Why Medicare indexation matters

2022

AMA's plan to **Modernise** Medicare

AMA

OVERVIEW

Medicare is Australia's healthcare insurance scheme that funded by Australian taxpayers and delivered by the Commonwealth government. Medicare supports access to public hospital treatment, medical services listed on the Medical Benefits Schedule (MBS), pharmaceuticals through the Pharmaceutical Benefits Scheme (PBS), and diagnostic imaging.

Medicare is designed to subsidise the cost of health services, as opposed to covering the full cost of providing the service, with most patients expected to pay some form of out-of-pocket cost for the majority of health services.[1] When a patient is bulk-billed for a service (for example, when a patient cannot afford to pay an out-of-pocket cost), the difference in cost for providing the service is cross-subsidised from the out-of-pocket costs from other patients, as well as other funding sources (for example, government grants or block funding).

Under an indexing process, the MBS fees are raised according to the Department of Finance's Wage Cost Index, a combination of indices relating to wage levels and the Consumer Price Index (CPI). Indexation of MBS rebates has been a source of controversy for many years, as government indexation of Medicare rebates has never kept pace with the rising costs of running a medical practice. As with all businesses, the costs of providing medical care go up each year, with increases in wages for staff, rent, medical equipment, cleaning, electricity, technology and insurance. All these costs are met by the fees the doctor charges for patient care. After years of frozen and low indexation, there is now a substantial disconnect between the MBS and the realistic cost of providing health services.

Over almost three decades, from 1995 to 2022, the MBS has had an annual average indexation rate of 1.1 per cent[2], whereas the average annual changes to the CPI and Average Weekly Earnings (AWE) — which are indicative of the increase in costs of running a medical practice — are 2.4[3] and 3.5[4] per cent respectively. Although the MBS received a boost in indexation of 2.5 per cent in 2006, this was followed by several years of low or no indexation. Since indexation was recommenced in 2018-19, it has only averaged at 1.3 per cent annually.[5] From 1 July 2022, Medicare items were indexed by 1.6 per cent,[6] and last year the indexation rate was 0.9 per cent, however it is predicted that inflation will reach 7.75 per cent in the year to December 2022.[7]

THE ISSUE WITH INADEQUATE INDEXATION

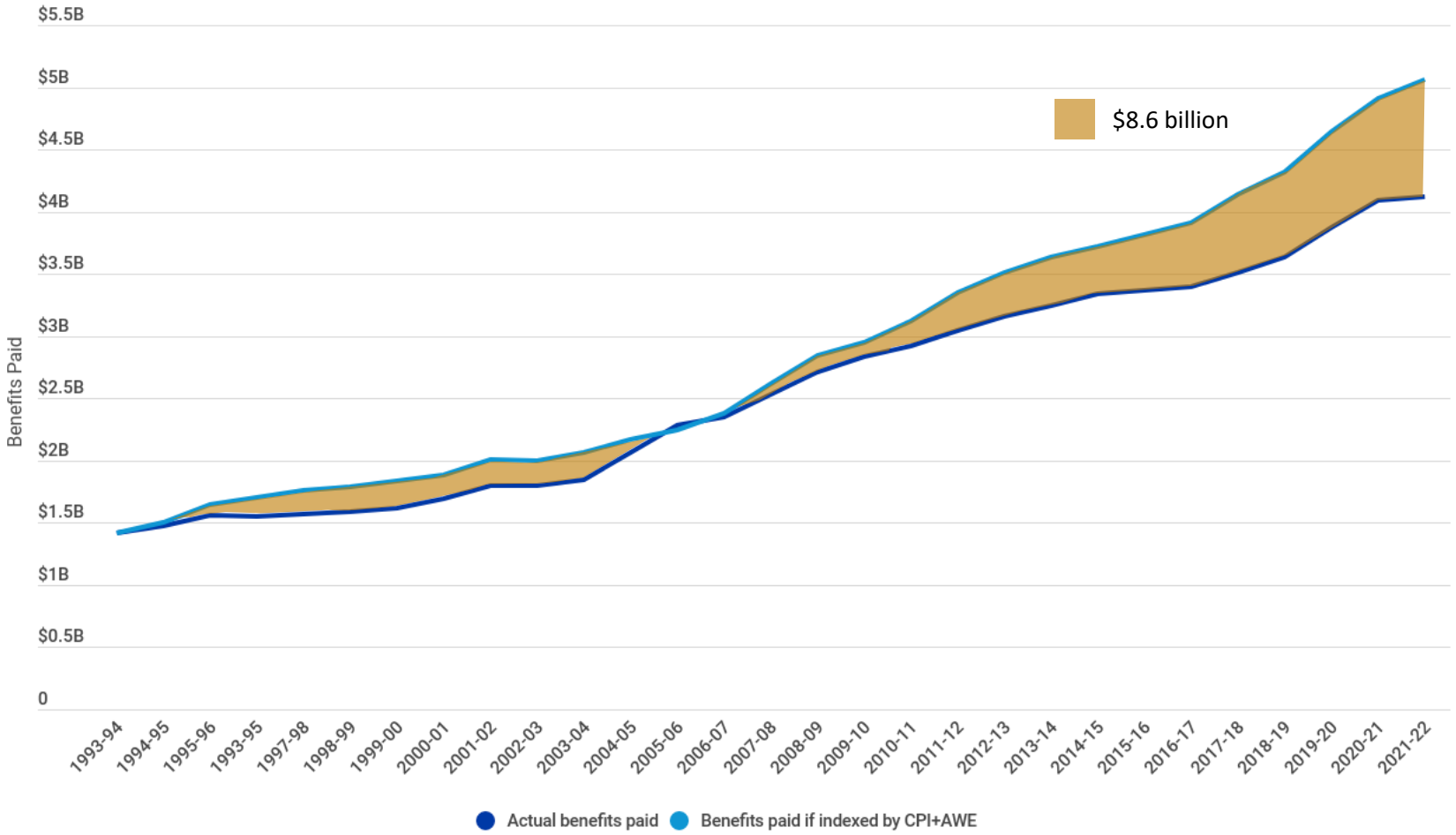
Years of inadequate indexation has meant that the patient rebate provided by Medicare no longer bears any relationship to the actual cost of providing high-quality services to patients, and the cross-subsidisation is not sufficient enough to make up the difference. The medical practice therefore has to either absorb these costs and risk becoming unviable, or pass more of the cost onto patients (with either higher out-of-pocket costs, reduced time spent with patients, or reduced bulk-billing of patients). This inadequate indexation has effectively resulted in a cost shift from the government to healthcare providers and patients.

