Chapter 3

Billing arrangements

Introduction

3.1 The terms of reference require the Committee to:

> inquire into and report on the Government's 'Medicare Plus' package including, but not limited to:
>
> (ii) the Government's proposed increase to the Medicare rebate for concessional cardholders and children under 16 years of age.

3.2 Under the Medicare Plus package, the Government proposes to provide an increase of $5 in the MBS rebate[1] where concession cardholders and children under 16 years are bulk billed. This additional payment will also be indexed in the same manner as other MBS items.[2]

3.3 According to the Department of Health, around 7 million Australians are covered by the three categories of concession card (comprising Pensioner Concession Cards, Health Care Cards and Commonwealth Seniors Health Cards). In contrast to the earlier '*A Fairer Medicare*' package, Medicare Plus does not proceed with either the geographically-based bulk billing bonuses or the system that would have enabled patients to pay only the gap payment at the point of service.

3.4 The aim of the measure is, according to the Department of Health and Ageing: 'to make it easier for GPs to bulk bill patients in financial need and children.'[3]

Reactions to the proposed billing arrangements

3.5 Reactions to this proposal are mixed, with submissions to the inquiry raising four general issues in relation to the proposal:

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1 The $5 increase applies to all services provided out of hospital that have an MBS number, including GP consultations, pathology and diagnostic imaging services. The $5 increase will also apply to services provided by a practice nurse using either of the two new MBS items for wound management and immunisation. Both vocationally registered and non-vocationally registered doctors will be eligible to claim the extra $5 on top of their respective rebate amounts.

2 Using Treasury's WCI5 (Wage Cost Index). Mr Davies, *Proof Committee Hansard*, 20 January 2004, p. 68

3 DHA, Submission 54, p. 10

- Whether the $5 incentive payment to targeted groups is consistent with the principle of a universal Medicare system.
- The equity of targeting concession cardholders and children under 16 years of age as categories of need.
- Whether the additional targeted payment will rectify existing problems in bulk-billing.
- A range of alternatives.

Universality, bulk-billing and the Medicare system

3.6 For many, a key philosophical objection is that the proposals constitute a step away from universality. The essence of this argument is that creating incentives to bulk bill certain groups, and – by implication – not others, Medicare no longer provides a universal benefit to everyone, irrespective of financial means. This point was expressed by many submissions. The Australian Council of Social Services (ACOSS) submission argued that:

> The objection to the proposal lies with the continuing attempt to divide patients into two groups – those who are expected to make a co-payment and those who are expected to get a 'free' service.
>
> This approach undermines both the concept of a universal health care system and the practice of a fair approach to meeting the costs of illness based on need.[4]

3.7 Catholic Health Australia agreed:

> Only concession card holders and young children are the targets for bulkbilling. In other words the Government is content that nearly half of all GP patients can hold little hope of being bulkbilled.[5]

3.8 The National Rural Health Alliance put a similar argument:

> Universality is the keystone of Medicare. In essence universality means that everyone in Australia contributes on the same basis to Medicare and its provisions apply equally to everyone. Achieving the other principles of access, equity, efficiency and simplicity is made possible through maintaining universality.
>
> Once universality is removed the other principles are immediately threatened. Access for everyone to affordable services becomes problematic when policy selects some groups for special arrangements, leaving other

4 ACOSS, Submission 45, p. 1

5 Catholic Health Australia, Submission 48, p. 1

> groups in similar or worse circumstances on the wrong side of the line. New poverty traps are created. Equity questions come to dominate, with some groups inevitably feeling disadvantaged. Efficiency is reduced and complexity increased. Administrative costs rise and uncertainty about entitlements causes extra worries at times when people need access to health services.[6]

3.9 UnitingCare, although finding the proposal superficially appealing, concluded that the policy amounts to:

> a deliberate attempt to undermine the general provision of bulk-billing. To undermine access to bulk-billing, by making it less attractive to doctors to bulk-bill some patients than others undermines Medicare as a universal system of health insurance.[7]

3.10 Mr Goddard, the Health Policy spokesperson of the Australian Consumers' Association concluded that if the targeted $5 incentive payment is accepted:

> We are giving up the universality of Medicare. That is what universality is. It is not about 100 per cent bulk-billing; it is about the promise that when people go to a doctor they will be treated equally based on what they clinically need rather than on what their income is. And this seems to us to be a strike against that.[8]

3.11 Two further issues are also relevant to the consideration of the concept of universality in Medicare: the role of community support through participation; and the importance of bulk billing to universality.

Universality, participation and community support

3.12 A view put by some witnesses and submissions relates to the practical importance of a system delivering undifferentiated, identical benefits to everyone. Mr McAuley, an academic from the University of Canberra explained that:

> We tend to forget the difference between welfare benefits and welfare intention. Medicare has huge welfare benefits, but it has those partly because it is a very low-cost social contract. … the universality of Medicare has been a low-cost way of enforcing a social contract. If that social contract breaks, if higher-income households no longer feel part of the system, they

6 NRHA, Submission 65, p. 5

7 UnitingCare, Submission 55, p. 6

8 Mr Goddard, *Proof Committee Hansard*, 19 January 2004, p. 29; see also Ms Wentworth, *Proof Committee Hansard*, 19 January 2004, p. 30; Geelong West Branch of the ALP, Submission 41, p. 5; Doctors' Reform Society, Submission 16, p. 1; NAPWA, Submission 44, p. 9; QNU, Submission 62, p. 4

> are not going to feel so happy about paying their taxes to support the poorer households. Fred Argy has a very nice term: downward envy.[9]

3.13 ACOSS put a similar view:

> Those who are encouraged to pay out of their own pockets may start to resent those who receive 'free' care and it is possible that Medicare could become a source of division in the community, a form of welfare rather than a symbol of what is shared by all.[10]

3.14 The Australian Consumer's Association provide detailed figures for the redistributive effects of Medicare. These illustrates the fact that those on lower incomes, who tend to have the highest health needs, receive the greatest dollar value benefits from the public health system.

Table 1. Publicly-funded health benefits, $ per week per head, by household income quintile

	Lowest 20%	Second quintile	Third quintile	Fourth quintile	Highest 20%
Hospital care	29	23	13	11	11
Medical clinics	13	12	10	10	10
Pharmaceuticals	7	6	3	2	1
Other health benefits	3	3	3	3	3
Total health benefits	53	44	29	26	25
Private income	10	90	227	342	592
Health benefits as percentage of private income	534%	49%	13%	7%	4%

Source: ABS *Household Expenditure Survey* 1998-99 Cat 6537.0 – household data divided by household size.

9 Mr McAuley, *Proof Committee Hansard*, 19 January 2004, p. 13

10 ACOSS, Submission 45, p. 1. See also Catholic Health Australia, Submission 48, p. 4; VCOSS, Submission 80, p. 1

3.15 The ACA conclude that:

> What this means is that universalism is inexpensive, because people in higher income households do not draw much benefit from publicly funded health programs. Universalism is a low-cost social contract.[11]

The importance of bulk billing

3.16 A second – but closely related – issue is whether the concept and objective of 'universality' includes universal bulk billing. Advocates of bulk billing point to four of the most important rationales for maintaining bulk billing as a key element of a universal Medicare:

- it is a crucial underpinning for encouraging preventive primary care;
- the unavailability of bulk billing GPs triggers overflows to other parts of the public health and welfare systems;
- the gap payments for those who are not bulk billed are increasingly unaffordable; and
- the widespread decline in bulk billing will see a return to a focus on discretionary billing by GPs and associated change in the power relationships between doctor and patient.

Preventive primary care

3.17 Bulk billing is an important mechanism to encourage preventive primary care. The Committee's first report described the changing patterns of disease in Australia, and the increasing importance of chronic illnesses such as diabetes, arthritis and depression relative to acute illnesses.[12] Many of these problems are chiefly associated with ageing and lifestyle factors, but, most importantly, these conditions are preventable. The National Health Reform Alliance explained that:

> Many significant health problems cause damage for years without producing significant symptoms – hypertension, high cholesterol levels, worsening lung function associated with smoking and even some cancers fall into this category. … Osteoporosis, which costs the taxpayer $1.5 billion in annual expenditure, and bowel cancer, the fastest growing cause of cancer deaths in this country, should both be recognised as preventable diseases.[13]

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11 ACA, Submission 36, p. 8

12 Senate Select Committee on Medicare, *Medicare: Healthcare or Welfare?*, Chapter 4.

13 NHRA, Submission 94, p. 9 & 11

3.18 Preventive health care, principally delivered by GPs, is therefore crucial to lowering the long term economic and social costs of these illnesses. However, cost plays an important part in peoples' decisions to go to GPs for preventive care, because the demand elasticity for this type of medical care is high: in other words, people suffering from an acute medical condition **must** go to the doctor, even if it costs a lot. However, the higher the cost of a GP consultation, the less likely it is that people will see a doctor for seemingly minor ailments. This is particularly true for poorer socio-economic groups, who also have the poorest general health and suffer most from lifestyle related illness.[14]

3.19 In the longer term, bulk billing is arguably as important for 'lower priority' consultations and routine check-ups, as it is for more immediately serious conditions. Gap payments are a disincentive for preventive care even for the relatively wealthy, so ensuring the availability of bulk billing is a crucial underlying precondition to encouraging preventive care.

3.20 While there are obvious cost implications for a policy that maximises bulk billing, contributors to the inquiry argued in favour of the long term cost effectiveness of this policy. If these conditions are not treated and worsen, the down-stream costs for the public health system are much greater than the earlier preventive treatment would have been. In a wider sense, there are also the social costs associated with increased human suffering, lost productivity, and premature deaths.

