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Decline in Bulk Billing: Explanations and Implications

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The Decline in Bulk Billing: Explanations and Implications

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Introduction

The release of the latest Medicare statistics by the Department of Health and Ageing on the 30 August 2002 provoked various commentators to claim that bulk billing is disappearing and that Medicare is in crisis.¹ While the new figures show that the majority of Medicare services continue to be bulk billed, the second full year of decline has sparked disquiet that the universality underpinning Medicare is being undermined. Central to this concern is the claim that medical services provided by General Practitioners (GPs) are becoming unaffordable for many patients and consequently universal access to quality medical care is being compromised. Moreover a series of claims linking the decline in bulk billing with increasing pressure on public hospitals, has sparked claims that there has been a shift in costs from the Commonwealth to the States and Territories. A comprehensive response to the decline in bulk billing has been hampered by disagreement between the peak association for medical practitioners the Australian Medical Association (AMA) and the Federal Government over the explanations for the decline.

This paper provides details of the decline in the proportion of Medicare services being bulk billed, and includes a summary of the rate of bulk billing amongst different practitioners and in each State and Territory. Explanations of the decline in bulk billing are also considered with a focus on the different positions of the Commonwealth Department of Health and Ageing and the AMA. Finally, the paper explores some of the suggested implications of a decline in the rate of bulk billing.

What is Bulk Billing?

Free or subsidised treatment by medical practitioners is one of the cornerstones of Medicare, the Commonwealth funded national health insurance scheme.² Medical services available under bulk billing arrangements are listed in the [Medicare Benefits Schedule](#) (MBS). The Commonwealth, in consultation with various stakeholders, sets the Schedule fee for these services.³ Under Medicare doctors are paid 85 per cent of the Schedule fee for outpatient services and 75 per cent for in-patient services in private hospitals.

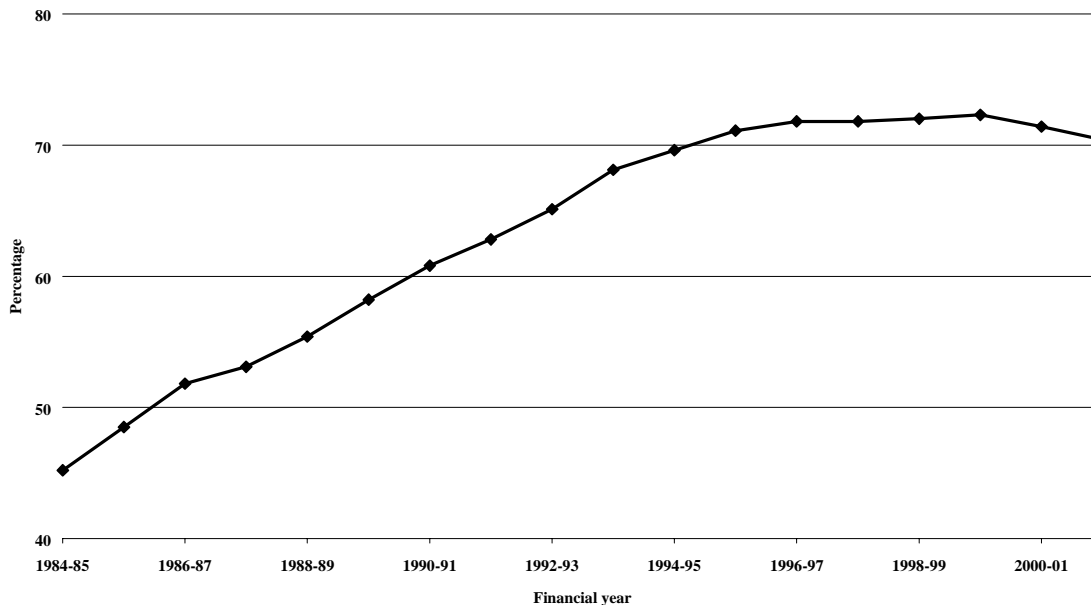
Patients themselves may claim Medicare benefits by paying the doctor's account and then claiming the benefit from Medicare. Or they can obtain a cheque from Medicare, payable to the doctor. This cheque along with any balance is then given to the doctor.