To illustrate this issue of inadequate indexation, an analysis of the indexation of the Level B consultation item (the most commonly used item by general practitioners, used for consultations lasting less than 20 minutes) was performed, using CPI/AWE (70 per cent weight based on the AWE and 30 per cent weight based on the CPI) as an indicator for the increase in costs of running a medical practice. Depicted in Figure 1, this inadequate indexation has saved the government around **$8.6 billion over the lifetime of the Level B consultation item**, with this cost shifting to Australian general practices and patients by way of out-of-pocket costs and shorter consultations for patients, and revenue loss for practices.

Interestingly, the Level B rebate was increased in 2004–05, and then again in 2005–06, when the government of the day (the Howard government) increased the Medicare rebate from 85 per cent to 100 per cent of the schedule fee for all GP visits[8] and introduced bulk-billing incentives.[9] This was in response to a significant fall in bulk-billing rates amongst GPs, which was highlighted in the Senate Select Committee on Medicare report[10] published in 2003: "*real incomes for GPs who exclusively bulk-bill, relative to average weekly ordinary time earnings, have fallen in the past ten years, and that an increase in net earnings of about 10.6 per cent would be required to retain relative parity" and that "this decline in remuneration in real terms for GPs who bulk-bill around 80 per cent of their patients is of serious concern, and the Committee concludes that the relative under-remuneration is a primary factor, along with practitioner shortage, in the falling rates of bulk-billing in Australia."* Since then however, the rebate for the Level B consultation item has significantly diminished over time. For example, the rebate was $37.05 in 2017–18[11] and $39.75 for 2022–23[12], which represents a 7.3 per cent increase over the five years, despite CPI and AWE increasing by 13.9 per cent[13] and 14.7 per cent[14] respectively over the same time period.

The analysis of the Level B consultation item is a clear example of how years of frozen and low indexation of Medicare rebates has stripped healthcare funding away from medical practices and the Australian population. To offset this, medical practitioners have to either increase out-of-pocket costs for patients or reduce the time they spend with patients to remain viable. In many cases, the patients that most frequently go to the doctor because of age, chronic conditions, and comorbidities are the ones that are least able to pay the out-of-pocket costs. As the population continues to age and the disease burden grows, the share of patients seen by general practices will increasingly be from this vulnerable cohort, and there will not be enough cross subsidisation from those patients who can afford the high out-of-pocket costs without additional funding from other sources. Ultimately, the current reliance on a few patients to help fund those vulnerable patients is a short-term and unsustainable solution that will ultimately lead to patient and community health needs not being met.

Figure 2: Medicare rebate for the Level B consultation item, 1993–94 to 2021–22[15]