3.21 A good example was provided by Ms Mohle, representing the Public Health, Hospitals and Medicare Alliance of Queensland, who told the Committee of concerns expressed by Women's Health Queensland Wide over the decreasing availability of GPs who bulk-bill for Pap smears:

> This is extremely concerning given that Australia has made tremendous improvements in recent years in the early detection and treatment of cervical cancer. A recent report released by the Australian Institute of Health and Welfare shows that pap smear screening decreased mortality rates for cervical cancer by 53 per cent between 1982 and 2001.[15]

Overflows to other parts of the system

3.22 If people cannot access bulk billing doctors nor afford gap payments, there can be immediate costs to other parts of the medical and social system. First, people who need medical care will go to Accident and Emergency wards of public hospitals. This issue was considered in detail in the Committee's first report.[16] The Committee notes

14 SVDP, Submission 58, pp. 1 & 6

15 Ms Mohle, *Proof Committee Hansard*, 19 January 2004, p. 33

16 Senate Select Committee on Medicare, *Medicare: Healthcare or Welfare?*, p. 50

additional evidence to this second inquiry, such as that of the NSW Nurses Association:

> The impact of this response to the lack of access to bulk billing has been reflected in a 14% increase in presentations to emergency departments for services more appropriately managed by GPs.
>
> The impact has also been examined by the Independent Pricing and Regulatory Review Tribunal of NSW. Its report, *Focusing On Patient Care,* details the adverse effects this decline has for the efficient operation of the health care system:
>
> Between 1996/97 and 2000/01 the number of GPs in Australia decreased by nearly 3 per cent, while their bulk-billing rates fell by 3.6% and the availability of after-hours GP services declined, especially in rural areas. In NSW, this has resulted in:
>
> - increased pressure on public hospital emergency departments. Over this time, emergency department attendances increased from 1,240,460 to 1,441,5957 while the GP bulk billing rate decreased from 82.7 per cent of all visits to GPs to 79.1 per cent
>
> - increasing hospital costs and average length of stay in hospital for patients located in areas with no local GP services. This suggests that reduced access to GP services may contribute to more and longer hospitalisations, because these patients present in crisis and with greater complications than would have been the case if they had seen a GP earlier.[17]

3.23 Second, as discussed above, people will delay seeing a doctor, with the result that treatment is delayed, medical conditions deteriorate and long run costs are higher. Professor Dwyer told the Committee:

> We have just done a survey in my hospital looking at all the geriatric admissions to the hospital over the last year … Sixty per cent of those admissions could have been prevented if earlier interaction had occurred. In other words, the people were not perfectly well 24 hours before they came into the hospital.[18]

3.24 Third, the overflow can run into the welfare sector. The submission from the Tasmanian Medicare Action Group stated that in a recent Anglicare Tasmania survey, the cost of medical care is a major issue for families seeking Emergency Relief

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17 NSW Nurses Association, Submission 63, p. 10. The submission quotes: IPART, Focusing On Patient Care, August 2003, p 10. See also Tasmanian Government, Submission 61, p. 2; Queensland Government, Submission 59, p. 2.

18 Prof Dwyer, *Proof Committee Hansard*, 19 January 2004, p. 11

Assistance, while the Salvation Army in Tasmanian presented evidence at a recent inquiry into poverty that:

> Those that do not have the money to cover gap fees often put off seeking medical attention. One of the issues that impact on our emergency relief in Tasmania is that we are being asked to pay the gap fees for doctors …[19]

3.25 Similar evidence came from the National Association of People Living with HIV/AIDS (NAPWA):

> The Bobby Goldsmith Foundation, a NSW-based charity for people living with HIV/AIDS reports that in the year 2002-2003 they paid out a total of $7,514 to 87 HIV positive people unable to meet the gap fees between the Medicare rebate and the cost of consultation, and a total of $22,176 for 136 clients unable to meet the costs of their co-payments for prescription pharmaceuticals.[20]

Affordability of gap payments

3.26 A related point is that, according to the evidence of some groups, the gap payments incurred when bulk billing is not available are simply not affordable for some members of the community. The Catholic Health Australia submission stated that:

> In each iteration of the Australian Government's Medicare reform package, there appears to have been a failure to understand the extent of the impact of copayments on low to middle income families, and generally for anyone who has to find increasing copayments each time they visit their GP. The impact will be hardest felt by those with chronic illnesses and multiple conditions.[21]

3.27 A similar perspective came from the NAPWA, relating to the roughly 14,000 people living with HIV and AIDS across Australia:

> our membership reports that they, like many Australians, are affected by the national decline in bulk-billing rates. NAPWA has confirmed that several metropolitan General Practices with high numbers of HIV patients (practices where antiretroviral Section 100 drugs are prescribed) are now no longer bulk-billing any patients at all, including pensioners and Health Care Card holders. This has represented a sufficient financial burden for some

19 TasMAG, Submission 22, p. 2

20 NAPWA, Submission 44, p. 8

21 Catholic Health Australia, Submission 48, pp. 2-3

> people that they are no longer able to receive their primary care from GPs who may have been caring for them for many years.[22]

Charity and the doctor/patient relationship

3.28 Fourthly, where bulk billing is not generally available, the inevitable result is an alternate system that expects, and relies on, a doctor's discretion to charge a sliding scale of fees according to an individual patient's capacity to pay. This already occurs to some extent, as the Committee's first report discussed, and in this respect the Committee has already expressed its concerns at the inappropriateness of GPs making such judgements and the arbitrary outcomes likely to emerge.[23]

3.29 However, this discretionary system introduces an inevitable degree of charity that fundamentally alters the power relationship between poorer patients and their doctors. According to the Queensland Nurses Union, the government response:

> … shows a fundamental lack of appreciation of the inherent power imbalances between doctors and their patients. There is a need for government intervention in transactions between doctor and patient because patients who cannot afford to access health services should not have to go through the humiliating experience of asking for charity from doctors. Doctors should also not be expected to dispense charity.[24]

3.30 As Ms Mohle told the Committee, doctors are trained to assess health not wealth and 'the power imbalance inherent in the patient-doctor relationship is large enough without instilling an economic dimension to it.'[25]

Perverse incentives and welfare categories

3.31 Finally, the creation of separate categories of beneficiaries can create perverse incentives for people to avoid getting jobs, earning money or becoming self sufficient in order to remain in the better rewarded welfare categories. This point was made in the submission from the National Association of People Living with HIV/AIDS:

> There is also a substantial disincentive to return to work for this group of people, since, by remaining on a pension a person would be able to more readily access bulk-billing and concessional-rate pharmaceuticals. However, a low-paid job may disqualify people from a health-care card, and introduce the spectre of substantially higher medical bills and the loss of the safety net, which would serve only to eat unreasonably into any additional income gained through working. In particular, people returning into the workforce

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22 NAPWA, Submission 44, p. 8

23 Senate Select Committee on Medicare, *Medicare – Healthcare or Welfare?*, p. 42

24 QNU, Submission 62, p. 4

25 Ms Mohle, *Proof Committee Hansard*, 19 January 2004, p. 34

> after a long absence due to illness are more likely to go initially into lower-paid or part-time positions.

3.32 As NAPWA points out, this disincentive to return to work is not in the interests of the individuals concerned, nor the government or the economy.[26]

The government view

3.33 Unsurprisingly, the government and its departmental officers do not share the views discussed above. According to the government, the proposed policy measures are in no way inconsistent with the government commitment to a universal Medicare or with the principles of universality.

3.34 The Prime Minister has continued to reassert the principle of universality:

> All Australians have the right to universal access to the three pillars of Medicare: a universal Medicare rebate for medical services; a universal Pharmaceutical Benefits Scheme; universal access to free public hospital care.
>
> The Australian Government remains firmly committed to the principles of Medicare, which have guided it over the past two decades.[27]

3.35 Mr Davies, from the Department of Health and Ageing, rejected the view that the proposed $5 incentive payments offered for bulk billed services to concessional patients and children under 16 years amounts to any deviation of these principles, arguing that:

> the universality offered by Medicare since its establishment has always been that all Australians receive the same MBS rebate. MedicarePlus does not change that. The eligibility of all Australians to be bulk-billed is also a key feature of Medicare, and it is not compromised by MedicarePlus. Under MedicarePlus all Australians will continue to receive the same level of Medicare rebate, and all Australians will continue to be eligible to be bulk-billed. Bulk-billing will not be limited to concession card holders and children. MedicarePlus simply makes it financially more attractive for GPs to bulk-bill people in those groups.

3.36 And:

> There is nothing in this package that says who does or does not get bulk billed. … To claim that this package is directing bulk billing towards a

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26 NAPWA, Submission 44, p. 9; see also COTA, Submission 73, p. 2

27 Prime Ministerial Media Release, 1st October 2003

> particular subgroup of the population in a legislated or regulated way is to misrepresent the package.[28]

3.37 A significant factor underpinning these views is the differing view of the role that bulk billing was intended to, and should in the future, play in the Medicare system. Mr Davies told the Committee:

> Medicare has never offered a guarantee of bulk-billing and it has never delivered 100 per cent bulk-billing. Therefore, it is clearly misleading to argue, as some have, for 'a return to universal bulk-billing'. Indeed, while we continue to allow doctors to set their own professional fees, universal bulk-billing can never be guaranteed.[29]

3.38 This view is also evident in the comments of the Minister for Health, the Hon Tony Abbott MP, who told the House of Representatives that while 'the government is committed to a high level of bulk billing as a key element of Medicare':

> no government can force any particular level of bulk billing, although governments certainly can take measures that support doctors and encourage them to bulk bill, as this particular bill does.[30]

3.39 Some submissions to the inquiry support this view as well. Dr Gault, a General Practitioner from Port Fairy in Victoria, argues that:

> The only aspect of Medicare that is universal is the rebate, which is the major 'safety net' of the system. …
>
> Historically, I cannot find evidence that bulk-billing was ever an integral part of the Medicare concept. Instead it is an arrangement, which, if properly funded, benefits all four parties involved.