Alternatively, medical practitioners can directly bill Medicare, accepting the Medicare rebate as full payment for the service. This arrangement is known as direct billing or 'bulk billing'. Under these arrangements no additional charges relating to a bulk-billed service may be made, consequently there is no out of pocket cost to the patient. Generally, when a Medicare service is not bulk billed, it is because the practitioner is charging more than the Medicare rebate.

How Much has it Declined?

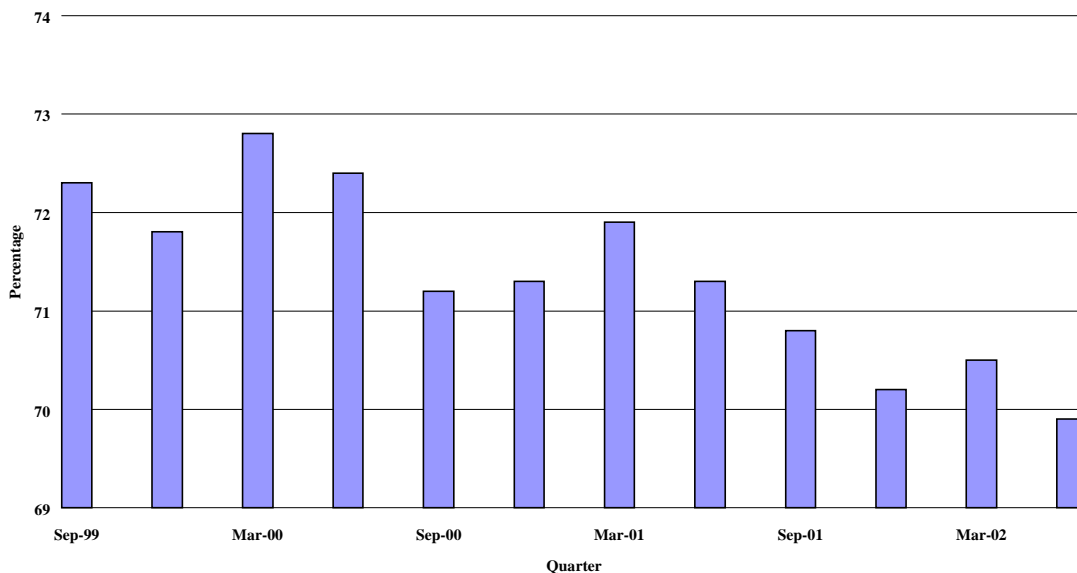
From the introduction of Medicare in 1984, the rate of bulk billing steadily increased throughout the 1980s and early 1990s. However, this trend was halted in 1996 and between then and 2000 the proportion of Medicare services bulk billed remained relatively stable. However, since peaking at 72.3 per cent in 1999–2000, the proportion of all medical services bulk billed has fallen by almost 2.5 per cent. Figures, released on the 30 August 2002 by the Department of Health and Ageing, show that in the year ending June 2002 the percentage of Medicare services bulk billed had dropped to 70.4 per cent.⁴ At 69.9 per cent, the bulk billing rate for the latest quarter (June 2002) is even lower and indicates that the decline is likely to continue.⁵ The following graph clearly shows the plateau and then decrease in the proportion of services bulk billed since 1996–1997.⁶

Graph 1: Medicare: Percentage of services bulk billed



Graph 2 provides a quarter by quarter account of bulk billing rates since September 1999, showing in more detail the changes in the percentage of Medicare services bulk billed since September 1999.

