CHAPTER 6

Proposed billing arrangements

Any health system should be judged not on what level of care can be received by those with money and influence, but by the level of care offered to, and received by the vast majority of those who have the least amount of money and influence in society.[1]

Introduction

6.1 A key aspect of the Government's 'A Fairer Medicare' package is the General Practice Access Scheme (GPAS). Under the scheme, practices that commit to bulk-billing all Commonwealth concession card holders will receive an incentive payment for each concessional patient bulk-billed. Payments vary according to location and are set at $1.00 per consultation in capital cities; $2.95 in other metropolitan areas (such as Geelong or Newcastle), $5.30 in rural centres (such as Toowoomba, Cairns or Broken Hill) and $6.30 in other rural and remote areas (such as Coonabarabran, or Mt Isa).

6.2 Participating practices will also be able to receive the rebate amount directly from HIC Online via electronic billing arrangements, with payment time reduced from eight to two days. Where there is a charge above the Medicare rebate fee, the patient will pay only the difference.

6.3 To assist in the costs of setting up computer systems that can connect with HIC online, participating practices will receive a payment of $750 in metropolitan areas, and $1000 in rural and remote areas. It is also intended that practices in more remote areas will benefit from other, government wide, initiatives to develop broadband connectivity in rural and remote areas.[2]

6.4 The General Practice Access Scheme is budgeted to cost $346.2 million over four years.

6.5 This chapter examines the GPAS in more detail and considers the likely outcomes when measured against the terms of reference – the viability of, and the access to, general practice.

The reaction of General Practice

6.6 The Government's 'A Fairer Medicare' proposal has not been well received by general practice, with the Committee receiving evidence from both individual

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1 Dr Carter, Submission 19, p. 1

2 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 52

practitioners and all major GP professional groups that there are significant problems with the package. These criticisms are reflected in the evidence that nationally, less than 20% of GPs are likely sign up to the package.[3] Dr Walters of the Australian Divisions of General Practice told the Committee:

> ADGP did a national survey which generated 800 responses. This is an almost unheard of number for this sort of thing, in our experience. It came back pretty overwhelmingly that GPs did not support it.[4]

6.7 As a representative of the Ballarat Division of General Practice concluded:

> [T]he package just doesn't go far enough; it's skewed too far in terms of the political issues for us to take it on. A very small number of our GPs – two or three out of 90 – have responded by saying that they would be interested in looking at the package.[5]

6.8 From the perspective of GPs, the key problem with the package is that it does not make financial sense. This conflicts with the claims of the Minister and officers of the Department of Health and Ageing. Mr Davies, representing the Department, told the Committee:

> The financial incentive payments have been carefully designed to ensure that the vast majority of practices will be better off by joining the scheme.
>
> … This table shows the net gain in income for practices participating in the General Practice Access Scheme.[6] No two practices are the same, so we have had to make some assumptions. We have assumed a practice with about 10,000 annual concessional services, which is close to the national average, and we have assumed that those concession card holders are currently charged a gap of $10, which is actually a little above the average for concessional patients who do pay a gap. This table shows that the net additional income to practices can be quite substantial. I emphasise again that these are net gains after subtracting any forgone income from the practice ceasing to charge gaps that are currently levied on patients covered by a concession card.[7]

6.9 Mr Davies explained how the incentives were calculated:

> The process underlying that is, basically, careful examination of the current level of gap charges levied from concession card holders. Then we assumed that a practice that signed up would forgo that income from patients who

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3 Estimates from GP polling varies – see for example: Queensland Division of General Practice, Submission 146, p. 4

4 Dr Walters, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 58

5 Mr Howard, *Proof Committee Hansard*, Melbourne, 27 August 2003, p. 56

6 See DoHA, Submission 138, p. 37 – Table 7

7 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 8

> hold a concession card, and the job of the incentives is to replace the income that they lose.[8]

6.10 Overall, the government has geared these calculations with the intention of providing the majority – about 75% – of GPs with an incentive to sign on. It considered that efforts to provide inducements for the final group at the margin become too expensive:

> The higher that proportion is set, the more the government will be spending on increasingly fewer doctors who are increasingly harder to persuade because they are already charging significantly higher gaps. The level of deadweight loss goes up; the level of additional new doctors for each extra dollar goes down.[9]

6.11 However, most GPs do not agree. Dr Sprogis, in Newcastle, for example, explained why:

> It is really very straightforward. The current co-payment for patients now roughly ranges between $10 and $30, and for those who are in the cardholders category that the government is proposing that would be roughly $10, and I think the offer is $3. You do not have to be a rocket scientist to work out the difference.[10]

6.12 Similar comments were made by Professor Charlton on the Central Coast, who found in a member survey of their Division of General Practice that only 17 percent would opt in:[11]

> For the vast majority, 85 per cent of our consultations are what is called level B consultations and it is on those that we charge the gap ranging from $5 to $15. … if our practice took up the government's initiative it would be $30,000 per year out of pocket. Fifty per cent of our patients are health care card holders. Practices which have a higher proportion – 70 per cent – would be $60,000 to $80,000 out of pocket if they took on the government's initiative. You would have to be mad to go backwards by that amount.[12]

6.13 Dr Boffa, from the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT), observed that some of Australia's richest GPs are rural GPs:

> [W]here there are so few doctors and there is so little competition, they can charge a lot, and they do. … When she went there, the minister was told by all the private practices that they will not take up her package. One GP said, 'Thank you very much. I charge concession card holders and pensioners $50

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8 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 70

9 Mr Stuart, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 71

10 Dr Sprogis, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 26

11 Professor Charlton, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 57

12 Professor Charlton, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 56

> an hour. Why should I accept $33? It is an extra six dollars. I am not going to do it.'[13]

6.14 Dr Boffa summed up:

> So the package, unfortunately, is not going to solve the problem because the GPs in areas of undersupply are already making such an amount of money that they are not going to accept reducing their income.[14]

6.15 Whether or not the package provides a real financial incentive for practices to sign on therefore depends principally on whose figures are to be believed. It is quite possible that the conflicting estimates of the effect of the package on GP incomes derives from inaccurate perceptions within the medical community in relation to what percentage of patients, and concessional patients, they currently bulk-bill.

