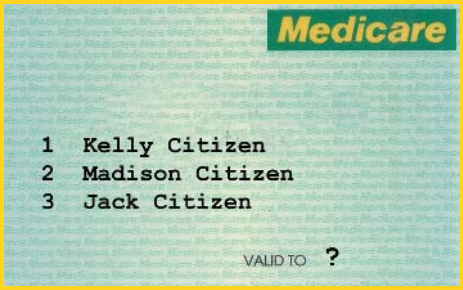

THE BULK BILLING CRISIS

A VICTORIAN PERSPECTIVE

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VCOSS Victorian Council of Social Service

City of DAREBIN

VLGA

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DRS

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EXECUTIVE SUMMARY

Socioeconomic status is the most important indicator of health status among Australians

This report has been endorsed by a coalition of agencies concerned about the dramatic reduction in bulk billing rates and the decreasing access to general practitioners (GPs) in a large number of Victorian communities over the past three years. These organisations are Darebin City Council, Doctors Reform Society, Health Issues Centre, Victorian Council of Social Service (VCOSS) and Women's Health Victoria. These organisations believe the reduction in bulk billing rates and decreasing access to general practitioners is a key concern, as effective universal health services are fundamental to the wellbeing and development of the Victorian community, and are key to minimising disadvantage.

A key feature of this report is the maps of Victorian federal electorates as well as Victorian Local Government Areas (LGAs) which highlight those areas where there has been a reduction in bulk billing. The report also provides information about the level of socioeconomic wellbeing and disadvantage in these communities. Such information, combined with the reduction in bulk billing rates, provides a profile of the characteristics of the communities experiencing decreased access to (what should be) universal primary care.

The aim of this document is to generate discussion in local communities about the rate of bulk billing and access to GPs in general. Local communities are encouraged to convene local meetings to discuss this information, and where necessary, raise the issues of the local rate of bulk billing and levels of access to GPs with local leaders and elected representatives.

KEY FINDINGS

Communities that have experienced the greatest reduction in bulk billing rates

The ten Victorian federal electorates that have experienced the greatest reduction in bulk billing rates from June 2000 to June 2003 are:

- Dunkley,
- Flinders,
- Ballarat,
- Issacs,
- La Trobe,
- Goldstein,
- Casey,
- Holt and
- Corangamite.

These electorates have experienced a marked decline in bulk billing, ranging from a reduction of 31% in Dunkley in metropolitan Melbourne, to a reduction of 23% in Ballarat in regional Victoria.

Communities that have experienced the highest increase in out of pocket costs

The ten Victorian federal electorates that have experienced the largest increase in out of pocket costs between June 2000 and June 2003 are:

- Melbourne Ports,
- Goldstein,
- Higgins,
- Kooyong,
- Bendigo,
- La Trobe,
- Jaga Jaga,
- Scullin,
- Deakin and
- Burke.

These electorates have experienced a range in the increase in out of pocket costs, from $4.26 in Melbourne Ports to an increase of $3.04 in out of pocket costs in Burke.

Communities that experience the lowest bulk billing rates and greatest level of socioeconomic disadvantage

The decline in bulk billing has resulted in reduced and uneven access to GP services. There is a marked difference between rural, regional and inner and outer metropolitan rates of bulk billing. In many rural and regional communities there is no access to general practitioners who bulk bill. Access to GPs who bulk bill is also limited in many outer metropolitan areas.

In looking at the experience of disadvantage, a key factor to consider is the level of socio-economic disadvantage experienced by a community. Socioeconomic status is the most important indicator of health status among Australians[1], with Australians of lower socioeconomic status more likely to experience illness and early death than others in the community.[2] The Australian Bureau of Statistics (ABS) has developed the Socio Economic Index for Areas (SEIFA) to provide a measure of the level of socio-economic disadvantage in different communities, and this is what has been used in this report.

The five Victorian federal electorates with the lowest bulk billing rates and are Indi, Murray, Corangamite, Wannon and Ballarat. All of these electorates, except Corangamite, have below the Victorian average SEIFA scores,indicating high levels of socioeconomic disadvantage.

What difference will *MedicarePlus* make to bulk billing rates?

The analysis presented in this report indicates that *MedicarePlus* will do little to improve the rate of bulk billing in many Victorian communities.

QUESTIONS TO GUIDE LOCAL DISCUSSIONS

This report recommends that local communities throughout Victoria use the following questions to guide their discussions about whether the current bulk billing rates in their federal electorate is appropriate to meet their communities' healthcare needs.

1. Are there enough bulk billing general practitioners and/or clinics in our local community?
2. What is the level of socioeconomic disadvantage in our community, and how does this impact on our community's health care needs?
3. Will *MedicarePlus* provide appropriate treatment options to those people in our community with chronic and complex conditions?
4. How will people in our community benefit from the safety net proposed in the MedicarePlus package?
5. What benefit is our local healthcare system receiving from Federal Government expenditure on the private health insurance rebate?