Graph 2: Medicare: Percentage of services bulk billed
September quarter 1999 to June quarter 2002



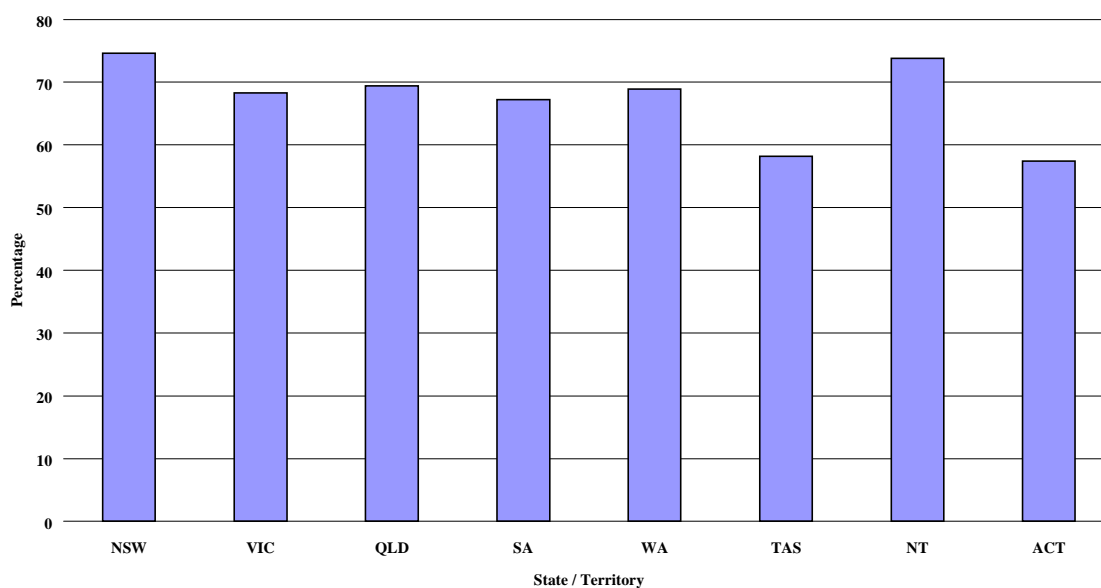
The decline in the rate of bulk billing is not spread evenly across all Medicare services. For instance, between the year ending June 2001 and the year ending June 2002, the proportion of services provided by Vocationally Registered General Practitioners (VRGPs) declined by 2.9 per cent, as did the proportion of obstetric services bulk billed.⁷ However other Medicare services, such as pathology and optometry increased slightly (0.9 per cent & 0.2 per cent respectively) in the same period. Different medical services are bulk billed at different rates. For instance, in the June quarter pathology and optometry services had bulk billing rates of 83.8 per cent and 96.4 per cent respectively. The bulk-billing rate for VRGPs was 73.1 per cent. Obstetric and anaesthetic services are much lower at 19.7 per cent and 9.1 per cent respectively.⁸

Medicare: Percentage of Services Bulk Billed, financial year of processing, by broad type of service

	VRGP	EPC	Specialist	Optometry	Pathology	Obstetric	Operations	Anaesthetics
2001-2002	74.1	96.7	29.5	96.4	83.9	20.1	41.3	9.1

The proportion of Medicare services bulk billed also varies between each State and Territory. The rate of bulk billing remains above 70 per cent in NSW and NT, however in the remaining States and Territories it has fallen below 70 per cent. In both Tasmania and the ACT less than 60 per cent of Medicare services are bulk billed. Graph 3 provides details of these differences.

Graph 3: Medicare: Percentage of services bulk billed States and Territories 2001-02



Of all the States and Territories only NT did not record a decline in the rate of bulk billing in the twelve months to June 2002, rather it increased slightly by 0.7 per cent. In contrast, during the same period bulk billing in the ACT declined by 3.2 per cent. The following table provides details of the rate of change in each State and Territory.

	NSW	VIC	QLD	SA	NT	WA	TAS	ACT
Percentage Change in bulk billing: year ending June 2002	-0.3	-1.5	-1.5	-1.2	+0.7	-1.0	-0.4	-3.2

Who is and Who isn't Being Bulk Billed

Various press reports have stated that general practitioners are gradually withdrawing from bulk billing health care card holders, patients on low incomes and older patients.⁹ In addition, there have long been concerns that the rate of bulk billing in rural and regional Australia is much lower than that in metropolitan areas. Senator Kay Patterson, the Minister for Health and Ageing, claimed in a recent press release that the bulk billing rate for GP services for patients aged 65 and over was 82.3 per cent and that the rate of bulk billing in some suburban areas is over 80 per cent.¹⁰

With an overall decline in the proportion of Medicare services being bulk billed, and an almost three per cent decline in the number of services provided by VRGPs, it is likely that there has been a shift in who is and who isn't being bulk billed for Medicare services.¹¹ However, the Medicare Statistics compiled and published by the Department of Health and Ageing do not include details of the proportion of Medicare services bulk billed by location. Nor is there available data that identifies the proportion of services provided to health care card holders and low income earners that are bulk billed. Until more extensive data is publicly available it is likely that the anecdotal claims made about who is and who isn't being bulk billed will remain unverified.