6.16 Mr Stuart of the Department of Health and Aged Care, noted that about 10 per cent of doctors bulk-bill everybody, about 10 per cent bulk-bill nobody and about 80 per cent bulk-bill somewhere in between. Part of the problem is:

> [I]f you listen to what GPs are saying, it is very difficult to understand how that number [the total bulk-billing rate] could be as high 68 per cent. After having had discussions with some GPs in different parts of the country, it is my belief that a part of the reason for that is that individual GPs are not always aware of the level of bulk-billing in their practices or of the proportion of concessional patients they are seeing in their practices. To an extent, some of those issues are dealt with by the front of house staff rather than by individual GPs, or GPs are making case-by-case decisions as patients come to see them but are not necessarily aware of how those numbers add up for their practice over time.[15]

6.17 Evidence from Dr Moxham, of the Australian College of Non-Vocationally Registered GPs, supported this view:

> People say, 'I charge everybody,' but, when you actually go through who they do not charge, you find that they do not charge the clergy and they do not charge veterans and they do not charge health care card holders. Their average is less than what they actually say.[16]

Other issues

6.18 The Committee also notes several practical difficulties that may emerge with implementation. The first stems from the requirement that whole practices sign onto

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13 Dr Boffa, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 50

14 Dr Boffa, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 50

15 Mr Stuart, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 77

16 Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 3

the package rather than individual doctors. Dr Bain of the AMA explained how this could cause difficulties:

> For practices that mix and match, with maybe a female GP coming in on Wednesdays to see female patients … every doctor who attends that practice will have to be prepared to sign-up. Getting a practice to sign-up to the package which might have seven or eight doctors rolling through it in the space of a week, and their locums and everybody else associated with it, will add a layer of extreme complexity to the whole exercise.[17]

6.19 Mr Grieves, from the Mackay Division of General Practice, commented on a problem that could arise during the roll-out of the package, where only a limited proportion of practices sign-on. He expressed concern at the effects on patient mix for the minority who do sign on:

> They are worried that if they take it up and the other practices around them do not, their practices will actually be altered in the terms of the patient mix and the number of patients within their practices who will be private billing in the future. The department has been asked about what will happen if a certain percentage of practices take it up within a region versus a very high proportion. They really have not done the modelling for that. The division is very worried that if there is only a small number of practices that take it up, those practices will be overwhelmed and patients will then be frustrated that the other practices have not taken it up.[18]

Conclusion

6.20 In spite of the department's modelling, it is clear that a large proportion of doctors in general practice do not consider the incentives in the government package to be sufficiently attractive to entice them to sign-on. The fact remains that irrespective of who is right, the package will not be workable if the majority of the medical profession do not sign-on.

Bulk-billing for Commonwealth Concession Card holders

6.21 As shown above, a key objective of GPAS is to ensure that holders of Commonwealth Concession Cards have access to bulk-billing. As Mr Davies told the Committee, this is an important focus of the government policy:

> This is, in fact, the first time since the launch of Medicare 20 years ago that those most in need have been offered a guarantee of bulk-billed services at specific practices. Secondly, A Fairer Medicare will reduce patients' out-of-

17 Dr Bain, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 33: see also Dr Gault, Submission 6, p. 2

18 Mr Grieves, *Proof Committee Hansard*, Bundaberg, 25 August 2003, p. 35

> pocket costs. Any patient who is charged a gap by their GP at a participating practice will leave the surgery with no more to do and no more to pay.[19]

6.22 However, numerous submissions have criticised the package for its focus on measures to guarantee bulk-billing rates for holders of Commonwealth Concession Cards. The objections focus on four key issues. Firstly – and critically – the policy steps away from the principle of universality of Medicare. Secondly, the proposal may be an attempt to solve a non-existent problem. Thirdly, a focus on concession card holders is not a useful or accurate measure of the need for medical services in the community. Finally, the proposed solution may itself act to create a differential lower level of health care for concession card holders.

A step away from universality?

6.23 A fundamental question is whether the government *should* create a policy that has the objective of achieving bulk-billing for concessional patients as distinct from the general population, and allocates higher rebates for concessional patients as the means to achieve this end.

6.24 Many critics of the policy described it as a move away from the fundamental principle of universality that underpins Medicare. As Mr Gregory of the National Rural Health Alliance asserted: 'As soon as you select any group you lose universality'.[20]

6.25 Whether or not the policy does run counter to the principle of universality depends on how 'universality' is understood. According to the government, universality is maintained, as Mr Davies explained:

> [U]nder 'A Fairer Medicare' that payment remains universal and it remains uniform. For all Australians who are entitled to the MBS, the level of rebate paid to the patient remains the same and it remains uniform.

6.26 He acknowledged the distinction, continuing:

> The incentive payments are paid to the practice. One might argue that that is a pretty fine distinction to be making, but it does remain the fact that the insurance coverage is universal and payments under that insurance coverage are uniform.[21]

6.27 In examining the concept of 'universality', it is useful to take into consideration the comments of Professor Richardson:

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19 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 67

20 Mr Gregory, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 33

21 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 35

> There are two quite distinct value systems which get confused in Australia so it makes it quite hard to separate them. One of them, which is associated with the left wing and the Labor Party traditionally, is what Europeans would call 'solidarity' – sometimes called 'communitarianism'. That is a social philosophy that says that certain commodities, certain activities, should not be part of the economic reward system – defence, law, public parks et cetera. The second value system is the liberal, libertarian value system which says that individuals should look after themselves as far as possible and the government will step in as a safety net. The implication of what has occurred is that we have set up a mechanism for transfer from the system of solidarity through time to a more liberal, libertarian social welfare system.[22]

6.28 Ms Flannery, from Queensland, described the package in similar terms:

> [T]hese changes signify a shift in the social philosophy and social principles undergirding our society. The Medicare scheme until now has been informed by an acceptance of community responsibility for the health care system, a commitment of Australians to Australians, …
>
> The proposed new system, on the other hand, takes the line that individuals can – and should – best look after themselves, and that the role of government is to provide a safety net for those exceptional people who can't.[23]

6.29 The Committee shares the view of most witnesses that the introduction of GPAS moves Medicare from being a universal health insurance scheme into a safety net system for concession card holders. Even if the establishment of such a change in philosophy were supported, evidence of low take-up and administrative difficulties suggests that it would be a largely ineffective one.