3.40 Dr Gault points out that the Pharmaceutical Benefits Scheme introduced co-payments in 1990, and has since increased them under both major political parties, and the MBS should be no different:

> With ever-increasing non-G.P. costs competing for the health dollar I doubt G.P.s will ever again be funded adequately for their services through rebates alone. The fact that patients still have a large proportion of their bill rebated and that the G.P. will always be paid at least that proportion is a vast improvement on the days before Medicare. [31]

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28 Mr Davies, *Proof Committee Hansard*, 20 January 2004, p. 44

29 Mr Davies, *Proof Committee Hansard*, 20 January 2004, p. 29

30 The Hon. Tony Abbott MP, Health Legislation Amendment (Medicare) Bill, Second Reading Speech, House of Representatives Hansard, 4 December 2003, p. 23331

31 Dr Gault, Submission 25, pp. 2-3

3.41 An important assumption in this argument is that it is neither unreasonable nor unaffordable for many people to afford a small gap payment, particularly where in practice, these gap payments vary significantly based on the GP's judgements of the patients' needs. Dr Gault concluded:

> The assertion that one third of Australia's population cannot afford to pay, say, $5, of their own money to see their G.P. is the greatest falsehood at the heart of this debate. …
>
> The old days of Medicare are gone. Long live Medicare, but as the universal insurer, not the universal payer.[32]

Conclusion – universality and the Medicare system

3.42 In the view of the Committee, the government's proposal to introduce a separate additional $5 payment for all bulk billed services delivered to concessional patients and children, raises a profound question over the concept of a universal Medicare and the role that bulk billing plays in this system.

3.43 The Committee does not agree with the government's view that the measures are consistent with the principle of universality. The simple fact is that although everyone remains entitled to the basic rebate payment, the end result is that different categories of people in Australia receive different benefits based on the government's perception of their relative need. Added to this are the signals that this policy sends. The policy gives encouragement to the medical profession to bulk bill concessional patients and children, but by giving no incentives or encouragement to any other group, the implicit message is that these two groups are the only ones the government wants to be bulk billed. The government's arguments to the contrary are, to be blunt, circular and disingenuous. The clear purpose of the policy is to direct bulk billing to those perceived as 'welfare recipients' and away from everyone else.

3.44 At the heart of this debate is the role of bulk billing in the Medicare system. The government's policy is underpinned by the view that universal bulk billing is not, and was never intended to be, a part of a universal Medicare.

3.45 The Committee disagrees, for two reasons. First, as the arguments set out above demonstrate, there are sound practical reasons why the ability to access bulk billing for all patients is important: it is a powerful element in the social compact of risk sharing; it is a crucial foundation stone for building a primary health care system focused on prevention; and it does much to prevent overflows to other parts of the hospital and welfare systems.

3.46 Secondly, there is abundant evidence to demonstrate that a substantial majority of Australians want bulk billing. The NSW Nurses Association drew the Committee's

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32 Dr Gault, Submission 25, pp. 2-3. Other submissions expressing a similar view include: Ms Hemlof, *Submission 4*, p. 2; Ms Thallur, *Submission 84*, p. 1; Mr Boyapati, *Submission 93*, p. 1

attention to polling that confirms 'strong support for the maintenance of Medicare and the central importance of bulk billing':[33]

> For example, a recent survey conducted by Australian Research Consultant[34] that sought the opinions of 1000 voters nationwide found:
>
> - 75 per cent of voters, including 69 per cent of federal government supporters, would prefer more spent on hospitals and schools, rather than tax cuts;
> - 71 per cent of those surveyed thought they would be better off if the government preserved bulk billing;
> - 69 per cent would support an increase in the Medicare levy if it was the only way to allow continued access to bulk billing.[35]

3.47 The St Vincent de Paul society told the Committee that:

> The most pressing imperative … is the restoration of bulk billing as the normal process of access of GP services to all Australians.[36]

3.48 A policy commitment to universal bulk billing does not necessarily mean 100% bulk billing, particularly in the broader context of specialists, diagnostic testing and imaging. This is neither constitutionally nor practically feasible. However, high levels of bulk billing remain important, if not essential elements of the system. The Committee agrees with the view put by Catholic Health Australia:

> While Medicare as it was established was never intended to be about achieving 100 percent bulkbilling levels, and a reasonable co-payment from patients who could afford it was expected, the system should at least support bulkbilling to the level at which people on low to average incomes are not unduly discriminated against in their capacity to access essential health care services. Clearly it is difficult to prescribe an arbitrary number at which this occurs. But it is not difficult to appreciate that communities experiencing less than 40 percent rates of bulkbilling are at a significant disadvantage … The outcome of declining MBS remuneration and consequent bulkbilling levels that diminish to such a level that low to middle income earners are rarely if at all able to access it, is that the purchasing power of their public insurance and the value of their entitlement to Medicare is eroded.[37]

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33 For example, Newspoll Polling For ACTU Congress 2003 conducted 8-11 August, 2003 http://www.actu.asn.au/public/news/files/newspolm.pdf

34 The Age, August 17, 2003

35 NSW Nurses Association, Submission 63, pp. 5-6

36 SVDP, Submission 58, p. 12

37 CHA, Submission 80, p. 4

3.49 Perhaps the most important requirement is a strong and explicit government commitment to a high level of bulk billing, that does not institutionally discriminate between classes of Australians based on perceptions of their wealth or 'neediness'.

Equity and the targeted groups as a measure of need

3.50 Setting aside the issue of universality, does the creation of incentives to bulk bill concession card holders and children under 16 years represent an effective measure of need for bulk billing? Evidence to the inquiry has raised two principal objections to the scheme.

3.51 Firstly, a focus on concession card holders and children tends to exclude a group loosely categorised as 'the working poor'. The Country Women's Association pointed to those who:

> do not have Concession Cards, yet their incomes are too often just above that threshold for eligibility. The lowest paid workers in our economy, shop assistants, hospitality workers, casual employees are all left out of this equation. So too, and this is of particular concern to our members, are young persons, over 16, who are usually on low wages as they work their way through traineeships, for example, or are in casual employment, that does not bring in an adequate income but nonetheless in our 'reformed' welfare systems classes them as 'employed' and therefore ineligible for assistance. They are often away from home, struggling to pay rent and look after themselves and it is their health care that regularly is ignored as being too expensive.[38]

3.52 The Liquor Hospitality and Miscellaneous Union made a similar case:

> There is another group of Australians, the forgotten Australians, that are key to this debate, they are low paid Australian workers.
>
> These workers cannot afford to lose access to Medicare, they cannot afford to lose access to bulk billing and they cannot afford to lose access to health care.
>
> It is these workers that must be remembered when considering reforms to the basis of our health care system, being Medicare. There are hundreds of thousands of low paid workers that do not qualify for Commonwealth concession cards, … primarily found in service industries, such as cleaning, security, hospitality, and a range of care and support work, including aged care, in-home care, childcare and teaching assistant work.[39]

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38 CWA, Submission 70, p. 3; see also Blue Mountains DGP, Submission 82, p. 1; Consumers Health Forum, Submission 66, p. 2; NSW Retired Teachers' Association, Submission 21, p. 1

39 LHMU, Submission 68, p. i and 2-3

3.53 This problem is detailed by ACOSS:

> Our analysis shows that people without children and earning the minimum wage (around $450 a week) and part time workers earning more than the concession card cut-off point of $340 a week, will miss out on the bulk billing incentives. They face a current average co-payment of $13 for every GP visit and $45 for an x-ray.
>
> Aside from the manifest unfairness of the proposal, the crude targeting of MedicarePLUS will create a poverty trap for people moving from government benefits to work and from very low paid to higher paid jobs.[40]

3.54 Secondly, the selection of the two categories of those more likely to be bulk billed is likely to have anomalous results. The Geelong and Region Trades and Labour Council argued that:

> The direct targeting of these groups will disadvantage those who do not fit into these categories, often inequitably. For example, while a millionaire's child (under 16 years) will be targeted for a bulk billed consultation with a GP under the MedicarePlus package, a woman with a low income job, no dependant children and a chronic disease such as multiple sclerosis (which requires periodic general practice and specialist consultations) would have to pay the full fee. This is … one example of the many anomalies that will become obvious under MedicarePlus.[41]

3.55 The Council on the Ageing (COTA) pointed to the illogical differences that would emerge:

- between concession card holders and those whose income is only marginally beyond eligibility limits;
- between low wage earners and people on income support payments; and
- between dependants who are 16 and dependants who are 17 – both still in education and being supported by their parents.[42]

3.56 Many submissions saw the proposal as ill-considered. UnitingCare described the policy as 'illogical and unrealistic'[43] while their representative, the Reverend Dr Wansbrough, explained at the public hearings:

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40 ACOSS, Submission 45, p. 2

41 Geelong and Region Trade and Labour Council, Submission 83, p. 2

42 COTA, Submission 73, p. 2. See also City of Whittlesea, Submission 86, p. 1; Geelong Medicare Action Group, Submission 46, p. 2

43 UnitingCare, Submission 55, p. 6

> The additional $5 rebate offered to GPs who bulk-bill concession card holders and children under 16 should be extended to all occasions of bulk-billing. There is a serious anomaly, in particular with families, in bulk-billing children under 16 but not their older siblings or their parents. As those families take their money from one purse, it does not really matter whether it is the children or the adults – the whole family is affected by the health care costs, whoever incurs them.[44]

3.57 Catholic Health Australia made the similar point that:

> [T]here are people with concession cards who have better means than average working families. The claim by both groups to affordable and certain health care are equal. Yet their opportunities to access care are not. When income levels determine capacity to access crucial human service the inequities are obvious.[45]

3.58 The Doctor's Reform Society conclude that:

> Doctors who currently bulk bill everyone are being told that they will be paid less for seeing a struggling worker in a low paid job than a comfortable pensioner or the children in a wealthy family. The message to the doctor is that he/she should charge the struggling worker a co-payment.[46]

3.59 Dr Lambie, a Queensland GP, felt:

> This idea will introduce discrimination between those hard working people who not only pay their taxes but also their Medicare levy and those who for many reasons pay no tax at all nor do they pay the Medicare levy.[47]

A tiered health system?