Explanations for the Decline

Public discussion about the decline in the rate of bulk billing has focused on the proportion of general practitioner services being bulk billed. Consequently, explanations of the decline in the rate of bulk billing have primarily centred on two competing claims: the level of the Schedule fee, and the geographical distribution of GPs. Other issues that have been raised include Medicare compliance costs, the corporatisation of general practice and anti-competitive practices.

The Scheduled Fee and the Medical Workforce

Debate about the decline in the proportion of Medicare services bulk billed has proven to be a significant source of disagreement between the Federal government and the AMA.

The AMA argues that because the Scheduled fee has not kept pace with either the cost of running a practice or the Consumer Price Index, rates of bulk billing are declining as doctors increasingly charge above the rebate level.¹² Consequently, the AMA claims that an increase in the Scheduled fee in line with the CPI would improve bulk billing rates.¹³

In addition to pointing to the failure of the Medicare rebate to keep up with inflation, the AMA has increasingly lobbied the Federal government to act on the findings of the [Relative Value Study of the General Medical Services Table of the Medicare Benefits Schedule](#) (RVS). The RVS was a review carried out by the Department of Health and Ageing and the AMA that focused to a large extent on increasing compliance with the Medicare Scheduled fee. The AMA claims that the RVS indicates that the Scheduled fee for GP services should be increased by approximately 50 per cent and that implementation of the study is necessary for the long-term survival of Medicare.¹⁴

The Federal government offers a different explanation to that of the AMA, arguing that rather than being driven by inadequate rebates and high practice costs, declining bulk billing rates and growing out of pocket expenses are the result of the size and location of the medical workforce.¹⁵

Arguing that there is currently a geographical maldistribution of doctors, the Commonwealth views below average bulk billing rates as an indicator of an under supply of doctors in a geographical area and there is some evidence to suggest that this is the case.¹⁶ An oversupply of practitioners can drive prices down to the Medicare rebate, increasing bulk billing rates.¹⁷ Conversely, the AMA has argued that there is a general shortage of doctors, at least partly due to inadequate remuneration.¹⁸

Not all research points to a strong relationship between the supply of doctors, bulk billing rates and higher patient costs.¹⁹ The market for GP services is complex and distorted by a number of factors, including the existence of bulk billing and that GPs can generate demand for their services. Fee setting is not simply a product of supply of GPs. Perversely, there is some evidence to suggest that an increase in the supply of doctors can lead to both increases in out of pocket expenses for patients and an increase in the rate of bulk billing. For instance, noting the complexity of the market for GP services, research by Richardson, Peacock and Mortimer tentatively concludes that:

... an increase in the doctor supply does not reduce fees; that it increases extra billing but promotes a compensating increase in bulk billing.²⁰

Both the AMA and the Federal Government recognise that the market for GP services is complex. However, there continues to be contention over the most effective means of influencing it. This disagreement about the primary cause of the decline in bulk billing has meant that the AMA has focused on lobbying government for an increase in the Scheduled fee and the implementation of the RVS. In contrast, the Commonwealths policy focus has been on encouraging the redistribution of doctors (particularly to rural and outer metropolitan areas) through incentive payments and other schemes.