Is it a problem that needs to be solved?

6.30 Given the government's focus on providing bulk-billing for concessional patients, an important starting point in assessing the package is whether there is actually a need to design measures around this policy objective. According to the government, the current rate of bulk-billing disguises inequities in the system:

> [W]hether you will be bulk-billed depends, more than anything else, on where you live. Bulk-billing rates today are more a reflection of the number of GPs practising in a locality than the ability of patients in that locality to pay the GP's fees. We note in our submission that, as a general rule, people

22 Professor Richardson, *Proof Committee Hansard*, Melbourne, 24 July 2003, p. 79

23 Ms Flannery, Submission 20, p. 1: see also Women's Health Victoria, Submission 45, p. 3; Missionary Sisters of Service, Submission 9, p. 1

> in cities are much more likely to be bulk-billed than those people outside cities.[24]

6.31 The government's argument therefore, is that some people who most need the bulk-billing are less likely to get it, while others who may not need it receive it, simply by accident of where they live.[25]

6.32 However, evidence given to the Committee makes it reasonably clear that the government is attempting to resolve a non-existent problem. Professor Richardson, in an article for the Australian Financial Review, argued that:

> The changes to Medicare have been introduced because, it is claimed, that they will 'improve the availability of bulk billing for concession card holders'. In December 2002, 81% of GP bills for people over 65 were bulk-bills. In rural areas the figure was between 65% and 75%. The average copayment for all persons above 65 was 94 cents. It is worrying that such a fundamental change has been introduced to solve a problem that does not seem to exist.[26]

6.33 The West Australian government made a similar observation:

> Most general practitioners already provide bulk-billing for the majority of pensioners and cardholders. The new measures are unlikely to impact significantly to the way these groups pay for their services.[27]

6.34 These views were borne out by figures produced in the report to the Committee by the Australian Institute for Primary Care. Table 6.1, reproduced from the report, shows that concessional patients, representing 34.8 per cent of the population, use 49.7 per cent of GP services overall. According to Professors Duckett and Swerissen, the figures indicate that in practice, most concession card holders are currently being bulk-billed, even in rural and remote Australia where the bulk-billing rates are much lower.[28]

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24 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 68

25 for a detailed examination of bulk-billing rates, see chapter 4

26 Professor Richardson, Submission 52, Attachment: *The Amendments to Medicare of 28 April*, AFR, 6 May 2003.

27 WA Government, Submission 177, p. 9

28 Profs Swerissen and Duckett, *Proof Committee Hansard*, Canberra, 23 September 2003, p. 8

Table 6.1 Incidence of Concessional Health Card holders by geographic area[29]

	HC Card	Proportion of GP services used	Current bulk-billing rates
	%	%	%
Major Cities of Australia	31.7%	45.3%	72.3%
Inner Regional Australia	41.8%	59.8%	54.4%
Outer regional and remote Australia	40.1%	57.4%	54.7%
Total	**34.8%**	**49.7%**	**70.0%**

6.35 This conclusion was reinforced by anecdotal evidence from many doctors that even in private billing practices, a policy of discretionary billing is followed in which concessional patients are either bulk-billed or charged a lower rate.[30]

Concession Cards as a measure of need

6.36 Another underlying question is the extent to which concession cards provide an accurate basis on which to determine social need. This question concerned a great number of witnesses to the Inquiry, who raised three main issues: first, that those who hold concession cards are frequently not in any genuine need; second, that a system that focuses on concession cards will miss many other genuinely needy people; and third, that by allocating more financial support to those with concession cards, the government indirectly creates an incentive for people to remain in concessional categories.

6.37 There are three types of concession card relevant to the discussion: the Health Care Card; the Pensioner Concession Card; and the Commonwealth Seniors Health Card. There are in the order of seven million cardholders in Australia across the three categories.[31]

6.38 Various witnesses to this Inquiry expressed the opinion that the concession card is a poor measure of social and financial need. Dr Parker told the Committee:

> One of the problems I have with the health care card system is that it is based on your taxable income. Many people who have got good accountants can offset their tax to such a point that they are on a health care card, and yet

29 AIPC Report to the Select Committee on Medicare, p. 22

30 See for example: Dr Del Fante, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 95; Prof Charlton, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 56; Dr Walters, *Proof Committee Hansard*, Hobart, 31 July 2003, p. 10

31 Deb Richards, *Card sharps*, Australian Doctor, 18 April 2003, p. 21

> they are employed in good jobs with good houses and good cars and they come in with a health care card.[32]

6.39 The Hon. Wendy Edmond, Queensland Minister for Health, expressed a similar view that:

> [S]ome people who hold concession cards – for instance, people on seniors benefits who may be self-funded retirees – may actually have a better ability to pay a gap than a person on a single income with three small children who all have asthma at the same time. [33]

6.40 The second issue addresses the opposite problem: not only may some concession cardholders not genuinely need them, but many who do face significant problems meeting the costs of accessing health care, are not entitled to any concession card. This problem arises from where boundaries are drawn, and affects any program that provides different entitlements for different categories of people. As Professor Duckett explained:

