Attachment 1

Bulk-billing E Durham Smith

Bulk-billing has become a litmus test of the social philosophy of political parties in their attitude to Medicare. No other feature divides them as much. Nor is any subject filled with so many myths and misunderstandings.

Bulk-billing (i.e. direct billing to the Insurance Fund for medical services) is designed to leave the patient with no co-payment and is understandably widely supported by the community. The fee paid to the doctor is currently set at the Rebate fee level, i.e. 15% less than the Schedule fee. The argument is all about the 15% out-of-pocket expense of that gap, and whether its presence for patients who are not bulk-billed is a denial of the Medicare claim to provide "universal coverage of basic medical care".

The current Coalition Government views bulk-billing as a safety net only for certain patients (Health Card recipients, and now additionally children), a concept equating to the "sick poor". This limited policy is inequitable because the 15% gap for low income families who do not qualify for the concession is much more of a financial burden than to those on high incomes. The Government's response is to offer $5 to the doctors above the Rebate to encourage a greater participation rate in bulk-billing. In designing this flat rate bonus the planners seem to be unaware that there a whole range of General Practitioner fees (and Specialist fees) depending on the length and complexity of the consultation – in some the $5 is adequate, in others quite inadequate. For example, General Practice consultations at the Surgery are in four levels with the gap between Rebate and Schedule fees being, respectively, $2.05, $4.50, $8.60, $12.65. There are several other categories (Home visits, hospital visits, etc) with wider gaps than $5. Similarly, the gaps for Specialist consultations vary from $10.65 to $22.80, and even more so for prolonged attendances. It is therefore extremely doubtful if the offer of $5 will provide any incentive for more doctors who currently do not bulk-bill to begin doing so only to be out-of pocket.

On the other hand, there are those who believe *every* service on *every* patient should be bulk-billed. There is no doubt that this truly would achieve "universality". No patient is left out-of-pocket and every citizen is covered equally. Attractive as this concept is in political terms it comes at considerable cost. Firstly, it is very doubtful if Medicare was designed on the assumption that all or even most medical services were "meant" to be bulk-billed. In fact, Medicare never defined who should or should not be bulk-billed. The scheme was designed with both a Rebate fee *and* a Schedule fee, indicating that the normal expectation under usual circumstances was a "fair and reasonable" Schedule fee. If all services were meant to be bulk-billed we would have only required one fee. In fact, historically, bulk-billing was not mandated but "encouraged" on the argument that billing at the lower Rebate level (15% below the Schedule fee) would "save" the practice the administrative costs of collecting fees from individual patients by 15%. This has proved to be a myth, as practice costs are scarcely diminished at all by the bulk-billing process, especially if the practitioner still provides an itemized copy of the account to the patient of the services, to inform the patient of real costs, as should occur as the ethical demands of a good practice require. Unless the patient is given a copy of an itemized account it hides the true costs of service. The reality is that bulk-billing is a *significant discount* for services. Secondly, because the fee is a discount there is a temptation to push through the maximum number of patients in the shortest time in order to keep up a viable income, which has spawned a growth in "Bulk-

billing Clinics" – and even some of these are now abandoning the practice as being uneconomical, as shown by recent decline in the rate of bulk-billing. Competitive pressures between practices to bulk-bill is a most potent risk of over-servicing by medical entrepreneurs. Thirdly, with no built-in check on free visits there is the danger of over-utilisation by consumers. It may be difficult to substantiate, but over-servicing and over-utilisation may be costing Medicare millions of dollars in unnecessary or inadequate services. Fourthly, rapid throughput in bulk-billing clinics has been substantiated to lead to lower standards of medical care (note the comments in the Health Service Commissioners Report in 1992, Victoria, that those clinics were the major source of complaints by patients). Finally, some would argue that wealthy persons should make some contribution to health costs, and not receive free treatment when they could afford to pay for it. Advocates of universal bulk-billing have to address these difficulties.