Cost Containment

It has been argued that the failure to adequately reimburse doctors is an indication that the Commonwealth is undermining Medicare as a universal system, while publicly maintaining that Medicare has the government's full support.²¹ It is important to note that a decline in bulk billing does not necessarily lead to a significant decline in the cost to government of Medicare.²² If a doctor does not bulk bill the Commonwealth, patients can claim the Medicare rebate back from Medicare. The latest figures show that over the past twelve months the overall number of services for which Medicare benefits were paid rose by 3.2 per cent and the amount of benefits paid increased by 6.9 per cent.²³ Consequently, although the Commonwealth has not increased the Scheduled fee for Medicare services, the cost of the MBS is continuing to increase as more services are provided. In the year ending June 2002, the Commonwealth paid approximately \$7.8 billion in Medicare benefits compared to \$7.3 billion in 2000-2001.²⁴ Regardless of whether the Commonwealth increases the Scheduled fee for GPs or not, it is likely that the cost of financing the MBS will continue to increase. However, by deciding not to increase the Schedule fee, the Federal Government is containing the growth in costs.

The point that increases in out of pocket expenses for patients diminish the universal access to medical care that is at the heart of Medicare is one that resonates with a wide range of commentators and stakeholders. This resonance is based on the understanding that the decline in bulk billing is most likely to impact on the medical care available to those least able to afford an up front fee.²⁵

Compliance Costs

The AMA and individual doctors have often pointed to the compliance costs involved in bulk billing patients as being another reason that GPs are deserting bulk billing.²⁶ Although the impact of compliance costs on participation in bulk billing is unclear, a recent survey of doctors commissioned by Australian Doctor found that GPs spend approximately seven hours a week completing paperwork generated by participation in Commonwealth and State government programs.²⁷ The Federal government has recently commissioned a study to examine GP compliance costs associated with Commonwealth Programs.²⁸

Corporatisation

There are several different models of general practice corporatisation, however, the models that have received the most attention are those defined as 'vertically integrated'. Vertical integration within medical practice is characterised by the co-location and management of a number of different medical services, including for instance, general practitioners, pathology services and diagnostic imaging. Vertically integrated medical services are often owned by large corporations and the range of different medical services are provided under one corporate umbrella. Inter-referrals (between co-located services)

are another feature of vertically integrated medical services. Of particular concern to the AMA is that this form of corporatisation usually generates profits for third parties, such as shareholders, rather than to the actual providers of the medical services.²⁹

The AMA has argued that increasing corporatisation of general practice is to some extent a result of the Medicare rebate for GPs not keeping pace with inflation.³⁰ However, there have been suggestions that the corporatisation of general practice may have some impact on bulk billing rates. Some of the larger GP management companies, such as Endeavour Health Care and Foundation Health, actively oppose bulk billing and GPs working for them are being encouraged not to bulk bill.³¹

Anti-Competitive Practices

There has been anecdotal evidence to suggest that in some geographical areas doctors are deciding, as a group of practitioners, not to bulk bill certain or all patients. Under the Australian Constitution the Commonwealth cannot coerce or force doctors to bulk bill patients. However, the Australian Competition and Consumer Commission (ACCC) has raised some serious questions about collusion between doctors, price setting and primary boycotts.³²