> A focus on pensioners and Health Care cardholders also will inevitably cause problems at the margin: working families not eligible for Health Care cards could find it difficult to access medical services without financial barriers. By definition, a targeted scheme creates a boundary line with people on one side of the boundary having access to the program, and people on the other not so entitled. A boundary line will always cause problems at the margin, where small increments in income could lead to large reductions in entitlements, creating a powerful disincentive to earn that marginal income increase. Boundary problems are particularly important in health care where there is an association between lower income and poorer health status. [34]

6.41 A differential program therefore creates winners and losers. Witnesses gave examples of the types of people who are likely to find themselves losers under the proposals. The Rural Doctors Association argued that:

> It is simplistic to assume that all those who have a higher need for care and a lower capacity to pay for it are covered by concessional health care cards.[35]

6.42 Dr Powell, the Principal of a General Practice in Bundaberg, related the experience of single income families:

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32 Dr Parker, *Proof Committee Hansard*, Bundaberg, 25 August 2003, p. 29

33 The Hon Ms Edmond, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 21

34 Professor Duckett, Submission 93, p. 3

35 RDAA, Submission 101, p. 5 see also: Australian Greens, Submission 100, p 8; SA Divisions of General Practice, Submission 33, p. 2; Women's Health Victoria, Submission 45, p. 6

> They may have three or four children, one or two of whom have a chronic illness. We find that they are a particularly financially distressed group who do not always fit the criteria for a health care card.[36]

6.43 These problems are particularly likely to affect those in industries in which there are high levels of underemployment and part time work. Ms Dorron, a nurse in Bundaberg, gave evidence of this problem in the field of aged care nursing:

> At my workplace 76 per cent of the nursing positions are part time. …the wages earned put these workers on the middle line whereby they earn too much to be eligible for Centrelink concessions such as the health card and the benefits of bulk-billing accorded to concession card holders. Consequently, they have to pay for visits to the GP – and in Bundaberg the average cost of a standard non-bulk-billing consultation ranges from $32 to $42, with the average consultation being $38.30. This significant shortfall means that people think twice before attending a doctor, when one also must take into account the cost of medication and other health services such as pathology or X-rays. For these families, health is becoming an either/or option. These are the people on the margins who will fall through the cracks with changes to the Medicare system.[37]

6.44 Sometimes, the rules can operate to the detriment of people in ways that are not immediately obvious. Professor Duckett gave one example of this:

> Typically, boundaries are set based on income limits but again for the poor, income can change rapidly as families drift in and out of employment. Poorer families are less well able to predict income variations, which can cause significant problems.[38]

6.45 Dr Boffa of the AMSANT gave another example from his practice area:

> The other point is that if you have one salary earner in a family and the family is large – Aboriginal families are still large extended families with large numbers of children – you might have someone earning $40,000 having to support 10 other people, and they will not get a health care card.[39]

6.46 The Consumers' Health Forum also warned that the creation of these boundary problems may run counter to the objectives of other Commonwealth health programs:

> Increases in out-of-pocket health care costs are a particular problem for people with high health care needs who are on low incomes or for families

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36 Dr Powell, *Proof Committee Hansard*, Bundaberg, 25 August 2003, p. 29: see for example Ms Hamill, Submission 41, p. 1

37 Ms Dorron, *Proof Committee Hansard*, Bundaberg, 25 August 2003, p. 40

38 Professor Duckett, Submission 93, p. 3

39 Dr Boffa, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 59

> with dependent children. Many of these individuals and families do not qualify for health care cards, for example, people who continue to try to work despite chronic or episodic health conditions. This large number of consumers would include most consumers targeted by the national health priority areas (asthma, cancer, cardiovascular health, diabetes, injury prevention, mental health, arthritis and musculoskeletal conditions).[40]

6.47 The third issue relates to the likelihood that a focus on providing benefits to concession cardholders provides a perverse incentive for those who are in a concessional category to avoid any changes that may result in the loss of that concessional status. According to the Tasmanian Organisation of Employment Seekers:

> One of the greatest mental barriers to overcome for many parents who are recipients of welfare payments, is a fear that if they were to obtain work and so no longer be eligible for a pension or a health care card, they would not be able to afford to obtain medical assistance for their children were they to become ill. … many people within this category would be happier to be in work, but feel that as things presently stand the responsibility they have to their families to ensure that they can access medical care, precludes them from entering the workforce.[41]

6.48 Finally, the Committee notes the concern raised by several doctors that there is considerable contractual uncertainty for any practice that signs onto GPAS. Participating practices are required to give an undertaking to bulk-bill all concession card holders but calculating the implications of this undertaking is difficult when the government is able at any time to vary the conditions of entitlement and thus, the number of beneficiaries under the system.[42]

Government view of concession cards

6.49 In defence of the concession card, Mr Davies, from the Department of Health and Ageing, responded that:

> The three concession cards that the GP access scheme component of 'A Fairer Medicare' works on are the same three concession cards that give entitlement to the lower rate of Pharmaceutical Benefits Scheme copayment, so ultimately there is an issue of consistency across the spectrum of Medicare.[43]

6.50 The obvious challenge, if some targeted measure is to be applied, is to find a better alternative. According to the Department, the criteria for any such alternative

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40 Consumers' Health Forum, Submission 102, p 3

41 Tasmanian Organisation of Employment Seekers, Submission 139, p. 3: see also Council on the Ageing National Seniors Partnership, Submission 98, p. 7

42 ADGP, Submission 37, p. 2; Dr Alexander, Submission 11, p. 1; Dr Gault, Submission 6, p. 2

43 Mr Davies, *Proof Committee Hansard*, 28 August 2003, p. 82

are administrative simplicity, predictability and fairness. Mr Davies pointed out to the Committee the problems meeting these criteria. He explained that:

> [W]e looked at a variety of different ways of targeting. One that we had to consider was a new card, if you like – a new set of concession conditions. What became very obvious then was that, in operating a whole new set of income and asset testing, issuing new cards and maintaining those cards, keeping them up to date and linking the database to the HIC, we probably would have spent quite a considerable proportion of what we are now planning to spend on doctors and subsidies for patient care.[44]