A further misunderstanding is to confuse the desire to relieve the patient of a co-payment with the level of the fee paid. Currently, bulk-billing assumes payment at the Rebate level, i.e. a discounted fee. Because the fee is discounted (and it is additionally claimed that the level of the Rebate has not kept pace with practice costs nor even with CPI), doctors claim it is uneconomic and bulk-billing rates are accordingly falling. But there is no reason why the bulk-billing fee should necessarily be pegged to the Rebate level. It could be struck at any level, e.g. the Schedule fee, and still leave the patient with no co-payment. Indeed, this is proposed by the Labour Party as an alternative to encourage a greater participation rate, but it is unclear whether this is for *every* service and for *every* patient. Clearly, if every patient is bulk-billed at Schedule rate there is no need for any cash incentives to be offered to doctors to encourage participation rates and no need for two fees in the Medical Benefits Schedule Book; yet cash incentives are being offered, suggesting that only *some* patients will be bulk-billed at the Schedule rate, but which ones are not defined.

These dilemmas underlie the failure to understand the basis of a fee. A fee charged should be *in relation to the quality of the service rendered* and has little to do with either the mechanism of payment of the fee, or the financial state of the patient. (for example, in the latter case I have never charged a known wealthy patient a higher fee than the Schedule fee just because they are wealthy). Where bulk-billing is applied, the logic should be that if the service rendered is significant the re-imbursement should be at the Schedule fee level; if for a minor or less demanding service, at the Rebate level. For example, for many Health Card recipients (elderly, disability pensioners, etc.,) by their nature often have complex problems and much co-morbidity, demanding more care and longer commitment than other patients, the bulk-billed fee should be at the Schedule fee level. Why is the medical service to such patients deemed to be of lesser value (by the Rebate fee of current Medicare) than the same service to a person who pays the full fee? On the other hand, logic would decree that services of a more minor nature should be bulk-billed at the Rebate level. It is for this reason that in the Standard Table of benefits in New Medicare (Section 6) bulk-billing is "at either the Schedule or Rebate fee level, depending on the nature of the medical service". In either case the patient is not out-of-pocket and the objective of bulk-billing is still achieved. On that principle, practices can remain viable with no necessity for the complication of cash bonuses.

Finally we now come to a political decision. Planners of policy simply have to come to terms with reality.

For those who want to have total universality, with every patient and every service being bulk-billed, that is a political decision. It will be very popular with consumers, and certainly achieves universality, but the costs must be accepted as set out above – the risks of over-servicing, over-utilisation, lower standards, and the necessity of legislation to make it mandatory or else a complicated set of cash incentives; if it is decided to bulk-bill at the Schedule fee rate for every patient, it will be very expensive; if at the Rebate level for every patient, it underestimates the value of some consultations.

For those who want some limitation on bulk-billing, but more generous than the philosophic approach of the current Government, there is the difficulty of defining who exactly should benefit, and at what level of re-imbursement.

Frankly, there may be no complete solution, and a compromise will be necessary, but it is possible to identify some major groups who should benefit, and protect their interests; however, there will remain an optional group where the judgment, insight and integrity of the attending practitioner is the nearest we will get to a fair scheme without invading privacy by legislative intrusion. A compromise for bulk-billing is suggested as follows:

- all services in Public Hospitals for public patients, medical services at the Rebate level, and accommodation and other ancillary serves at 100% recovery rate.
- accommodation and ancillary services for private patients in shared wards in either Public or Private Hospitals at 100% recovery rate.

- medical services both outside and inside hospitals for the following identified groups – Health Card recipients (see definition in text)
  Children under 16 years of age
  Unemployed and underemployed
  Patients in Nursing Homes and Institutions of care
  Self-supporting students, Pastors, Clergy, and religious Orders.

- medical services to other groups where additional information is required. These groups are no less important than the identified groups but the information involves privacy issues, e.g. the income level of a family. On this account the inside knowledge, sensitivity and empathy of the attending practitioner is the only realistic guide. I do not think it can be legislated for, as much as some ideologues would wish for it to be written in stone, without breaching privacy. These include – financially disadvantaged low income families not on Health card concessions, families in a period of financial or emotional distress, elderly and others without family support when even the paper work is difficult, nurses and professional colleagues in the health field.

Apart from these categories, it remains an option for a doctor to bulk-bill any or all patients at his/her discretion.

Finally, the fee level of bulk-billing should be determined by the nature of the medical service, either at the Schedule or the Rebate fee level, as described above. *In this way no additional cash or other incentives are necessary.* The fees charged would only be what they would be without bulk-billing.