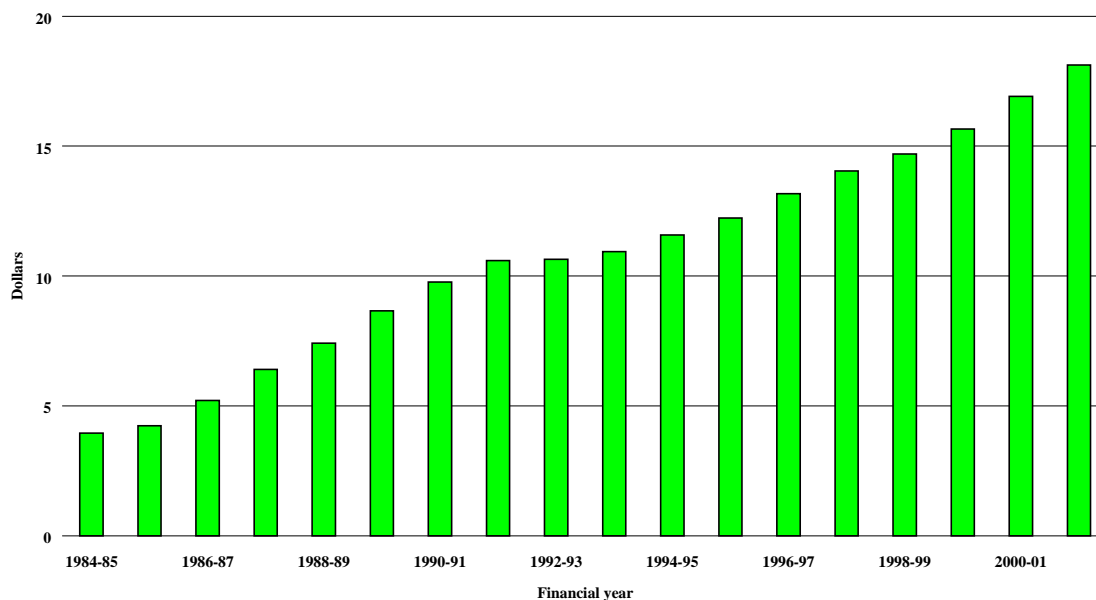
The Implications of the Decline

The impact the decline in bulk billing is having on the Australian health system includes increased out of pocket expenses for individual patients. Speculation and some research has also indicated that there has been a shift of costs to the States with patients seeking primary care at Accident and Emergency Departments in Public Hospitals rather than paying to see a GP. There are also broader concerns about health outcomes for the general community.

Cost-shifting to Patients

With the decline in bulk billing amongst GPs, there has been an increase in the average out of pocket expenses that patients are paying for Medicare consultations with GPs. Recent Medicare figures indicate that the average patient contribution for patient billed services has increased from \$17.43 in June 2001 to \$18.68 in June 2002, rising by just over 7 per cent in 12 months.³³ As the following graph shows, such increases are not unusual. Even when the rate of bulk billing was increasing during the early 1990s the average patient contribution for Medicare services was increasing. What has prompted concern in some quarters is that with a decreasing proportion of services being bulk billed more patients have to pay a co-payment for Medicare services.

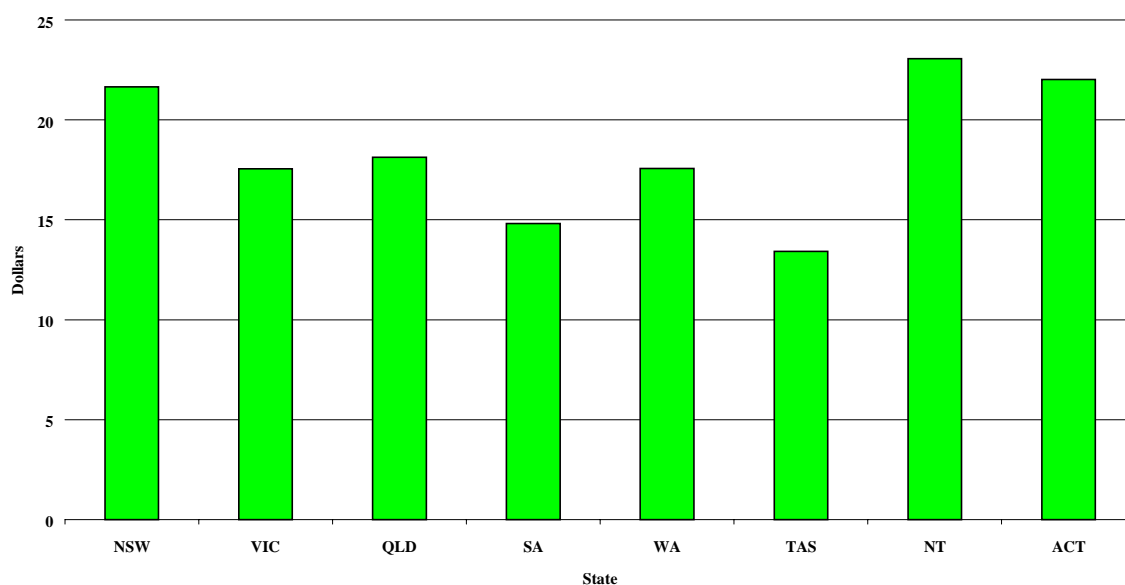
Graph 4: Average patient contributions per service



These increases are not distributed evenly across the States and Territories. For example in the 12 months to June 2002 there was an increase of 8.8 per cent in NSW and 6.6 per cent in Victoria while only a 2.6 per cent increase in the NT.