6.51 The Department also considered using other measures, such as the Australian Bureau of Statistics SEIFA ratings (Socio-Economic Indices For Area, of which there are five), however the internal variation within postcodes of income, even in low SEIFA areas, was found to be much higher than that of income within these concession card groups.[45]

6.52 The Department concluded that, overall, it is very difficult to find a better predictor of low income status:

> These three cards, taken together, best pass that test. We know who the people are; they are readily identifiable. There is a direct relationship to other policy in the same area in relation to the PBS. They all have cards by which they can readily be identified at a GP surgery and so on. … The level of homogeneity within these three cards taken together is actually pretty good and you know quite a lot about their income status.[46]

6.53 The Committee acknowledges the wider issues of the appropriateness of selectively targeting concessional patients, but agrees with the Department's view of concession cards. While there are undoubtedly some problems with the allocation of cards, to develop an entirely new card for Medicare purposes would be costly in terms of administration. In general terms, concessional cards are also almost certainly a more accurate basis for determining need than *ad hoc* decisions by GPs made on the basis of impressions of wealth, which can be misleading and inaccurate.[47]

Restricted access for concession cardholders?

6.54 While concession cardholders are the intended principal beneficiaries of 'A Fairer Medicare', there are fears that the policy may in fact operate in ways that exclude concessional patients. This concern arises out of the potential for practices to

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44 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 85

45 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 82

46 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 82. This view is shared by Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 5

47 see for example Sen Knowles' comments, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 4

limit the percentage of concessional patients they accept, because they earn the practice less than full private patients.

6.55 This arises in part from the observation that the government scheme is likely to be more attractive to practices with a low percentage of cardholder patients. As the AMA's Dr Rivett told the Committee:

> It is a dream scheme if you have a small practice under the Centrepoint Tower in Sydney and you are dealing with business people who are all fit and healthy and coming in for check-ups, overseas travel and other things. It just hits the nail on the head for you. But, for the general practitioners out there servicing most of the population, it is not a way forward at all. In a few isolated cases, it will be very attractive to them.[48]

6.56 The point was extended by Dr Merigan in his submission:

> [P]ractices instead of seeing more card holders, would be economically influenced to not see new patients if they were card holders, and indeed, make it harder and harder for card holders to attend the practice. This would leave these patients with no where to go – other nearby bulk billing and obviously busy practices wouldn't want them, and they might not be able to afford to go to private billing clinics.[49]

6.57 In summary, practices with only a small percentage of concessional patients on their books could sign up, accept all the benefits of the package such as direct electronic payment of the rebates and practice nurses, and charge the majority of their patients a copayment, with only the requirement to bulk-bill their few concessional patients.[50] The AMA's concern with the government package was that:

> [I]t will provide a clear junction in health care, where we will see opt in practices providing for the less well-to-do and opt out practices providing for the others, and we will have two tiers of care in Australia. We will walk away from our universally funded health access.[51]

6.58 The Rural Doctors Association also saw the changes as encouraging a:

> [C]lear cut distinction between cardholders and other patients. Sadly, some doctors and/or their staff believe that patients who pay up front or contribute a copayment are more important than those who do not. … under the proposed changes the likelihood of cardholders receiving a second rate

48 Dr Rivett, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 50

49 Dr Merigan, Submission 122, p. 1

50 see discussion Sen Lees, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 73

51 Dr Rivett, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 40: see also NSW Retired Teachers Association, Submission 23, p. 1

> 'safety net' standard of care, with reduced or delayed access to care, will be increased.[52]

Problems with access to After Hours services

6.59 The AMA's Dr Bain raised an additional problem:

> [D]octors who used to charge a co-payment on weekends or after hours, if they opt-in, will no longer be able to do that with concession cardholders. … So the incentive to be open at those times would be reduced and we expect that there would be a fall-off in the services that will be offered after hours by doctors who opt-in.[53]

6.60 As was discussed in Chapter 3, there are already significant problems in many parts of the country in accessing after-hours medical care from general practice, with supply of these services influenced by the long working hours and in some cases, safety concerns. These supply shortages are reflected in the often substantially higher than normal up front payments required to see a GP after hours. If, under the terms of their agreement with the government, GPs are prohibited from charging any gap payment to concessional patients (who, it will be remembered, account for around fifty percent of GP services) the effect is highly likely to be a dramatic further reduction in the availability of after hours services by GPs – as the AMA warned. This in turn, is likely to further drive up demand at public hospital accident and emergency departments.

6.61 The Department is aware of this problem and one suggested solution is the After Hours Primary Medical Care Program, which provides funding of $43m for a series of 85 trials, and of which the Hunter region service is an example.[54] Another solution is the splitting of practices, as Mr Davies explained:

> Some GPs may work in one practice during the day and in another one after hours … the daytime practice may register for the GP access scheme but the after-hours cooperative may choose not to do so. Basically, if anything, I think it adds a degree of flexibility to the way in which GPs organise their practices and their billing practices.[55]

6.62 However, for many GPs this would result in the need to maintain several sets of accounts, and the associated burden of complying with taxation, audit and other business administration. As suggested by the Department, some GPs may already be

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52 RDA, Submission 25, p. 2

53 Dr Bain, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 34: see also the comments of the Ballarat Division of General Practice – Mr Howard, *Proof Committee Hansard*, Melbourne, 27 August 2003, p. 56

54 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 84. The Hunter Region services are discussed in greater detail in chapter 11.

55 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 85

doing this, voluntarily, but the Committee does not support a policy that would institutionalise incentives to create more complex business structures.

Access to GPs for non-concession card holders

6.63 The proposed measures also have important implications for the access to general practice for those who do not have a Commonwealth Concession Card. According to evidence received by the Committee, two predictable results are: first, the package is likely to have an overall inflationary effect, driving up the cost of the gap payments for non-card holders. Second, the overall level of bulk-billing is likely to fall, greatly reducing the access of non-card holders to a bulk-billing GP.

