The (Un)Fairer Medicare Package

This was the Doctors Reform Society submission to the Senate Select Committee on Medicare, **June 2003**.

Access to and Affordability of General Practice under Medicare

1. The decline in the bulk billing rate for general practitioner services from a high of 80% in 1996 to the present level of 69% is essentially due to two factors. Firstly, doctors are dissatisfied with their working conditions. Secondly, doctors are able to do something about it i.e. charge more.

2. Doctors are dissatisfied for a wide variety of reasons which include a relative decline in income due to a failure of rebate rises to keep pace with the costs of running a practice, increasing administrative and bureaucratic responsibilities, decreased availability of locums and after hours support, lack of Government support for medical indemnity issues, and overwork in areas of GP undersupply.

3. Practice Incentive Payments have helped those practices which are sufficiently well organised to make use of them. Some of the busiest practices, especially in poorer areas, find these payments difficult to access, partly because they don't have the resources, partly because they don't see sufficient patient benefit, partly because they are simply too busy providing the day to day service. These are likely also to be the very practices which feel obliged financially to abandon bulk billing.

4. The reasons doctors can do something about their dissatisfaction are twofold. Firstly, they are permitted to charge as much as they like. Secondly, health care is a sellers market. Patients need care. If they can afford it (and often even when they can't afford it), they will usually find the money. This enables GPs to charge what they like when there is no competition. This amount varies considerably between doctors. If, however, there is competition because of adequate doctor numbers then the level of that charge is held in check. If the competing doctor feels Medicare offers fair and reasonable conditions, bulk billing rates will rise, as they did from 1984 until 1996.

5. The observed decline in bulk billing rates is already affecting access to health care. Patients in one country town in Victoria are confronted by two large GP clinics which do not bulk bill anyone. The hospital emergency department is run on a fee for service basis by the same GPs with no bulk billing system. Pay up or travel 60km to the next town. Patients simply put off going and hope that whatever their complaint is, it will get better. If it doesn't and they get worse, they may find the money, or get a lift to the next town. Access to health care is being denied these people. As for any thoughts of seeing a doctor to work out a plan for preventive health care, that's a joke. And yet we know that prevention can be so helpful, for the individual, and for our society. Financial barriers exist and are growing.

Impact of Proposed Government Changes

6. *Incentives to bulk bill pensioners and health care card holders.*

Note that there are no incentives for "free care" in the package despite the terms of reference of this inquiry: bulk billing is access to an insurance product, it is not `free care', taxes pay for it. By `free care' what is implied is no charge at point of service. This has commonly become known as bulk-billing as doctors who agree to charge 85% of the schedule fee can directly bill the government in bulk for these consultations. People pay for this through taxation. The government's 'Fairer Medicare' package attempts to encourage bulk-billing (i.e. no extra charge for patients at point of service) for concession card holders and actively discourages bulk-billing for non-card holders.

The package does this by giving a lower rebate for non-card holders' consultations while at the same time making it easier to charge an extra fee or copayment from the patient (see point 7 below). In a survey of GPs conducted by Dangar Research for *Australian Doctor,* the most common reason given by doctors for why they would accept the package was so that they could more easily charge copayments for people without concession cards. Doctors who were least likely to take up the package (6%) were those who already fully privately bill and those most likely (70%) were those currently fully bulk-billing. This will clearly have the impact of reducing the rate of bulk-billing for non-card holders for minimal gains in the rate of bulk-billing for card holders. Currently over 85% of those over 65 are bulk-billed which suggests the great majority of card holders are already bulk billed.

The proposed changes encourage a clear cut distinction between card holders 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. Last year the Medical Board of Victoria Bulletin gave details of a case of a patient waiting in a GP practice with a broken arm, while another patient who arrived later was seen before the patient with the fracture. After a complaint was lodged, "the receptionist indicated that the other patient was private and it was the clinic's policy to put these patients first as they paid cash" (Medical Board of Victoria Bulletin Vol 3 2003). This two tiered system already exists. But under the proposed changes the likelihood of card holders receiving a second rate `safety net' standard of care, with reduced or delayed access to care, will be increased.

7. Allowing copayments at point of service

Allowing doctors to directly bill the HIC for 85% of the schedule fee while charging a copayment will result in less bulk-billing, higher out of pocket costs and poorer access to health care for low to middle income earners who do not qualify for a concession card. This will cause poorer health outcomes. In contrast, access improves for those undeterred by

copayments i.e. the wealthy.

