwealth government's Dental Health Program, waiting lists for public dental treatment across Australia grew by 20% (Ziguras & Moore 2001). In June 2002, 223,741 patients were waiting for treatment in Victoria's public dental system, an increase of 17.7% from the previous year (Dental Health Services Victoria 2002). Patients in Victoria can expect to wait 22 months for restorative care and 24 months for dentures (Department of Treasury & Finance 2003). So it is doubtful that this initiative will be sufficient to meet needs.

Out-Of-Pocket Costs

While patients will now be eligible for the \$300 and \$700 safety net under Medicare Plus, there is no guarantee that the safety net thresholds will not be adjusted upwards in the medium term, thereby shifting the burden of health care costs to the individual. Such a scenario is likely if the Commonwealth faces the type of future budgetary pressures forecast by the Intergenerational Report (Costello 2002). The Intergenerational Report predicts that Commonwealth expenditure will have to rise by 5% of GDP by 2041 to meet cost pressures associated with an ageing population and rising pharmaceutical costs. A number of commentators have argued that the Intergenerational Report is too pessimistic as it fails to take into account evolving policy positions and improvements in population health by 2041. If the Commonwealth chooses not to raise taxes to meet rising health care costs, alternative options include cutting health expenditure or shifting the burden of health expenditure from the government to the individual through increasing direct patient charges (Ford 2003, p. 159). The latter would follow the trend of shifting the burden of health care costs to the individual. According to the Australian Institute of Health and Welfare (2002, p.32) total health expenditure by individuals as a proportion of all non-government expenditure has risen from 51.2% in 1991-92 to 58.6% in 2001-02.

Conclusion

Although the Senate has only recently passed the Medicare Plus legislation, there is little evidence that the package will have any positive impact on the rate of bulk-billing throughout Australia. Rather, it is likely bulk-billing will continue its downward trend while patient out-of-pocket costs for general practitioner services will continue to rise. Ongoing analysis of Medicare Plus will need to consider whether general practitioners will be more disposed to increasing out-of-pocket costs to restore relative income levels in the knowledge that their patients are now covered by a two-tiered safety net. It will be important to ask what guarantees are in place to ensure that the safety net will be kept at its current level, particularly in light of future cost pressures canvassed in the Intergenerational Report.

Consumer Criteria for Assessing Medicare Plus*

1. *Universality: Does the policy recognise health care as a basic human right and build upon the universal basis of Medicare?*

Medicare Plus is a break from the universality of Medicare. This is due to the introduction of a two-tiered safety net for patient out-of-pocket costs and incentives for general practitioners to bulk-bill concession card holders and patients under 16 in rural, regional and remote Australia and Tasmania. There is little in the package to reverse the decline in bulk-billing or the rise in patient out-of-pocket costs for general practitioners' services.

2. *Equity of Access and Outcomes: Does the policy promote equitable access to health services, and encourage equitable outcomes for all population groups in Australia?*

Through funding for new medical school places to meet the needs of rural, regional and remote communities, Medicare Plus seeks to address the lack of access to general practitioners services faced by people living in these areas. By contrast, incentives for general practitioners to bulk-bill concession card holders and patients under 16 in rural, regional and remote Australia and Tasmania may see bulk-billing level out at the percentage of the population with concession cards and those under 16 in these areas, but will do little to lift the overall rate of bulk-billing throughout Australia. Funding for allied and dental health services for patients with chronic conditions and complex needs will have only a small impact on population health outcomes.

3. *Quality: Does the policy promote quality of care and focus on health outcomes as defined by consumers?*

Quality of care and health outcomes is not the focus of the Medicare Plus package.

4. *Transparency: Does the policy provide for information and accountability to consumers in terms of both cost and quality?*

The government's initial package, A Fairer Medicare, was developed with almost no community input. By contrast, Medicare Plus has been scrutinised as a result of the Senate Select Committee on Medicare and the ongoing public debate that followed. The effectiveness of Medicare Plus will be judged, in part, by examining future trends in bulk-billing and patient out-of-pocket costs.

5. *Affordability: Does the policy ensure the affordability of health services to consumers and the community and minimise the incidence of uncapped consumer co-payments?*

There is little in the Medicare Plus package that will stem the decline in bulk-billing by general practitioners and therefore make general practitioners more affordable. It is likely that general practitioners will continue to increase patient out-of-pocket costs in an effort to restore their relative income levels. For consumers, the Commonwealth will pay 80% of out-of-pocket costs once they reach the \$300 or \$700 threshold.

6. *Directness: Does the policy maximise the funding that goes directly to health service provision, and minimise the funding, which is channelled through indirect sources such as public and private administration?*

Funding provided through Medicare Plus is largely directed towards the following: funding 80% of patient out-of-pocket costs over the \$300 and \$700 thresholds; incentives for general practitioners who bulk-bill concession-card holders and patients under 16 in rural, regional and remote Australia and Tasmania; funding for additional medical school places; and expanding HealthConnect/MediConnect.

7. *Value for Money (technical efficiency): Is the policy efficient and does it avoid 'false' economies, such as cost shifting, unintended consequences and flow on effects?*

There is little in the Medicare Plus package that will lead to a rise in the overall rate of bulk-billing in Australia. It is likely that general practitioners will continue to increase patient out-of-pocket costs as they seek to restore their relative income levels.

8. *Best Use of Money (allocative efficiency): Does the policy encourage the allocation or reallocation of resources in ways that are likely to bring about equitable and optimal health outcomes?*

A far more efficient and effective allocation of resources would have seen bulk-billing incentives directed to general practitioners who bulk-bill all patients.

9. *Health Creation: Will the policy contribute to the creation of a healthier community, rather than merely treating existing illness and/or injury?*

Medicare Plus will have a positive impact on population health through additional medical school places to meet the needs of rural and remote communities. Another positive, but limited, aspect of Medicare Plus is funding for allied health and dental health services. By contrast, Medicare Plus will fail to improve the health of the community if bulk-billing rates continue to fall and patient out-of-pocket costs continue to rise.

10. *Consumer Participation: Have consumers been actively involved in the development of this policy? Will consumers be included as partners in implementation, monitoring and evaluation?*

Consumers have been involved in the development of the Medicare Plus package by participating in the Senate Select Committee on Medicare through written submissions and verbal evidence to the Committee.

*Adapted from Health Issues Centre 1999, *Health Financing: Bringing Consumers into the Loop*, Melbourne

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