Effects on gap payments

6.64 There is a widely held view that the package will exert pressure on doctors to increase gap payments to non-concessional patients in order to make up for the fees lost by bulk-billing card holders. Dr Moxham, an Adelaide GP, explained this view:

> The incentive is that you get paid a certain amount of money but you have to agree to bulk-bill all of your health care card holders. At the same time, if you agree to bulk-bill all your health care card holders, your income may well go down. You have to make up that income somehow, so you have to charge your non-health care card holders in order to obtain the same amount of income. No-one is going to sign onto this if they actually make less income. In order to have an equal amount of income, they are going to have to charge their non health care card holders more. It is going to create very much a divide between the health care card holders and the non-health care card holders.[56]

6.65 Dr Churcher, a GP from Ballarat, gave this example:

> If we were to change and go to that package, my income would drop by about $26,000 a year. With our small outpatient profile, we have a very high card-holding group; I would then have to try and recoup that $26,000 by charging an increasing gap payment to that group of people who do not have a card.[57]

6.66 These views were borne out in part by the modelling undertaken by the AIPC, who found that in order to meet income targets:

> [A]verage out-of-pocket costs per service would need to be set at $10.98 for metropolitan capital city practices, $11.40 for other metropolitan practices, $15.84 for rural practices, and $13.79 in outer rural and remote areas. This

56 Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 3

57 Dr Churcher, *Proof Committee Hansard*, Melbourne, 27 August 2003, p. 55: see also Mr Mehan, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 53; Dr Woodruff, *Proof Committee Hansard*, Sydney, 22 July 2003, p. 61; Prof Deeble, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 46; Ms Thomas, Submission 21, p. 1

> would result in a reduction in the average out-of-pocket charge currently levied to non-bulk billed patients in metropolitan settings, but a probable increase in average out-of-pocket fees for rural and remote patients.[58]

6.67 Others rejected this view. Mr Davies from the Department of Health and Ageing told the Committee that:

> [T]he vast majority of practices who participate in this scheme will be financially better off without making any change to their current gap-charging policy. That provides no financial imperative or financial justification for them to introduce or increase their gap charges. They will make more money by virtue of participating in 'A Fairer Medicare'. …
>
> It is an axiomatic view that if this gives them more money then it does not give them any justification to introduce or increase gap charges.[59]

6.68 Mr Schneider of the Australian Health Insurance Association agreed, saying that the medical profession has always charged wealthier patients more than the poorer ones:

> That has occurred through bulk-billing or through any other system. I can see nothing in this package that would promote the idea that a doctor who is getting paid more for his concession card holders should not reverse the arrangement for a change and use that to cross-subsidise those people on slightly higher incomes which take them out of the concession area. Doctors could bulk-bill those people and continue the practice of charging the people they think can afford it whatever they think the market can bear.[60]

6.69 Dr Gault, a Port Fairy GP, also warned against placing too much faith on purely economic modelling:

> [G]eneral practice is not a business … that obeys quite the same rules of demand and supply that operate in other businesses. General practitioners, by their nature, are very closely connected with their patients and are concerned with issues of access. In our own case, as a solo practice in the town, we enjoy a monopoly in business terms. But, rather than exploit that monopoly, we have felt a duty to keep our fees on the low side, because we are concerned that people have nowhere else to go. There is also no Medicare office in town, so people cannot claim rebates easily.[61]

6.70 Dr Walters, of the Australian Divisions of General Practice, concluded that:

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58 AIPC Report to the Select Committee on Medicare, p. 28

59 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 37. see also Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 69

60 Mr Schneider, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 38

61 Dr Gault, *Proof Committee Hansard*, Melbourne, 27 August 2003, p. 47

> This concept that general practitioners are, under changes in arrangements, suddenly going to jack their fees up and make radical changes to their billing is just fictitious. It is not going to happen. General practitioners do know their patients well. They make constant allowances.[62]

Effects on the overall rate of bulk-billing

6.71 A further effect of the package is that it would actually drive down the rate of bulk-billing for non card holders. The AMA's Dr Bain told the Committee that:

> Under 'A Fairer Medicare' package, the real value of the rebate will continue to sink and we expect that bulk-billing would continue to sink with it. As the participation rate falls, and there are fewer full-time equivalent doctors, that would also tend to reduce the rate of bulk-billing.[63]

6.72 Senator Forshaw also pointed out that doctors are likely to respond over time to the underlying policy settings of the government:

> If the message that is being sent is that bulk billing is … to be seen to be directed more at concessional patients, or health care card holders, then it follows as a matter of logic that while you can say, 'They can bulk-bill whoever they like,' that is not where the policy drive is anymore in this package for Medicare. It naturally follows that over time one would see a greater proportion of people who are not concession and health care cardholders not being bulk-billed in the future.[64]

6.73 Dr Moxham explained an additional aspect of this:

> [P]art of the package makes it easier to privately bill. One of the big barriers to private billing is that you have to chase the debts from the patients. If you make it easier to privately bill, the costs of chasing up debts, of writing letters to patients or of patients bringing cheques in disappear, so it actually becomes cheaper to privately bill under this new proposal than it would be if things were left as they are. Just the 45c for a postage stamp is an expense.[65]

6.74 There is also the possibility that the measures contained in the new package, working in connection with the forces discussed above, may trigger a sudden drop in bulk-billing rates. According to Dr Bain:

> [T]here was a very high expectation that there would be a quantum increase in the rebate, as a consequence of the relative value study. Now that the

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62 Dr Walters, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 61: see also Dr Haikerwal, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 38