The average copayment for a non bulk-billed standard GP consultation is currently $12. However, it is as high as $35 in some areas. What controls the size of the copayment is again competition and the willingness and capacity of patients to pay. If too much is charged, a practice may suffer a decline in income because of decreased attendances. In addition, bad debts may increase. Currently a $12 copayment means a $37 bill. The proposed changes would reduce that bill to $12. A GP who feels the practice needs more income but had not increased the charge previously because of concern regarding declining attendances and bad debts, will inevitably see this as an opportunity to increase the practice income by increasing the copayment, say to $15. But next year it might be $20, then $30 and in five years a US equivalent e.g. $150.

Allowing copayments at the point of service is convenient for the doctor. That is the danger. It is also convenient for the patient not to have to take the bill to Medicare and get the refund. But, for the patient, this is a short term benefit. In the long term, the copayment will rise and patients will be worse off. Even if fees are initially capped these are unlikely to remain contained. Charges will eventually increase because governments are more likely to raise caps than rebates.

Importantly, introducing capped copayments legitimises them as part of the health care system. It is a statement that they are normal and not an aberration created by some combination of an inadequate Medicare rebate or unduly greedy doctors. It is a recognition that bulk-billing for the majority of the population is not a goal and people will have to pay at the point of service. The current situation, where doctors are only able to directly bill the HIC when there is no extra charge to the patient, was deliberately introduced to encourage doctors to bulk-bill. This new proposal will encourage the opposite. It must also be remembered that around 69% of GP consultations are still bulk-billed but this is likely to decrease to less than 50% (the percentage of consultations to card holders) under the proposed package. That is, many people who currently do not now pay copayments will start doing so.

This may not matter to the wealthy on reasonable incomes who occasionally visit the doctor. The convenience may outweigh the extra dollars. For those on low and middle incomes who are not card holders but have quite a few visits every year, such as working families, single working parents, people with chronic illnesses e.g. diabetes, asthma, hypertension etc, the increasing copayment will be a disincentive to access health care. Necessary acute care will be limited. Preventive health care will be ignored. They will suffer.

Much evidence exists that patient payments at point of service such as copayments affect access to health care adversely for the less well-off while improving access for the wealthy. This is for both 'necessary' and 'unnecessary' visits. There are often underlying factors creating these visits and patients do not have the medical skills to make this distinction. After copayments were introduced for optometrists' visits in the UK it was found that cases of undiagnosed glaucoma (a treatable cause of blindness) increased.

These effects are already being seen in Australia. The Commonwealth Fund Report 2002 indicated that 16% of non-institutionalised sicker adults surveyed had not seen a doctor when sick over the preceding two years because of cost and 23% had failed to fill out prescriptions due to cost. There are anecdotal reports of pensioners running out of their medication and delaying filling their scripts until pension day. Next it will be more women skipping their Pap smears, parents delaying attending for possible meningococcal disease or waiting in overworked Accident and Emergency Departments in public hospitals. Delaying or avoiding primary health care results in worse health outcomes with higher use of more expensive secondary or tertiary health care.

Copayment schemes are complex and expensive to administer. The World Health Organization's "European Health Care Reform Analysis on Current Strategies" (Saltman & Figueras 1997) review of cost sharing found that direct charges to patients are *not* useful for improving efficiency or containing health costs. They are unlikely to generate substantial revenue without adverse equity consequences. Via taxation we already have a more efficient and equitable method of determining what people pay. The Federal Government's proposal consolidates copayments into the system. It does not recognise bulk-billing (i.e. no user fee at point of service) as a worthwhile objective for all Australians. It makes it easier for doctors to charge copayments. Even if copayments are initially capped any benefits are illusionary and short-term.

Quality health care needs to be paid for. The decision is whether this is chiefly via the public purse and taxation or privately via private health insurance and user fees such as copayments which put a heavier burden on the sick and less well-off with many missing out. All copayments redistribute money from users of health care to health care providers and upper-income taxpayers. Copayments ignore the unequal ability to pay and the unequal need for health care.

8. Safety Nets

Safety nets come into play after a certain level of spending has been recorded in a calendar year. They can be very helpful in reducing or removing financial barriers for those who plan their budget over a twelve month period. Unfortunately, people who struggle with financial barriers to health care are generally unable to budget for twelve months. Many have trouble budgeting for one week. Up-front costs for a doctor's visit will deter many people from attending before the safety net takes effect. Even if the safety net helps these people in October or November, what happens to their health in January when they or their kids get sick? And why only for card holders? Those just above the card holder threshold are being denied this supposed 'benefit', and offered private health insurance.