3.60 Many of these groups fear that the practical outcome of this differentiated system will be the creation of a multi-tiered health system. The Australian Council of Social Services argued:

> In the face of clear problems in the health system there is no point encouraging divisions between groups of patients and between public and private provision. This can only divert attention from desirable reform and create a political environment where a genuinely two-tiered system – in which the comfortably off provide for themselves under private health

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44 Rev Dr Wansbrough, *Proof Committee Hansard*, 19 January 2004, p. 79

45 Catholic Health Australia, Submission 48, pp. 2-3

46 DRS, Submission 16, p. 1. See also Consumers Health Forum, Submission 66, p. 2

47 Dr Lambie, Submission 34, p. 1

> insurance while an under-funded public system struggles to deal with the 'charity' cases – becomes possible.[48]

3.61 There is already evidence of such a system emerging. The Moreland City Council submission warned that over the past year, their area has seen the emergence of general practices that are offering speedier access to individuals who pay a premium, with similar developments in neighbouring municipalities.[49] Similarly, the NSW Retired Teachers' Association have experience of some general practices in which:

> those patients wishing to bulk bill are made to wait long periods of time and in others there is no bulk billing after 3PM or at weekends. This arrangement could create a two-tier health system with low income patients facing increasing health costs.[50]

Conclusion – the targeted groups as a measure of need

3.62 The Committee concludes that, setting aside the general undesirability of targeting categories of people for bulk billing, membership of the two groups selected – concessional patients and children under 16 – is not an equitable or accurate measure of need.

3.63 The proposed target groups overlook many people who have limited resources, particularly young people and those on low incomes, as well as those with chronic illness, but who are still working. At the same time, the policy includes target groups who may have the income to afford gap payments – such as the 'millionaire's child' mentioned by some submissions.

3.64 This is not to suggest that concessional patients and children under 16 are not deserving of bulk billing. Quite the opposite. Rather, these inequitable and arbitrary outcomes serve to reinforce the Committee's preference for a universal system with a general commitment to providing access to GP services that are bulk billed or charged at the schedule fee. Most importantly, this universal system should not be concerned with capacity to pay a gap fee, but focus solely on medical need. This avoids the inevitable administrative complexity and arbitrary results of a system that tries to 'pick winners'.

Effective reforms? Fixing the problems in bulk-billing

3.65 The third issue that must be considered in assessing the proposed $5 rebate bulk billing incentive payment is the extent to which it will address the current problems in

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48 ACOSS, Submission 45, p. 1. See also NSW Nurses Association, Submission 64, p. 12; Geelong West Branch of the ALP, Submission 41, p. 5

49 Moreland City Council, Submission 81, p. 2

50 NSW Retired Teachers' Association, Submission 21, p. 1

Medicare. The Committee's first report found equitable access to primary health care in Australia is being compromised by four key problems:

- declining rates of bulk billing;
- an uneven distribution of bulk billing, both by State and region;
- rising average gap payments; and
- an uneven distribution of Medicare benefits.

3.66 The September Quarter 2003 Medicare statistics show that the national bulk billing rate has fallen to 66.7%, amounting to a 1.7% fall since the previous year. Although this reflects a problem in itself, a closer examination of the statistics shows the uneven distribution of bulk billing rates. In Tasmania and the ACT, for example, the bulk billing rates are well below the national average, standing at 55.2 and 53.2 percent respectively, in comparison to 72.5% in NSW.[51] Looked at in terms of region, the pattern also reveals inequitable results: in 2002, 80.8% of GP services delivered in capital cities were bulk billed, contrasting with 56.6% in rural and remote areas.[52] As the Department of Health and Ageing point out, geographical location is a much greater determinant of access to bulk billing than income, with an analysis of GP bulk billing rates by income showing a remarkably even distribution.[53]

3.67 In assessing access to health services however, access to bulk billing GPs is not the whole picture. With the increasing use of specialist and diagnostic services, it is of considerable concern that only 27% of specialist visits are bulk billed, with levels of only 19.6% for obstetrics; 9.3% for anaesthetics; and 58.8% for diagnostic imaging.[54]

3.68 Another way of analysing this issue is in terms of observance of schedule fee – that is, cases in which specialists do not bulk bill their patients, but still only charge the fee set out in the Medicare Benefits Schedule. In 1984/85, although only 21% of specialist services were bulk billed, a further 52% were charged at the MBS fee. So overall, 73% of services were either free of extra charge or were only subject to a 15% gap payment. Over the years, specialists have rarely bulk billed more than a third of their services, but what has declined rapidly in the past few years is their adherence to the scheduled fees. In 2002/03, some 27% of specialist services were bulk billed but only a further 14% were charged the schedule fee.

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51 Department of Health and Ageing, Medicare Statistics 1984/85 to Sept. Quarter 2003, p. 11

52 Senate Select Committee on Medicare, *Medicare: Healthcare or Welfare?*, 2003, pp. 38-39

53 DHA, Submission 54, pp. 3-4 and Figure 1.

54 Department of Health and Ageing, Medicare Statistics 1984/85 to June Quarter 2003, p. 11

3.69 Another problem is the rising levels of out-of-pocket costs or gap payments. As evident from earlier discussion, the level of gap payments are closely related to low bulk billing rates, low per-capita doctor numbers – particularly in rural and regional areas – and the limited availability of after hours care in many parts of Australia. The average GP gap payment has risen to $12.77,[55] however the Department of Health and Ageing states that 'by far the largest increase in cost to patients has been in specialist, diagnostic and treatment services':

> In 1984/85, patients contributed an average $2.86 for GP services and $5.03 for non-GP services. In 2002/03, patient contributions to GP services increased to $12.90 (65 percent in real terms) while patient contributions to non-GP services increased to $41.82 (310 percent in real terms).[56]

3.70 While fixing these problems is obviously the priority, solutions must also work within the context of the changing health care environment, which is characterised by an ageing population with growing health needs; a shift from acute to chronic health conditions; increasing levels of out-of-hospital treatment; and a dramatic increase in medical technology and associated diagnostics and treatments. These factors are driving attendant rises in both costs and consumer expectations.[57]

3.71 Overall statistics can distract attention from the important human realities: increasing levels of out of pocket costs means a decreased access to health care and it is clear that in some parts of Australia, the system is failing Australians. Professor Dwyer told the Committee that:

> if you live in the poorer suburbs of Sydney's outer-west region you are five times more likely to die prematurely from what doctors can demonstrate to be largely preventable problems than if you live on Sydney's more affluent north-shore.[58]

3.72 Similarly, life expectancy for those in country areas is shorter than in cities,[59] and the continuing problems in indigenous health are well known. Given the generally lower incomes in regional areas, this all means that if you are poor and/or live outside a major city, you are more likely to get seriously ill and to die younger than the rest of the population. NATSEM research shows that if the entire population had the same health status as those in the highest income quintile:

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55 DHA, Medicare Statistics, p. 41

56 DHA, Submission 54, p. 4

57 For general a discussion on these background issues see the Department of Health and Ageing submissions to both inquiries: DHA, Submission 138 [First inquiry], p. 7 *et seq*; and DHA, Submission 54, p. 2

58 AHRA, Submission 94, p. 9

59 Prof Dwyer, *Proof Committee Hansard*, 19 January 2004, p. 13

- around 180,000 life years could be saved annually;
- around 800,000 fewer persons would have been disabled in 1998, and 1 million fewer in 2018; and
- savings of around A$4 billion a year could be achieved in 1998 (and A$5 billion in 2018), due to lower health care costs and lower government outlays on Australia's disability support pension.[60]

3.73 This section therefore considers the likely outcome of the targeted $5 payment on bulk billing rates, distribution, and gap payments.

The effects on bulk-billing

3.74 Consideration of the effects of the $5 incentive payment naturally has two elements: first, the implications on bulk billing rates for those in the two target groups – concessional patients and children under 16 – and second, for the remainder of the population.

Bulk billing for target groups

3.75 Various groups and individuals were pessimistic about the implications of the package for concessional patients and children. The Doctors' Reform Society felt that:

> It will lead to a fall in the bulk billing rate.
>
> The average copayment for GP consultations is now $13.61. A GP currently charging anything more than $5 copayment to any of the eligible group is very unlikely to revert to bulk billing them because it will mean less income. With the average copayment at that level now it is clear that most doctors are charging more than $5.
>
> Doctors charging less than $5 copayment to such patients may decide to bulk bill them but with the average copayment being $13.61, the number of patients paying less than $5 copayment is small.[61]

3.76 Professor Hall from the Centre for Health Economics Research and Evaluation told the Committee that current average gap payments across electorates range from about $8 to about $22. That suggests that:

> for those practices that are already not bulk-billing, $5 does not sound like it is going to be enough to throw a lot of them over the line. One of the problems in the area … is that there is no such thing as an average general practice. There are all sorts of different styles of practice with numbers of practitioners practising in different areas with different attitudes to bulk-

60 SVDP, Submission 58, p. 2

61 DRS, Submission 16, p. 1

> billing and so different practices will react differently. Certainly it would seem to me just on those data that the $5 additional rebate for bulk-billed patients is unlikely to reverse current bulk-billing rates, though it may do something to change things on the margin to halt the decline.[62]

3.77 The view of the Royal Australian College of General Practitioners' (RACGP) was very similar:

> In submissions provided to the Committee during the first Senate Select Committee, GPs often reported that their private billing 'gap' fee was the difference between the rise in practice costs and the lagging value of the rebate. Therefore, given that gap fees, on average, are significantly higher than the proposed $5.00 incentive per consultation, it would be unlikely that this initiative will bring about a change to the level of bulk billing.[63]

3.78 However, there is also evidence to support a more optimistic view.

3.79 The two target groups between them constitute 63% of GP consultations,[64] and currently this group is bulk billed at a level of 79% – well above the overall national average.[65] This amounts to a total of around 50 million GP services annually provided to concession card holders and their dependents, with a further 10 million services provided to children not covered by concession cards.[66]

3.80 In this context, it is therefore possible that these measures will at least maintain or improve levels of bulk billing for the target groups. As the Department of Health and Ageing submission points out, more than 95% of GPs already bulk bill at least some of their concessional patients, with (perhaps more significantly) most GPs bulk billing a sizeable majority of the concessional group. The breakdown of these figures is shown in the table below, reproduced from the Departmental submission.