63 Dr Bain, *Proof Committee Hansard*, Canberra, July 23 2003, p. 33: see also ACT Government, Submission 171, p. 6

64 Sen Forshaw, *Proof Committee Hansard*, Canberra, 28 August 2003, p.74

65 Dr Moxham, *Proof Committee Hansard*, Adelaide, 30 July 2003, p. 18

> government has sent the message that it is not going to implement the relative value study in any way, shape or form, the message we are getting back from the members is that they know they are on their own and that they will have to find ways of funding their own practices because it will not come via the rebate. The message from 'A Fairer Medicare' package is that, from the government's point of view, the RVS is dead. We believe the consequence of that will be that a lot of doctors will increase their charges … .[66]

6.75 Mr Goddard from the Australian Consumers Association agreed, suggesting that 'once things start to unravel in a fundamental sense, sometimes the rate can be fairly uncontrolled':

> It may be … that there is a cohort of practices out there that have been holding on to bulk-billing, or a high level of bulk-billing, and are starting to say: 'It is just not an option any longer. The things which are being proposed do not answer our objections.'[67]

6.76 The government response to this argument could be seen to condone this outcome. According to Mr Davies, there is not and never has been any implicit or explicit target level for bulk-billing, and a focus on the headline bulk-billing rate is not a useful indicator of access to health care:

> Whether the headline bulk-billing rate under this package went up or down, you would always want to supplement that information with information about the proportion of vulnerable Australians – card holders – who are being bulk-billed.[68]

6.77 Thus, for the government, the key outcome is whether there is an increase in the bulk-billing rate for those concession card holders.[69] As the AIPC modelling shows, this outcome is likely to be achieved, seeing a small rise in bulk-billing in rural and remote areas, but an overall reduction in bulk-billing rates to approximately fifty percent.

Direct rebate at point of service

6.78 As described above, medical practices that sign-on to the government package will be able to access the MBS rebate for each patient directly from the Health Insurance Commission for both bulk-billed and other patients. According to Mr Davies the current two-stage billing process is outdated:

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66 Dr Bain, *Proof Committee Hansard*, Canberra, July 23 2003, p. 47

67 Mr Goddard, *Proof Committee Hansard*, Canberra, July 23 2003, p. 34

68 Mr Davies, *Proof Committee Hansard*, Canberra, 28 August 2003, p.75

69 Mr Davies, *Proof Committee Hansard*, Canberra 21 July 2003, p. 39

> It has been described as patients actually acting as couriers carrying paper forms between the GP and the Medicare office. Once this was possibly the best available technology; it is certainly not the case any longer. In our daily lives, we have learnt to expect simple, quick and efficient one-stop service in other areas of our lives but many patients cannot get such service from Medicare. The current system imposes time costs on patients but also generates up-front costs that can be a barrier to access. More specifically for patients with very limited cash resources, having to pay for the government's rebate contribution on top of any gap charge and then claiming it back must sometimes be a barrier to accessing necessary care. Why should they have to be out of pocket by $25 or more even if only on a temporary basis?[70]

6.79 This change has significant cost savings implications for the government. Professor Marley told the Committee:

> [T]he more that it is electronic the lower the costs in the system to government as a whole. So, if you look at it purely as cost to government, the more the processing can be electronic the lower the cost will be to government.[71]

6.80 Savings have been estimated at around two dollars per transaction[72] and may in fact be greater – if the government package is widely taken up by general practice and direct rebates for all patients become the norm, at least parts of the national network of Medicare offices may become redundant.

6.81 The change also offers considerable benefits to patients who are not bulk-billed, who will no longer be required to act as go-between for the Health Insurance Commission and the doctor. As Mr Davies noted above, it also relieves the patient of meeting the initial up-front cost of the consultation prior to reimbursement. The Committee notes that these advantages are particularly beneficial in rural and remote areas where access to a Medicare office may be difficult. Dr Slaney of the Rural Doctors Association concluded that:

> [T]he ability for a patient to go in to pay the gap and have the amount rebated electronically to the doctor will, I believe, increase patients' access to medical care.[73]

Inflationary pressures

6.82 While the proposed arrangements for direct rebate at point of service will undoubtedly be more convenient for both doctors and non bulk-billed patients, it is

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70 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 4

71 Professor Marley, *Proof Committee Hansard*, Newcastle, 23 July 2003, p. 38

72 Dr Rivett, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 37

73 Dr Slaney, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 117

clear from the evidence that they also have a downside – the strong likelihood that by significantly changing price signals, out-of-pocket contributions are likely to increase in both size and frequency.

6.83 This comes as a result of the change from currently billing one entity – either by bulk-billing to Medicare or presenting an account to the patient – to a system in which a doctor can effectively bill two entities: the patient and Medicare.[74] This was described by the Australian Institute for Primary Care as the 'hard threshold':

> The incentive provided by the removal of the hard threshold will be to render highly marginal the demand response to actual increases in co-payments, as patients would be able to pay a much more modest up-front fee and avoid the transaction costs associated with claiming a rebate from Medicare. We are unable to cost these transaction costs within the constraints of this project, since they will vary significantly between individuals, with direct costs ranging from the price of a stamp and stationery to the costs associated with attending a Medicare office, and personal costs varying significantly between individuals depending upon their circumstances. However, the removal of the hard threshold is highly likely to induce an increased incidence of co-payments and a concomitant reduction in bulk-billing rates to the minimums required for access to the GP Access Scheme.[75]

6.84 Professor Swerissen elaborated:

> At the end of the day, it allows them to move from a situation where they are forced to issue a bill of, say, $40 on average to one where they can … issue a bill for $15 and then claim the rebate as the alternative. That is a very attractive proposition in terms of being able to adjust price signals for patients in a very sensitive way. At the moment they are forced into a very high threshold situation in order to achieve that, which is a very strong constraint on price because it is a non-marginal price signal. They would be able to move to marginal price signals, which, as I said in the presentation, have much less impact on utilisation.
>
> Going from, effectively, zero bulk-billing and a zero price signal to patients to a situation where you are no longer bulk-billing those patients and suddenly issuing $40 price signals is a very big jump.[76]

6.85 The overall result, according to the AIPC's modelling, is likely to be a:

- Reduction in average incidence of bulk-billing to the bulk-billing 'floor' of around 50% of services.