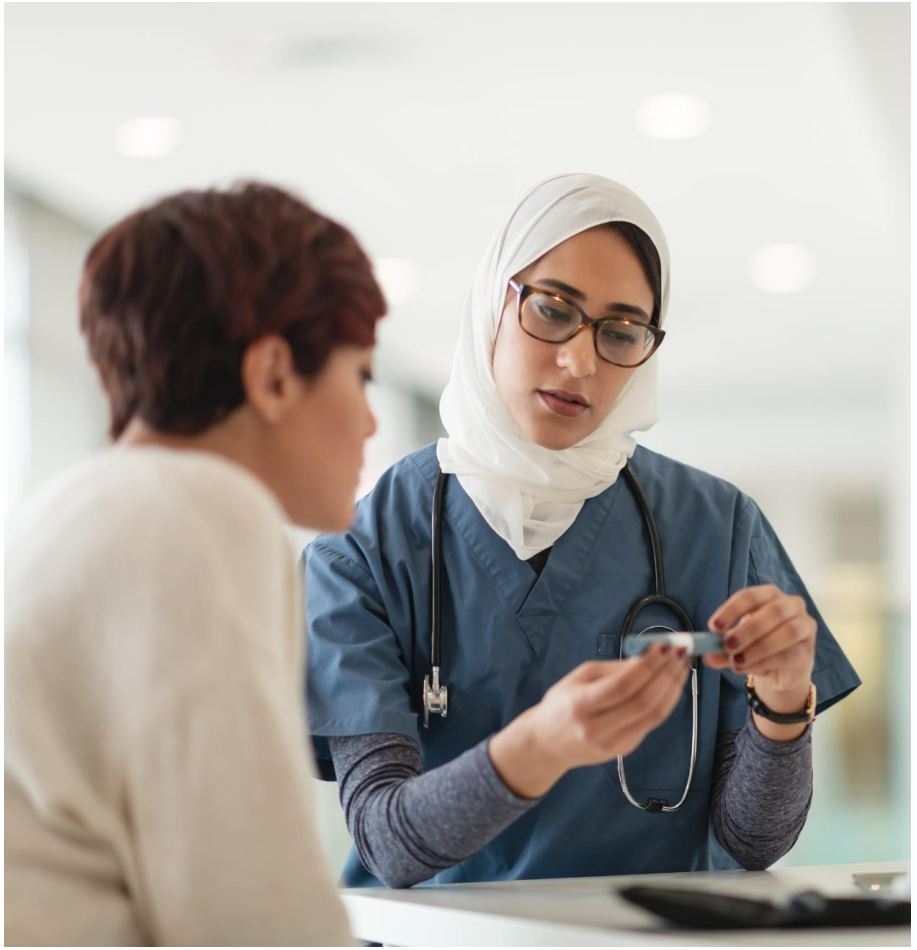


WHAT IS THE SOLUTION?

The AMA is calling for the government to implement a revised indexation tool to ensure rebates better reflect the rising costs of providing high-quality medical care and running a medical practice. This will reduce patient out-of-pocket costs, encourage greater access to medical services, and build an important foundation for delivering sustainable, high-quality and value-based health services into the future.

Implementation of the revised indexation tool should prioritise those services where there has been a decline in bulk-billing and minutes per consultation, and an increase in patient out-of-pocket costs, as these may be the areas where the rebate does not sufficiently support the delivery of high-quality and holistic services. Ultimately, these rebates should be indexed to enable medical practices to meet the health needs of their patients and community.

Medical practices, in particular those practices who bulk-bill the majority of their patients such as general practices, are increasingly struggling to remain viable. This year there have been many reports of bulk-billing GP clinics in financial stress and forced to close their doors. There has also been a decrease in bulk-billing of patients, particularly by general practices, which signals that practices are struggling to remain viable and are therefore needing to charge patients an out-of-pocket medical gap in order to pay for the increasing costs of running a medical practice. If the gap between the Medicare rebate and cost of providing medical care continues to increase, practices will increasingly be unable to absorb the costs associated with providing high-quality healthcare. This will result in more bulk-billing practices closing their doors and out-of-pocket costs for patients, which will ultimately impact patient access to timely and affordable care.



WHAT WOULD IT COST?

A simple indexation costed projection has been performed as an indicative example, to demonstrate the potential cost to government if the indexation of MBS items was improved to better reflect the rising costs of high-quality medical care and running a medical practice.

The overall MBS indexation rate as at July 2022 (1.6 per cent) was used for the analysis. Projecting forward MBS utilisation by Broad Type of Service (BTOS), a baseline cost for expenditure by broad MBS category can be established. Below, the AMA has estimated the cost of lifting this rate to match a simple index of 70 per cent weight based on the AWE (assumed 3.5 per cent) and 30 per cent weight based on the CPI, which has been projected to return to the centre of the Reserve Bank of Australia (RBA) band of 2.5 per cent. The difference between the current rate of indexation and this simple metric was applied across all BTOS categories. The gap between the projected index and 1.6 per cent was applied to 'Pathology' as several pathology items have not been indexed in recent years.

In performing the review of indexation, government should consider the amount of capital and labour that reflect the cost of providing services within each BTOS, and whether indexation rates should therefore be different for each BTOS to account for the differences in healthcare settings, services provided, technology requirements etc.

Table 14: Cost of lifting MBS indexation for each Broad Type of Service category

	2023–24	2024–25	2025–26	2026–27	Total
GP (all items) ($m)	153	324	514	725	1,717
Specialist Attendances ($m)	52	111	178	253	594
Obstetrics ($m)	4	8	12	17	41
Anaesthetics ($m)	10	21	33	46	109
Pathology ($m)	62	132	209	295	699
Diagnostic Imaging ($m)	88	191	310	447	1,037
Operations ($m)	42	89	140	197	467
Assistance at Operations ($m)	2	3	5	8	18
Optometry ($m)	9	20	32	44	105
Radiotherapy and Therapeutic Nuclear Medicine ($m)	15	34	58	87	195
Net cost to government ($m)	**438**	**933**	**1,492**	**2,120**	**4,983**

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