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62 Prof Hall, *Proof Committee Hansard*, 19 January 2004, p. 4. On this issue, see also Mr Lyons, Submission 2, p. 1; NSW Retired Teachers Association, Submission 21, p. 1; VMAG, Submission 27, p. 4; Geelong and Region Trades and Labour Council, Submission 83, p. 3

63 RACGP, Submission 67, p. 6

64 NRHA, Submission 65, p. 7. See also DHA, Submission 54, p. 10 which puts the figure at 'around 60% of all services'.

65 Mr Davies, *Proof Committee Hansard*, 20 January 2004, p. 34

66 DHA, Submission 54, p. 10

Table 2: Bulk billing range of concessional patients by full time workload equivalent GPs, 2002[67]

% Proportion of Full Time GPs	% Bulk Billing Range
25.3%	100%
35.0%	90-<100%
10.2%	80-<90%
6.4%	70-<80%
3.9%	60-<70%
3.2%	50-<60%
2.7%	40-<50%
3.0%	30-<40%
3.1%	20-<30%
3.1%	10-<20%
2.8%	>0-<10%
1.3%	0%

3.81 A GP providing around 7000 services per year, with a typical patient profile, and receiving the additional $5 payment certainly has every reason to maintain or increase the percentages of concessional and child patients who they bulk bill. Mr Davies, representing the Department, told the Committee:

> There is one group for which the rational response of a doctor would be to either continue or begin bulk-billing. That group is those concession patients and children under 16 who are either currently bulk-billed or charged a gap of $5 or less. The rational thing for a GP to do for those patients would be to bulk-bill. If we assume that a GP is an income maximiser, that would be the rational thing for the GP to do.[68]

67 DHA, Submission 54, p. 12

68 Mr Davies, *Proof Committee Hansard*, 20 January 2004, p. 45

3.82 Professor Deeble generally agreed:

> the $5 is not going to lure back people who have reduced or ceased bulk-billing, but I think it will hold the proportion up. Doctors in the metropolitan areas who have built their practices on bulk-billing will take that extra $5 and they will be under great pressure from their patients to bulk-bill children under 16 because the government has virtually promised it.[69]

Bulk billing for non-target groups

3.83 Assessing the implications of the measure for the non target groups is a more complex task. In the view of some submissions to the inquiry, the outcome:

> [W]ill almost certainly do little to encourage bulk-billing for low-income Australians more generally.[70]

3.84 According to the Mt Druitt Medical Practitioners' Association:

> It seems unlikely that Medicare plus will produce any change in the trend away from bulk billing, nor in itself facilitate the provision of comprehensive preventative care. … The targeted incentives are unlikely to be enough to ensure access to bulk billing for non card holders and adults, and will in fact send an implicit message to those doctors who are currently bulk billing all consultations that they will need to change their billing patterns or be expected to continue subsidising the system.[71]

3.85 On this analysis, the overall bulk billing rate could be expected to drop from its current level of 67% to a floor of around 60% as bulk billing becomes confined to concession card holders and children. This would be due to the combination of: incentive payments for the bulk billing the target groups; the implicit message this sends to doctors as to who should be bulk billed; and the fact that bulk billing the target group will be considerably more profitable than general bulk billing.

3.86 This is not a far fetched scenario given the preponderance of bulk billing already going to the target groups in current conditions – that is to say, statistically the target groups are already much more likely to be bulk billed than the average, and account for the majority of overall bulk billed services.

3.87 A further concern is that not only will bulk billing become scarcer for patients not in the target groups, but that gap payments for this group will also increase. This could be triggered by cross-subsidisation in practices where existing gap charges are

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69 Prof Deeble, *Proof Committee Hansard*, 19 January 2004, p. 5

70 NAPWA, Submission 44, p. 9. See also Moreland City Council, Submission 81, p. 3; AHRA, Submission 94, p. 17; CWA, Submission 70, p. 2; COTA, Submission 73, p. 2

71 Mr Druitt Medical Practitioners Association, Submission 1, Attachment 1, p. 1

more than $5, but which decide to begin bulk billing concessional patients and children in order to receive the $5 incentive payments. To recoup their losses they would then raise the gap charges for everyone else.[72] As Dr Lim, a GP from Western Sydney told the Committee:

> it does send an implicit message to doctors currently bulk-billing all consultations that they will be expected to either cross-subsidise other patient groups with this or change their billing patterns, which may well lead to a decrease in the availability of bulk-billing. This is going to impact most heavily on those with chronic diseases and low incomes …[73]

3.88 The danger of inflationary pressures on the gap payments on non concession card holding patients was examined in the Committee's first report, and was also a focus on the research commissioned from the Australian Institute for Primary Care. The Committee found that in relation to *A Fairer Medicare*, there was considerable likelihood of these gap payments being driven upwards.[74]

3.89 While it is not possible to directly extrapolate these findings in relation to the government's revised package, the similar structure of the incentives program invites the comparison.

3.90 These outcomes are not certain however. Dr Moxham, President of the Australian College of Non-Vocationally Registered GPs, suggests that:

> There are many doctors who are 'thinking about giving up bulk billing'. Such doctors would be encouraged by this measure to continue bulk billing, at least for their more disadvantaged patients.[75]

3.91 The Department argues that the potential dangers of an overall reduction in bulk billing rates and cross subsidisation is substantially mitigated by three factors. First, the $5 payment is expected to add around $15,500 to a GP's income:

> To the extent that the $5 payment adds to the GP's income … it may even make it easier for a GP to maintain or even possibly to extend the scope of bulk billing should they choose to share some of that financial benefit with their patients. [76]

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72 Catholic Health Australia, Submission 48, pp. 1-2. See also Ms Gilmore, *Proof Committee Hansard*, 19 January 2004, p. 80

73 Dr Lim, *Proof Committee Hansard*, 19 January 2004, p. 56

74 Senate Select Committee on Medicare, *Medicare: Healthcare or Welfare?*, p. 74

75 ACNVRGP, Submission 35, p. 2

76 Mr Davies, *Proof Committee Hansard*, 19 January 2004, p. 30

3.92 Secondly, the combined effect of all elements of the government package add substantial amounts to overall practice incomes, amounting to $35,051, $43,056 and $39,525 for practices in RRMA 1, 2 and 3-7 respectively, of which the $5 bulk billing payments comprise less than half.[77] This overall increase in practice income must substantially address many concerns GP's have raised in relation to the viability of practices and remove at least some of the downward pressure on general bulk billing rates.

3.93 The table overpage, reproduced from the Department of Health and Ageing submission, demonstrates these expected increases in GPs' income.

3.94 Thirdly, to the extent that bulk billing rates are a function of GP supply, the workforce measures in the package are predicted to increase doctor numbers across Australia, which can be expected to increase overall levels of bulk billing.

3.95 However, exact predictions of the outcome are difficult. Mr Davies of the Department of Health and Ageing concluded that ultimately, the question is:

3.96 [W]hat will the GP choose to do with that additional income? They can either add it to their practice income and take it to the bottom line – and improve the viability of the practice or their annual remuneration as an individual – or use that $15½ thousand to eliminate or reduce the gap charges that they levy off non-bulk-billed patients. So the impact it has will ultimately be a reflection of the accumulation of those individual decisions made by GPs as to whether they want to take this additional income to their bottom line or to share all or some of it with patients.[78]

77 DHA, Submission 54, p. 33. Note the corrections to the figures in this table, provided in the corrigendum: DHA, Submission 54A, p. 2

78 Mr Davies, *Proof Committee Hansard*, 19 January 2004, p. 45

Table 5: Additional Income under MedicarePlus per full time equivalent GP by Rural, Remote, Metropolitan Area classification[179]

Measure	**Per Full Time Equivalent GP in:**		
	RRMA 1	**RRMA 2**	**RRMAs 3-7**
More affordable health services – for children and Commonwealth Concession Card holders	$17,780	$15,785	$13,370
Patient convenience through new technologies	$250	$250	$333
Support for practice nurses through a new Medicare item	$3,570	$3,570	$3,570
Extension of grants for employment of practice nurses to urban areas of workforce shortage	$8,000	$8,000	Already available
Better access to medical care for residents of aged care homes	$2,765	$2,765	$2,765
More GP training places, and support for practices and GP supervisors	$2,667	$2,667	$2,667
Bringing more graduate doctors to outer metropolitan, regional, rural and remote areas.	$0	$10,000	$10,000
Supporting rural and remote GPs, especially procedural GPs	$0	$0	$6,800
TOTAL	**$35,051**	**$43,056**	**$39,525**
Existing grants for employment of practice nurses in rural and remote areas			$8,000
Total For Comparison	***$35,051***	***$43,056***	***$47,525***

Note: Costs assume that the GP will subscribe to all measures for which they may be eligible under **MedicarePlus.**

79 DHA, Submission 54A, p. 2

Addressing regional imbalances

3.97 Some commentators feel the package fails to address the current low rates of bulk billing in rural and regional areas, or the higher per capita distribution of Medicare benefits to city areas. The Rural Doctors' Association argue that:

> The proposed $5 incentive payment to GPs to bulk bill certain patients will not bring bulk billing back to higher levels in rural areas.
>
> [quoting a procedural rural doctor:] 'There is nothing in it for the majority of rural patients and rural docs! An extra $5 for bulkbilling will make little difference in rural areas except for those who still bulkbill and I don't believe there are many left.'[80]

3.98 Similarly, the National Rural Health Alliance point out that:

> the proposal provides the greatest rewards in areas with current high levels of bulk-billing. In areas where bulk-billing rates are currently low and out-of-pocket costs are high, levels of bulk-billing are unlikely to increase substantially. The measure is a reward for General Practitioners who currently bulk-bill their patients, rather than an incentive to increase bulk-billing for those General Practitioners who tend not to.
>
> The likely impact of this is that there will be little change in bulk-billing rates in the short-term in rural and remote areas with already low levels of bulk-billing. This is of major concern to the Alliance as cost barriers for General Practitioners' services are already high and increasing in country areas.[81]

3.99 In this view, the decision not to proceed with the geographically-based bulk billing bonuses contained in the earlier *A Fairer Medicare* package is a retrograde step. Doctors in urban areas, with already high rates of bulk billing, will receive an extra $5 (up from $1 and $2.95 in RRMAs 1 and 2) while doctors in rural areas get less ($5, which is down from $5.30 and $6.30 in RRMAs 5-7 respectively).