Similarly, average patient contributions for MBS services differ depending on which State or Territory the service is provided in. As the following graph shows, although the NT has maintained a high rate of bulk billing, it also has one of the highest average patient contributions for patient billed out of hospital services.

Graph 5: Average patient contribution per service (patient billed out of hospital services only)
June quarter 2002



Cost-shifting to the States

There is some evidence to suggest that patients are seeking treatment at Accident and Emergency (A&E) departments in Public Hospitals rather than pay the extra cost of a visit to a GP, although a clear causal relationship has yet to be verified. This issue was the subject of a letter from State and Territory Health Ministers to the Federal Minister of Health and Ageing in August 2002. The State and Territory Ministers claimed that the decline in bulk billing combined with the closure of 24 hour medical clinics and increased out of pocket expenses for patients visiting GPs was placing added pressure on public hospital A&E departments.³⁴ There is some research that appears to support this position. For instance findings from a recent NSW Department of Health study indicate that in rural towns where bulk billing was low or non-existent, there was a significant increase in presentations in local hospital emergency departments compared with towns in which GPs did bulkbill.³⁵ Another report funded by the ACT Division of General Practice indicates that the lack of availability of after hours care from GPs also results in increased presentations at A&E departments.³⁶ The ACT study indicates that bulk billing rates are not only to do with the billing practices of GPs, but are also to do with the match (or lack thereof) between GP workforce numbers, hours of work and patient need. If these studies are accurate then the result of increased presentations at A&E departments will be a cost-shift to the States and Territories, as they are financially responsible for public hospitals. This issue is likely to arise during the negotiations over the next Australian Health Care Agreements.³⁷

Impact on Health Outcomes

The increase in the out of pocket expenses for medical services provided by GPs has begun to cause concern over the likely impact this may have on the health of individuals. Since 1996, a particular focus of Commonwealth health policy has been on developing an integrated primary health care system that addresses chronic disease management.³⁸ A significant role for GPs has been established in the management of diabetes and asthma, immunisation programs, mental health and health screening. It is foreseeable, although not yet substantiated, that recent gains in primary health care will be unsustainable in the face of declining bulk billing rates and higher out of pocket expenses for patients with complex needs.

Conclusion

Because of its centrality in the national health insurance system any decline in bulk billing rates provokes a significant amount of public and political interest. While the AMA maintains that the decline has been caused by a failure to increase the Schedule fee, other features of the Australian health system may also be contributing, including compliance costs and pressures resulting from the corporatisation of general practice. The Federal government continues to maintain that the decline is due to the supply and distribution of

the medical workforce and has concentrated its policy efforts on encouraging doctors to work in areas where there is an under supply.

Outcomes of the decline in bulk billing include an increase in the direct cost of health care for patients and possible cost shifting to the States. There is also a possibility that some of the recent gains in primary care will be eroded.

Endnotes

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3. Details of the production of the Medicare Benefits Table are available through the [Department of Health and Ageing, Medicare Benefits Branch Committees and Groups](#).
4. Medicare Statistics, [June Quarter 2002](#), released 30 August 2002, p. 4.
5. *ibid*, p. 7.
6. The data for all graphs included in this publication has been drawn from the Medicare Statistics, [June Quarter 2002](#), released 30 August 2002.
7. *ibid*, p. 4.
8. *ibid*, p. 11.
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 17. *ibid*, 57, see also AMWAC, *op. cit.*
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 19. See particularly Jeff Richardson, Duncan Mortimer & Stuart Peacock, 'Does an Increase in the Doctor Supply Reduce Medical Fees? An Econometric Analysis of Medical Fees across Australia' paper presented to the 24th Australian Conference of Health Economists Sydney, 18–19 July 2002.
 20. *ibid*, p. 20.
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 22. Of course a failure to increase the Medicare Scheduled fee does contain costs by diminishing the real cost to government of Medicare services.
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