9. Private Health Insurance

The introduction of limited private health insurance to cover the copayment is both a disaster and a curious piece of twisted

thinking. The Government refuses to increase the amount paid for a working patient, makes it easier for the GP to charge a bigger gap, and then encourages patients to avoid paying the gap by asking them to take out a second insurance policy. The difference between the first insurance policy (Medicare) and the second private insurance policy is that the premium for the second private policy is the same no matter how rich or poor you are, whereas with Medicare, the premium is proportional to income. Why introduce a second less equitable insurance policy instead of simply expanding the first equitable, and vastly more efficient Medicare? In addition, further public money will be spent paying 30% of these new gap insurance policies via the PHI rebate. This situation is both economically irrational and inequitable.

Another danger of the introduction of private insurance into the funding of non-hospital services is that once one example of such funding exists, it paves the way for an expansion of private insurance into all non-hospital health services. This would very quickly take us to a US-style health system where inequity is rampant, where patients struggle with medical bills to the extent that the commonest cause of personal bankruptcy is failure to pay medical bills.

Alternatives

10. Private Health Insurance Rebate

This rebate was meant to induce downward pressure on premiums, increase private health insurance cover, and reduce public hospital waiting lists. Instead, there has been a 7% yearly increase in premiums over the last two years, no increase in the cover following the rebate introduction (the increase occurred after the change to community rating), and even using very optimistic figures about hospital waiting lists, at best a tiny change only (which may be due to quite unrelated factors). The PHI rebate has been estimated to cost up to $3.7 billion annually when one accounts for indirect spending (Segal 2003, *New Doctor* 79). The following table gives some idea of the magnitude of the effect of reallocating just $2.5 billion directly into areas of public health, where the distribution of benefits of that money is not on the basis of capacity to afford private insurance, but rather on need.

	$ millions	$ millions
Private Health Insurance Rebate		2,500
Supporting General Practice ($5 increase per consult, made up by addition of + $140 m from current Gov proposals)	280	
Package for GPs who bulk bill everyone (yearly bonus, practice nurse, support for capital infrastructure, medical indemnity)	80	
Funding Government run multidisciplinary primary health care centres.	100	
Public Hospitals (increase by 10%)	710	
Aged Care (increase by 10%)	300	
Dental Health Scheme	750	
Saving the PBS: Education Program for Doctors Prescribing Drugs (to reduce pressure on PBS from pharmaceutical industry)	160	
Aboriginal Health (increase by 10%)	120	
Total	2,500	

11. GP Remuneration Models

An increase in the rebate is required. Although it could be an increase for all consultations, that is probably not the most cost efficient way to spend the money and improve the adherence to the principles of Medicare. Restricting the increase in rebate to bulk billed services gives direct encouragement to the concept of bulk billing. But by itself, an increase in the rebate is not the best way to improve access to quality health care independent of income.

A package of measures directed to doctors who bulk bill everyone would, if adequate, further encourage bulk billing. This package could include a yearly cash bonus, funding for practice nurse, infrastructure support, medical indemnity cover. There is no magic amount which will restore bulk billing. Part will depend on re-establishing competition by having enough doctors. Changes suggested with respect to doctor numbers will take years to have their maximal effect.

However, the reliance on fee for service doctor clinics for provision of primary health care needs to be reconsidered. Many GPs are now effectively salaried, working for corporate medical centres, perhaps on a fee for service basis, but with a very predictable income. The funding through Government, of multidisciplinary primary health care centres, with proper integration of all of the different health care providers, with access to such services bulk billed, could be a major advance for patients. The provision of such services in all areas would offer effective competition to current services and help to control the gradually increasing copayments which are financial barriers to access.

12. Extension of Medicare to Dental and Allied Services

Medicare is a very cost effective way of providing hospital services, drugs, and medical primary care. Extension to dental and other health care would provide an opportunity to greatly improve access to such care for those currently denied it because of costs. It would also help to control the escalating costs of these services. It is important to note however that Australia has committed dental services in the category of business services to deregulation under the General Agreement on Trade in Services (GATS) of the WTO and, as such, there may already be a barrier to a significant publicly-funded, universally-accessible dental health scheme.

Conclusion

Medicare is about access to quality health care irrespective of income i.e. health care according to your need not according to your ability to pay. That is its universal nature. A 'Medicare' which does not foster access to quality health care for everyone has no relationship to the Medicare which was introduced in 1984 as a system of public health insurance, for everyone.