3.100 However, to return to the point made above, rural practices will benefit from a range of measures under the package which will serve to lift their overall practice incomes. As well, the workforce measures have a particular focus on rectifying workforce shortages of both doctors and nurses in rural areas. The combined effect of raising incomes and increasing supply can be expected to work to increase access to medical care and bulk billing rates in these regions.

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80 RDA, Submission 87, p. 8

81 NRHA, Submission 65, p. 7. See also RACGP, Submission 67, p. 6; Prof Hall, *Proof Committee Hansard*, 19 January 2004, p. 4; Mr Gregory, *Proof Committee Hansard*, 19 January 2004, p. 81

3.101 Professor Deeble told the Committee that the new package is an improvement on the original, since fixing the rural problems is more complex that simply 'throwing more money at them by way of higher fees':

> [I]t was unlikely to raise the amount of services that people got in country areas by paying the doctors a bit more, and I think that the [revised] package is better for that. My view would be that you may not even be able to do what is in this package, because of the constraints on the supply of doctors and nurses. … If you want to retain people in the country areas I think you have to identify the reasons why doctors are not in there – and it is not just money.[82]

Specialist bulk billing rates

3.102 A final issue, and one that is often overlooked in a debate on Medicare that generally focuses on general practice, is the levels of bulk billing and gap fees for specialist services.[83] As discussed above and in the previous chapter on safety nets, bulk billing is virtually non-existent among some specialists, with the resulting gap fees an increasingly important issue in access to health care.

3.103 The government package does little, if anything, to address these issues. The $5 incentive payment applies to any specialist MBS item that is bulk billed. However low rates of bulk billing in combination with average gaps of – for example – $29.11 for specialists and $44.65 for diagnostic imaging,[84] are unlikely to see this measure exert any influence on current billing patterns. As officials of the Department of Health and Ageing admitted, the net effect is a 'business as usual' price signal to specialists.[85]

3.104 The evidence suggests that the workforce measures designed to increase supply are also unlikely to have any discernable effect. While the Department expects a proportion of both the newly trained doctors and the Overseas Trained Doctors to be specialists, the 'impact in terms of competition, to put it bluntly, on specialists as a results of this package will be less than marked.'[86]

3.105 The impact of supply measures on specialists is, in any case, questionable, as Professor Deeble explained:

> If you look at how competition works in the medical profession, you will see that it does not work in the specialist area, because the specialist does

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82 Prof Deeble, *Proof Committee Hansard*, 19 January 2004, p. 21

83 – a point made by the Doctors' Reform Society, Submission 16, p. 4

84 Department of Health and Ageing, *Medicare Statistics*, p. 41

85 Mr Davies, *Proof Committee Hansard*, 20 January 2004, pp. 49 & 63

86 Mr Davies, *Proof Committee Hansard*, 20 January 2004, p. 63

> not tout for patients. The specialist operates by referral. The doctor who is referring refers on the basis of clinical competence and very rarely on the basis of what that specialist charges. For general practitioners, where the service is regarded by the patient as much the same, price is important. For a specialist, price is not so important, because it is very much associated with the referral to that individual doctor. Flooding the market with specialists is not going to lower the price even as much as it would for GPs.[87]

3.106 Given the increasing shift of specialist and diagnostic services to the out-of-hospital, private consultation setting as well as the increasing range of diagnostics available, it is curious that this issue receives so little public attention. Dr Gault, a Victorian GP, noted that:

> The expectation to bulk bill rarely seems to extend to medical specialists. Public dental care is a disgrace but private dentists are rarely criticised for providing so little of it.[88]

3.107 As Mr Goddard of the Australian Consumer Association comments, 'the failure to deal with specialists is one of the great failures of Medicare.'[89] The focus in the government's proposals on safety nets may therefore reflect an acceptance of the inability of government to control high medical costs – as Professor Deeble suggests.[90]

Predicting bulk billing rates

3.108 A key problem in assessing the impact of the $5 incentive payment is that there is little consensus on the determinants of bulk billing behaviour among doctors. Evidence from the medical profession tends to focus almost exclusively on price issues – that is, the inadequacy of the rebates compared to real practice costs. Thus for example, Professor Dwyer of the Australian Health Reform Alliance stated that:

> … the history of Medicare in Australia tells us that **'**when the Medicare rebate available for a specific service approximates a fair remuneration to a general practitioner very high rates of bulk billing are guaranteed'.[91]

3.109 Government officials, supported by some academics, place more importance on workforce supply issues and the effect of the laws of supply and demand. The Department of Health and Ageing submission considers that of several key factors, the predominant one is supply: 'The impact of competition between GPs in a local area

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87 Prof Deeble, *Proof Committee Hansard*, 19 January 2004, p. 18

88 Dr Gault, Submission 25, p. 1

89 Mr Goddard, *Proof Committee Hansard*, 19 January 2004, p. 38

90 Prof Deeble, *Proof Committee Hansard*, 19 January 2004, p. 6

91 AHRA, Submission 94, p. 8

remains a primary influence on the numbers of services that a GP bulk bills.'[92] Similarly, the Australian Consumer Association submission concluded that:

> The fall in bulk billing is largely related to changes in demand and supply. In markets where both demand and supply are reasonably inelastic, small changes in either demand or supply can have a strong effect on prices.[93]

3.110 However, the University of Canberra's Mr Ian McAuley (who was involved in the research for the ACA) also submits that 'there is no generalisation about the behaviour of medical practices.'[94] In research presented to the Committee, he tested the supply related hypothesis that bulk billing rates are highest in high income regions on the basis that there is likely to be a higher concentration of medical practitioners. He found that there is evidence of a relationship but it is not a simple linear one, and the causal factors are not clear:

> The relationship between income and bulk billing is complex. Bulk billing does, indeed, rise with income, but only up to a point, and the relationship is probably explained by region as much as by income. The lowest incomes and the lowest bulk billing rates are in rural electorates. As one moves to provincial cities, and on to outer metropolitan regions, incomes and bulk billing rates increase, but, for electorates in the three highest income decile groups, bulk billing falls with income.[95]

3.111 Explaining this relationship further during public hearings, Mr McAuley told the Committee that:

> Bulk-billing is highest in those outer metropolitan electorates which have reasonably high incomes – they probably also have very high needs – but it is lowest in the very poorest electorates, the country electorates in particular and the provincial cities. There it is very hard to see, given the very low supply, that there would be any significant boost to bulk-billing, even if there are these minor increases in supply.[96]

3.112 A different view was presented by Professor Deeble:

> I know that economists like to go back to the principles of economics and say that if the you increase the supply then the price will drop. I do not believe that that always holds. I think the level of bulk-billing … was partly a set of expectations that the doctors had about what the government might

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92 DHA, Submission 54, p. 3

93 ACA, Submission 36, p. 5

94 Mr McAuley, *Proof Committee Hansard*, 19 January 2004, pp. 11

95 Mr McAuley, Submission 96, p. 1

96 Mr McAuley, *Proof Committee Hansard*, 19 January 2004, pp. 11-12

> do to them if they did not bulk-bill and a set of expectations about what the patients expected.
>
> The rise in bulk-billing up to 1996-97 was not associated with a rise in coverage and it was not associated with a rise in doctor numbers particularly. The drop after that has not been associated with those things either. It was a perception that the doctors had, which was also endorsed by the relative values study, that they were underpaid. Whether or not they were underpaid did not matter – they thought they were.[97]

3.113 The difficulty in predicting what effect changes in GP supply and income levels will have on overall bulk billing rates makes the process of policy formulation problematic and is of great relevance to the discussion of alternatives in the following section. It is clear that bulk billing rates are dependent on a complex mix of factors including: doctor numbers in a particular area; MBS rebate levels; the income of the people in an area; doctor's earning expectations; and the somewhat intangible impact of government policy expectations on the role and extent of bulk billing.

3.114 Deducing which of these are the most important causal relationships is further complicated by the fact that different factors are likely to have different degrees of importance at various points of the decision making spectrum. Thus for example, government and societal expectations of doctors to bulk bill are unlikely to greatly influence bulk billing levels in a situation where the MBS rebates are substantially below real costs. Conversely though, these expectations may be crucial to preventing or limiting high gap fees if the rebate is relatively generous.

Perverse incentive towards shorter consultations

3.115 A final, structural, issue is the concern that a single flat rate $5 payment for any item, however long, short, or costly it may be to deliver, effectively provides an incentive towards short consultations. Dr Lim, a GP from Western Sydney explained that:

> as the incentive would appear to be a fixed amount regardless of the duration of each consultation, it would appear to reward mostly shorter visits. It actually does nothing to reward longer or more comprehensive consultations. Therefore, it does not encourage quality or preventative care.[98]

3.116 Thus, for example, a doctor who sees:

> 10 patients an hour is therefore going to be significantly ahead of someone who sees four patients an hour or a doctor who spends more time on

97 Prof Deeble, *Proof Committee Hansard*, 19 January 2004, p. 5

98 Dr Lim, *Proof Committee Hansard*, 19 January 2004, p. 58

> comprehensive consultations and therefore spends half an hour with each patient. The latter doctor would be rewarded the least by this system.[99]

3.117 This could potentially exacerbate an existing tendency of the Medicare system to encourage a 'churning' or high through-put of patients. The Royal Australian College of General Practitioners consider the $5.00 payment to be:

> extremely regressive as an incentive, since shorter consultations receive a higher percentage increase on the MBS, than longer consultations. Despite the College's faith in GPs providing adequate consultation times to meet their patients' needs, the College is concerned from a policy viewpoint that the incentive will reward shorter consultations.[100]

3.118 The importance of longer consultations in high quality primary care and in addressing lifestyle issues is well known, as Professor Dwyer from the Australian Healthcare Reform Alliance explained:

> Longer consultations cost more per patient visit but produce far better outcomes and in the long-term are extremely cost effective. A ten-minute consultation with someone about whom a doctor knows little is unlikely to alter a dangerous lifestyle. All experienced physicians will tell you that they need time to 'listen between the lines' and let the real problems that a patient wishes to discuss come to the surface.[101]

3.119 Departmental officers commented in response that this tendency is corrected in part by the higher rebates payable for long consultations. Secondly, on practical grounds, rectification of the problem would essentially require a sliding percentage based rebate:

> We are constantly aware of the desire not impose additional administrative burdens on GPs. … To set it as a percentage would have required essentially a new item to twin with every MBS item.[102]

Conclusion – effective reforms

3.120 The Committee concludes that the proposed measures are likely to maintain if not marginally increase the levels of bulk billing for those in the two target categories – concessional patients and children under 16. However, the package is likely to see a slide in the overall levels of bulk billing to the wider population to around 60%, as

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99 Dr Lim, *Proof Committee Hansard*, 19 January 2004, p. 63

100 RACGP, Submission 67, p. 6. This problem also noted by Catholic Health Australia, Submission 48, pp. 1-2; Australian Healthcare Association, Submission 56, p. 6; Dr Alexander, Submission 26, p. 1; Rural Doctors' Association, Submission 87, p. 8

101 AHRA, Submission 94, p. 7

102 Mr Davies, *Proof Committee Hansard*, 20 January 2004, p. 68

bulk billing becomes generally available *only* to those in the target categories. The bottom line is Medicare Plus neither restores wide scale bulk billing, nor intends to.