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74 Sen Forshaw, *Proof Committee Hansard*, Canberra, 28 August 2003, p.74

75 AIPC Report to the Select Committee on Medicare, p. 26

76 Professor Swerissen, *Proof Committee Hansard*, Canberra, 23 September 2003, p. 13

- Small increase in non-metropolitan bulk-billing rates of between three and six percentage points.
- Reduction in average co-payments for non-bulk-billed services in metropolitan areas, but increases in non-metropolitan areas.
- Increase in average co-payments (across all services) of around 56%.
- Improved convenience for those presently not bulk-billed, with possibility of lower actual out-of-pocket costs for this group.[77]

6.86 Many of these conclusions were supported by Professor Richardson, who argued in his submission that:

> Even a small co-payment results in administrative inconvenience for the patient who must seek reimbursement whether the co-payment is small or large. Removal of this impediment to co-payments will almost certainly encourage fees to rise.[78]

6.87 Professor Richardson also saw the hard threshold as one of three measures built into Medicare to limit inflationary pressures:

> First, bulk-billing was specifically designed so that a doctor who ceased bulk-billing inconvenienced their patients who must seek reimbursement of their expenses. Bulk-billing avoided this which increased the effects of price competition. Secondly, the elimination of copayments, by definition, minimises fees. Thirdly, patients presently see the total bill and will recognise (more or less) excessively high charges.[79]

6.88 Dr Woodruff of the Doctors Reform Society commented:

> [T]he idea of bulk-billing was that it was hassle free; it was hassle free for the doctor – no bad debts, no accounting system. It was also hassle free for the patient – just sign the form. To require a copayment was a hassle. The doctor had to have an accounting system – more complicated – and had to chase bad debts, and the patient had to go to get the Medicare cheque. … [T]he introduction of a system where we remove that hassle is simply going to make it easier for doctors to charge copayments.[80]

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77 AIPC Report to the Select Committee on Medicare, p. 5. See also p. 28

78 Professor Richardson, Submission 52, p. 2

79 Professor Richardson, Submission 52, Attachment, p. 1: see also Prof Marley, *Proof Committee Hansard*, Newcastle, 23 July 2003, pp. 31 & 36; Dr Ryan, Submission 14, p. 2

80 Dr Woodruff, *Proof Committee Hansard*, Sydney, 22 July 2003, p. 61

Conclusion: a three tier system?

6.89 This chapter has considered the key elements of the government's proposals relating to bulk-billing: a system of incentive payments for practices that agree to bulk-bill all concession card holding patients; and the capacity for participating practices to receive rebates for all their patients directly from the HIC.

6.90 Overall, the Committee is opposed to these measures, on both practical and philosophical grounds. As evidence to this Inquiry has argued, a policy that focuses on bulk-billing of concessional patients may not always provide access to the most needy group, since the majority of these people are in all likelihood already bulk-billed.[81] The AIPC research supports this, predicting a drop in bulk-billing rates to 50%. The Committee is inclined to agree the package essentially focuses on a solution to a problem that does not exist.

6.91 Far more serious are the practical ramifications of the proposals. The Committee accepts the view that, if put into effect, the General Practice Access Scheme will reduce levels of bulk-billing for those who are not concession cardholders. Many Australians in genuine need of bulk-billing, but who do not have concession cards, will have increasing difficulty in accessing it. As a consequence, they will have to cover both more gap payments, and overall, a rise in the cost of such payments.

6.92 The proposals to enable direct payment at the point of service will have an important impact on these outcomes. The Committee acknowledges there are inefficiencies inherent in requiring patients to pay up-front the whole consultation amount and subsequently gain reimbursement from a Medicare office. This is particularly the case in rural areas, where Medicare offices may be difficult (if not impossible) to access. However, as the evidence shows, this system plays an important part in maintaining price control over the system, and to separate the rebate and the out-of-pocket contribution would in all likelihood open the door to considerable price rises.

6.93 Further, allowing practitioners to charge Medicare and the patient concurrently at point-of-service will act as a disincentive on doctors to bulk-bill patients who are not concession card holders.

6.94 At a philosophical level, the Committee strongly considers that the government package amounts to a substantial step away from the principle of universality that has underpinned Medicare since its inception. The Committee does not accept the government's argument that, because everyone continues to be eligible to be bulk-billed and receives the same rebate, universality is preserved. This

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81 It is not possible with current statistical data to accurately determine the exact number and proportion of concessional patients who currently receive bulk-billing. The levels of bulk billing are therefore inferred from the analysis by the AIPC, and from anecdotal evidence of billing practices provided by GPs during the Inquiry.

argument is disingenuous and ignores the reality of the incentive system the government seeks to put in place. In practice, a GP will receive more public money for treating a concession card holding patient than they will for treating a non-concessional patient. The fact that the incentive payment has a different label to the rebate payment is of minimal practical significance, particularly given the direct rebate of funds to the practice.

6.95 The Committee concludes that the underlying purpose of the General Practice Access Scheme is to move Medicare to the role of a safety net for concessional patients, instead of maintaining its intended role as a national, universal insurer.

6.96 The Committee notes the warnings about the implications for many in the community. As one doctor explained:

> By only focussing on Medicare as a safety net for Health Care Card holders the government will set up a three tier health system: those who are recognised as 'poor' and needy, those who are the unacknowledged 'poor' who will miss out the most and those who can afford to pay for what they want.[82]

6.97 The Committee concludes that the remedies for the current problems in Medicare do not lie in refocusing the system on concessional patients, nor in tinkering with the criteria for the granting of those concession cards. Rather, the solution lies in a reorientation towards the role of Medicare as a universal insurer, granting equal benefits for everyone.

Recommendation 6.1

The Committee recommends that the General Practice Access Scheme not be adopted.

82 Dr Tait, Submission 121, p. 1: see also Dr Costa, *Proof Committee Hansard*, Sydney, 22 July 2003, p. 62