3.121 Given the complexity of predicting bulk billing rates and gap payments, it remains unclear whether this move would also drive a rise in gap payments for general GP consultations, as practices cross-subsidise to take advantage of the rebate incentives. For this reason, the Committee agrees that there are legitimate grounds for linking higher payments to incentives to bulk bill.

3.122 Perhaps the greatest paradox in the government proposal is that it focuses on providing bulk billing to categories of people who already enjoy the highest rates of bulk billing in Australia. To a large extent, the policy puts forward a solution to a non-existent problem, while overlooking – if not worsening – the more pressing issue of declining access to bulk billing for everyone else.

3.123 The Committee also finds that the proposal does not address the underlying structural inequities that currently plague the operation of Medicare: the low levels of bulk billing in regional areas, and the problems in accessing many specialists and diagnostic services due to low bulk billing rates and high gap payments.

Alternatives

3.124 The Committee heard various alternatives to the government's proposals which, it could be argued, better address the existing problems with access to Medicare health services. Three principal alternatives were suggested:

- paying the $5 extra rebate to all bulk billed patients;
- raising the rebate for all consultations; or
- additional targeted measures.

A $5 incentive for all bulk billed services

3.125 Based on the underlying importance of bulk billing and the pitfalls of selecting certain categories of people to the exclusion of others, both discussed above, a number of submissions considered that the government's proposals would be improved by extending the $5 incentive payment to any service that is bulk billed, irrespective of the recipient.[103] In this way the principle of universality would be maintained. As the Preston Reservoir Progress Association submission argued:

103 Advocated by a number of submissions, including: AHA, Submission 56, p. 6; Humanist Society of Victoria, Submission 23, p. 2; Combined Pensioners and Superannuants Association of NSW, Submission 28, p. 4; Dr Lambie, Submission 34, p. 1; TasMAG, Submission 22, p. 4. VMAG, Submission 27, p. 4 (the latter two also recommend the use of bulk billing targets.)

> If the government believes that the $5 incentive will be sufficient to ensure continued bulk billing, then why not extend it to the other 40% of the population.[104]

3.126 This view accepts a legitimate role for targeted incentives aimed specifically at raising the level of bulk billing. Mr Goddard of the Australian Consumer's Association stated:

> I think there is certainly a good case for rewarding bulk-billing, for saying that we value doctors who bulk-bill and that there be something extra in it for them.[105]

3.127 A significant advantage of this approach is that it would limit the extent to which increases in the rebate would be simply swallowed up by the medical profession – at great public expense – with no impact on bulk billing rates. This problem was discussed in detail in the Committee's first report[106] and remains a concern of the government.

3.128 However, such a solution does not address the underlying problems with the rebate levels, and as such, would not do anything to restore doctor confidence in the fundamentals of the system. Further, as noted above, such a payment would not have any influence on the currently low levels of bulk billing for most specialist and diagnostic services.

Raising the rebate

3.129 Many submissions consider that the key shortcoming of the Medicare Plus proposals is its failure to come to terms with the fundamental issue of setting and maintaining a realistic level for the MBS rebate.[107] Thus, for example, the Tasmanian Medicare Action Group argued:

> The fact that the government has allowed Medicare rebates to fall so far behind … actual fees charged by GPs is evidence of its lack of commitment to a universal and equitable national health insurance scheme.[108]

3.130 In general, the doctors' groups share this view and see a general reassessment and raising of the rebate as the central solution to current levels of bulk billing.[109]

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104 PRPA & DDEMG, Submission 85, p. 4

105 Mr Goddard, *Proof Committee Hansard*, January 2004, p. 46

106 Senate Select Committee on Medicare, *Medicare – Healthcare or Welfare?*, p. 180

107 Australian Pensioners' and Superannuants' league Qld., Submission 3, p. 3; Mr Winterton, Submission 10, p. 1; NSW Retired Teachers Association, Submission 21, p. 1; UnitingCare, Submission 55, p. 7; City of Darebin, Submission 42, p. 3; Mr Boyle, Submission 47, p. 1

108 TasMAG, Submission 22, p. 4

3.131 Evidence received by the Committee's first inquiry showed that although rebates have been increased in line with inflation, based on a government wage cost index (WCI5), there has been a genuine decline in that part of a doctor's Medicare income relative to average weekly earnings. This, in combination with higher-than-indexed costs of medical practice, were said to be the principle drivers of falling bulk billing and rising gap fees.[110]

3.132 The report by the Australian Institute of Primary Care, commissioned by the Committee for the first inquiry, found that when comparing doctors' incomes from the MBS with average weekly ordinary time earning (AWOTE), Commonwealth expenditure on GPs in 1992-93 was about 5.2 times AWOTE, falling to 4.7 times AWOTE in 2002-03.[111]

3.133 However, as the discussion in the previous section of this report illustrates, it is far from clear whether increases to the MBS can guarantee any significant rise in bulk billing rates. This was the Committee's conclusion in the first report.

3.134 Mr Davies of the Department of Health and Ageing admitted that even the extra income generated by doctors from the current proposals will not necessarily increase the current levels of bulk billing for either the target groups or the wider population.[112]

3.135 Even where the need for a general increase in the MBS is accepted, it still leaves the vexed question of how much it should be increased by. This issue has already been discussed in some detail in the Committee's first report, examining the claims of the doctors' groups and the outcomes of the Relative Values Study.[113] During this inquiry the St Vincent de Paul society recommend raising the rebate for all GP services by $10 and indexed,[114] while Mr Goddard told the Committee:

> there is a reasonable prima facie case to say that there should be comparative wage justice for doctors as well as for everybody else; we should restore the level to where it was when the Medicare rebate was actually pretty generous, and it was comparatively at its most generous right at the beginning and again at the beginning of the nineties – and tak[ing] that as the measure of real value you would need to increase the rebate for

109 AMA, Submission 9, pp. 1 & 2; RACGP, Submission 67, p. 6

110 Senate Select Committee on Medicare, *Medicare: Healthcare or Welfare?*, p. 17

111 Senate Select Committee on Medicare, *Medicare: Healthcare or Welfare?*, p. 17

112 Mr Davies, *Proof Committee Hansard*, 19 January 2004, p. 45

113 Senate Select Committee on Medicare, *Medicare: Healthcare or Welfare?*, p. 169

114 SVDP, Submission 58, p. 8. See also Mr Winterton, Submission , p. 10; Geelong West Branch of the ALP, Submission 41, p. 3; Catholic Health Australia, Submission 48, p. 6

> basically every service by between $5 and $7, on average. On top of that, the profession talks about a lot of costs which are specific to general practice. I do not think we have the research really to know what those are. Our feeling is that the case for that has not been proven. That is not to say that there is not a case there; the case has not been demonstrated.[115]

3.136 Catholic Health Australia compared the cost implications of the various proposed MBS increases for GP consultations:[116]

- Extending the $5 increase to all bulkbilled services will cost $326.6 million (ie $5 x 96.9m services x 67.4% bulkbilled), or $59.3 million additional per year than in the Government package. This assumes the bulkbilling rate stabilises at 67 percent and the number of services does not decline further.

- Extending the $5 increase to all GP services whether or not they are bulkbilled will cost $484.6 million (ie $5 x 96.9m services), or $217.3 million more per year than in the Government package. Again this assumes the number of services does not decline further.

- To provide a $10 increase for all GP consultations would cost around $969 million, or $701.7 million more per year than the Government's current package.

3.137 However, the Committee also notes the cautionary comments of Professor Deeble, that raising the rebate does not mean matching the prevailing level of average gap payments, currently at $12.77:

> The submissions say that, if the amount of payment that the government offers is less than the gap that we can get by charging patients what we think they can pay, then the logical extension of that is that the government has to match whatever the doctors decide to charge. That is not necessarily true. But if they will only bulk-bill if they get the same amount that they think they could get from patients then you might as well give up Medicare, because it is completely untenable to go chasing any level of fee that a doctor thinks they can get.[117]

3.138 The Department of Health and Ageing also pointed to the fact that although remuneration to GPs for consultations was under-funded 'to a small degree', other government initiatives – such as the Practice Incentives Program (PIP) – has delivered increases in practice income that 'more than offset this under-funding'.[118]

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115 Mr Goddard, *Proof Committee Hansard*, 19 January 2004, pp. 45-46

116 Catholic Health Australia, Submission 48, pp. 6-7

117 Prof Deeble, *Proof Committee Hansard*, 19 January 2004, p. 5

118 DHA, Submission 54, pp. 7-8. Note also Table 5

3.139 In relation to specialists, the ACA also saw little benefit in raising the schedule fee due to the already low rate of bulk-billing:

> This is not to sweep the problem under the carpet; there are clear inequities in a system which allows specialists to charge virtually open-ended fees. The problem needs to be taken up on the supply side, particularly restrictions on entry to certain specializations. The best approach may be on a profession-by-profession basis, for there is no single pattern of shortage.[119]

3.140 A second issue, that in the longer term underpins the question of increasing the MBS benefits, is reform to the indexing system by which the MBS is adjusted.

3.141 The Schedule is currently determined by the Medical Services Advisory Committee, administered by the Department of Health and Ageing. According to the Department, it is a historical schedule which is indexed annually and occasionally adjusted for new technologies or new forms of treatment.[120] Again, this issue was addressed in the Committee's first report, which explained the current indexation method.[121]

3.142 The key to the importance of this issue is the strongly held view within the medical profession that the current system has failed to deliver realistic payments and has been discredited.[122] The Medical Benefits Schedule forms the central structural backbone of the Medicare system, and as such, is the foundation of bulk billing. As long as the schedule remains discredited, efforts to restore bulk billing are likely to enjoy limited success. It is arguable therefore that a reformed method, preferably with greater transparency, is needed to restore doctors' commitment to the Medicare system. Mr Goddard told the Committee:

> I think the important thing is indexation … a number of GPs have told me they do not want this situation to arise again – if they are going to get back into bulk-billing, they want to make sure that they are not in the same situation again in another five or 10 years – and realistic indexation, based on an objective measurement of genuine costs, would I think provide them with the assurance that it would be worth getting back in. Getting them back in is going to be a problem.[123]

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119 ACA, Submission 36, p. 14

120 Mr Davies, *Proof Committee Hansard*, 20 January 2004, p. 50

121 Senate Select Committee on Medicare, *Medicare: Healthcare or Welfare?*, p. 179

122 RDAA, Submission 87, p. 15

123 Mr Goddard, *Proof Committee Hansard*, 19 January 2004, p. 46

3.143 These sentiments are reflected in the comments of a number of submitters.[124]

Additional targeted measures

3.144 Other groups recommended that if the proposals were to proceed in their current form, affordability and access for those groups in identified need would be improved by special additional measures not contained in this package.

3.145 The National Association of People Living with HIV/AIDS (NAPWA) put forward one such suggestion, arguing for the creation of a chronic illness card. This card would entitle holders to the benefit of the bulk billing incentives and lower safety net thresholds in the package, thereby helping to mitigate the impacts of chronic illness, which require 'a complex matrix of clinical management, and often, additional allied health support', particularly in relation to the cost of accessing pharmaceuticals.[125]

3.146 As Mr Goddard explained, the GPs who treat chronic illness specifically are required, sometimes by regulation, to have a higher level of qualification and skill than many generalist doctors – their general knowledge plus the specialised knowledge of the illness:

> But not only is there no benefit to them for that; there is a disincentive. For example, when I go to my doctor to talk about HIV, I am never out in less than half an hour. But there is no way that the doctor, who sees a lot of us – and we do tend to congregate – can claim for all of that. In the present situation, without recognising that looking after chronic illness is different, we are actually financially penalising some of our best doctors.[126]

3.147 Representatives of the Consumers Health Forum of Australia, the Public Hospitals, Health and Medicare Alliance of Queensland and ACOSS all supported the need to better address the needs of this group.[127]

3.148 The Committee also received evidence from the National Association of Developmental Disability Medicine. They point to health outcomes significantly below average for the group they represent, which includes those with intellectual disability, cerebral palsy, and autistic spectrum disorders, and show that people in these groups typically die twenty years younger than the general population. The Association considers one of the principle barriers to be the inadequacy of the MBS

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124 Dr Matthews, Submission 05, p. 1-2; Mrs Scholem, Submission 7; Dr Alexander, Submission 26, p. 3; SVDP, Submission 58, p. 8

125 NAPWA, Submission 44, p. 10; Mr Menadue, *Proof Committee Hansard*, 19 January 2004, p. 41

126 Mr Goddard, *Proof Committee Hansard*, 19 January 2004, p. 40

127 Ms Hokins, Ms Mohle and Mr Harvey, *Proof Committee Hansard*, 19 January 2004, pp. 40-41

rebate relative to the amount of additional time needed to properly assess and manage the health problems associated with these conditions.

3.149 They recommend, among a number of measures, the provision of specific funding for health assessments for people with developmental disability, similar to those already provided for the aged and indigenous population under the Enhanced Primary Care initiatives.[128]

3.150 Finally, the Rural Doctor's Association of Australia renewed its calls for special recognition of the higher costs of providing medical services in regional and remote areas, by means of a rural loading for MBS or separate consultation item numbers for these services.[129] This suggestion was discussed in the Committee's first report.[130] Since that time, the RDAA has released the findings of their recent study, conducted in conjunction with Monash University: *Sustaining Medical Practice in Rural and Remote Australia: a summary of the viable models of rural and remote practice project*,[131] which found that one in five medical practices in rural and remote Australia are not viable.[132]

Specialists costs

3.151 As the discussion above demonstrated, the government package does nothing to address the issue of low bulk billing rates and high gap fees for specialists and some diagnostic services. The Committee strongly believes that no meaningful improvements to access and affordability under the Medicare system can be achieved without addressing specialist costs.

3.152 Several alternatives to the proposed safety nets are worth broadly canvassing.

3.153 First, measures could be taken to increase the number of specialists providing services in public hospitals, potentially through flexible funding arrangements enabling bulk billing by specialists in public hospitals or expanded outpatient clinics. Second, funding could also be provided to incorporate specialist and diagnostic services into Community Health Centres (discussed in greater detail in Chapter 5). Third, the government could move to a system of bulk purchasing for selected services. For example, regional tenders could be offered for the provision of a specified number of services in a particular region. This may prove an effective means

128 National Association of Developmental Disability Medicine, Submission 17

129 RDAA, Submission 87, p. 16

130 Senate Select Committee on Medicare, *Medicare: Healthcare or Welfare?*, p. 185

131 RDAA, Submission 87, Attachment 1

132 RDAA, Submission 87, p. 8. See also RDAA, Submission 87A, Attachments 1 & 2

of price control particularly in relation to largely uniform, undifferentiated services, but is less relevant for more variable services.

3.154 The Committee also notes the example offered by the long-standing government agreements with pathologists and optometrists, which have seen capped funding and high bulk billing rates in both areas, amounting to 84.1% for pathology services and 96.5% in optometry.[133]

Conclusion – alternatives

3.155 The Committee sees considerable merit in some of these alternatives. In particular, the Committee considers that these $5 incentive payments must be extended to all bulk billed patients, consistent with the principle of universality and the need to address falling levels of bulk billing.

3.156 It is clear though, that these actions will not be sufficient to – nor are targeted towards – bring about any substantial change to the current level of bulk billing or its overall downwards trend, and as such can only be an interim solution. In the longer term, the fundamental issue of rebate levels must be addressed for both general practitioners and specialists.

3.157 This Committee is not in a position to make substantive recommendations on what these levels should be. What is clear though is that both the current levels and the ways in which they are set, are discredited in the eyes of the medical profession as being out of touch with true practice costs and doctor income expectations. This dissatisfaction is evident in the rising gap payments across almost all medical services. As stated above, the Medicare Benefit Schedule sits at the heart of the bulk billing system and if it is perceived to have become irrelevant, the viability of Medicare as a universal health insurer is undermined.

3.158 The Committee concludes that the only solution to this problem is to reform the current system for determining the MBS and introducing a more transparent manner of considering the complex matrix of issues that relate to practice costs and remuneration. A great deal of work has already been done, including the finding of both the Relative Values Study and the Attendance Item Restructure Working Group. These initiatives must be pushed through to a conclusion.

3.159 Only this type of reform can deliver an outcome that has the necessary legitimacy with both the medical profession and the general population. This legitimacy is needed both to entice the medical profession to recommit to the bulk billing system, and to sustain the confidence of the Australian public who pay for Medicare.

133 Department of Health and Ageing, Medicare Statistics 1984/85 to June Quarter 2003, p. 11

Recommendation 3.1

The Committee does not agree that the $5 bulk billing incentive payment be limited to concession card holders and children under 16 years of age. Rather, the Committee recommends that the additional $5 rebate payment be extended to all bulk billed services.

Recommendation 3.2

The Committee recommends that the government initiate discussions with key stakeholder groups, including medical and health consumer groups, to revise the method for setting and indexing items on the Medical Benefits Schedule, with the aim of improving the transparency of the process and the legitimacy and acceptance of the outcome.

3.160 Finally in relation to specialist costs, the Committee considers that given the scope of the terms 'specialist and diagnostic services', it is necessary to be circumspect about advocating any particular solutions to this problem. Also, as noted above, raising rebate levels for specialists may have little or no effect on their billing practices and as such, it should be acknowledged that fee for service is not necessarily the best model for purchasing specialist and diagnostic services.

3.161 The Committee concludes that a three-fold approach is necessary to address the issue of specialist costs.

3.162 First, the government should initiate (where they have not already) negotiations with each of the colleges and professional organisations with the objective of raising bulk billing levels, minimising gap payments, and maximising adherence to the schedule fee.

3.163 These negotiations must be underpinned by a national policy commitment by the government to the objective of bulk billing, as well as a preparedness to fund increases – where necessary – to the Medicare Benefits Schedule to reflect real costs.

3.164 Second, and in recognition of the limits of the above approach, the government should explore alternative models of providing specialist and diagnostic services, such as those outlined in paragraphs 3.150 above.

3.165 Third, the government must take further steps to reduce barriers to entry to specialist colleges in order to increase the number of specialists.

Recommendation 3.3

The Committee recommends that the government adopt, as a formal policy objective, the raising of the level of bulk billing and observance of the schedule fee by specialists.

The Committee recommends that the government pursue this policy objective by means of negotiation with the relevant professional specialist groups and the development of agreements with those groups to improve the outcomes in line with these objectives.

Where such agreements are impractical, the government should actively explore and adopt other options some of which have been outlined by the Committee.