INTRODUCTION

Effective universal health services are fundamental to the wellbeing and development of the Victorian community, and are key to minimising disadvantage

The purpose of this report

This report has been endorsed by a coalition of agencies concerned about the dramatic reduction in bulk billing rates and the decreasing access to general practitioners (GPs) in a large number of Victorian communities over the past three years. These organisations are Darebin City Council, Doctors Reform Society, Health Issues Centre, Victorian Council of Social Service (VCOSS) and Women's Health Victoria. These organisations believe the reduction in bulk billing rates and decreasing access to general practitioners is a key concern, as effective universal health services are fundamental to the wellbeing and development of the Victorian community, and are key to minimising disadvantage.This report has been compiled to assist local communities to better understand the rates of bulk billing and level of socioeconomic wellbeing and disadvantage in their local area. The authors of this report are committed to providing the best information to local communities so they can both be informed about, and participate in, the ongoing public discussion about access to general practitioners (GPs).

The aim of the report is to generate discussion in local communities about the rates of bulk billing and access to general practitioners (GPs) in general. Local communities are encouraged to convene local meetings to discuss this information, and where necessary raise the issue of access to doctors with local leaders and elected representatives.

How to use this report

The report was developed for the purposes of informing and generating public discussion in local areas. Such discussion may focus on whether the level of access to GPs who bulk bill in their particular area is acceptable, and if there are concerns about the rates of bulk billing, what the local community can do to voice their concerns. This may include having discussions regarding local bulk billing rates with community leaders, elected local government representatives, local state and federal members of parliament, and local health services such as community health services, hospitals and divisions of general practice.

The report is structured in a way that allows readers to quickly identify what the bulk billing rate is in their community (through their Victorian Federal Electorate figure), as well as the Australian Bureau of Statistics' (ABS) measure of socioeconomic wellbeing and disadvantage relating to that electorate, known as the Socio-Economic Index for Areas - SEIFA (an outline of SEIFA is provided on p.8). Such information can be useful to inform communities' discussions regarding their health care needs, and whether the current rates of bulk billing are adequate - particularly if there are higher numbers of people on low incomes living in the area (as indicated by a low SEIFA score).

The report also includes the SEIFA measure for each Victorian local government area (LGA)

(Maps Three and Four). As noted, such data will assist in providing a context for local discussions.

Finally this report includes a section outlining the overall reduction in the number of visits to a GP and the increase in out-of-pocket costs in each Victorian federal electorate for the period between June 2000 to June 2003. Such information will also contribute to providing a deeper understanding of the links between increased out of pocket costs, the reduction in the numbers of people attending a GP, the decline in the availability in bulk billing, and the anecdotal evidence of people turning to the emergency sections of public hospitals.

The ABS Socio-Economic Index for Areas (SEIFA)

Every five years, as an additional component of the Census, the ABS produces the Socio-Economic Index for Areas (SEIFA), which is a series of indices relating to the relative socioeconomic wellbeing of areas within Australia.

The SEIFA indices provide a measure of the socioeconomic wellbeing of Australian communities and identifies areas of advantage and disadvantage. There are four separate measures of Australia's population in the SEIFA that each concentrate on a different aspect of the social and economic conditions in an area. These four measures are :[3]

1. Index of Advantage / Disadvantage
    - includes variables relating to income levels and living conditions
2. Index of Disadvantage
    - includes attributes such as income levels, unemployment, households without motor vehicles, focuses on low income earners
3. Index of Economic Resources
    - includes variables relating to income expenditure, assets of families, household size
4. Index of Education and Occupation
    - includes variables relating to educational and occupational characteristics of communities.

In essence, these measures provide the relative socioeconomic advantage and disadvantage of each area in Australia.

The SEIFA index is a useful way of identifying areas that have been 'left behind', where (for example) incomes may be low, unemployment high, job opportunities limited and educational attainment low.

Understanding SEIFA

In measuring the socioeconomic wellbeing of communities using SEIFA, the lower the SEIFA number, the higher the level of disadvantage.

SEIFA is presented in two forms in this report - first in table form, and secondly in map form. In the maps, the lighter colours depict the areas with greatest socioeconomic disadvantage (lower SEIFA measures) and the darker colours depicting the least socioeconomic disadvantaged areas (higher SEIFA measures).

MEDICARE: THE STORY SO FAR...

Medicare plays a central role in ensuring the affordability of general practitioners

MEDICARE: AUSTRALIA'S UNIVERSAL HEALTH SYSTEM

Effective universal health services are fundamental to the wellbeing and development of the Victorian community, and are key for minimising disadvantage.[4]

Medicare plays a central role in ensuring the affordability of general practitioners (GPs), and hospital and medical services, particularly to those on low incomes. Bulk billing, through Medicare, has been demonstrated to be both effective and efficient in ensuring timely and universal access to health care - it has ensured that all Australians, including those on low incomes, have been able to visit a GP. Experts maintain there is ample evidence that the current Medicare system is effective, efficient and equitable, and that it compares extremely well to other OECD countries in terms of total health expenditure.[5] Medicare has helped ensure that Australian health outcomes are amongst the best in the world.[6]

Professor John Deeble recently made the following comments about Medicare, the health care system he was instrumental in designing over two decades ago:[7]

> *Medicare is not a discretionary Government handout. Nor is it a welfare scheme. It is an insurance system to which everyone contributes according to their income. They then have a universal right to coverage. That solves all the problems of protecting pensioners, the unemployed, other low-income earners, large families and the chronically ill with equity, dignity and less intrusion into their affairs than any alternative.*

The principles of Medicare are:

Universality
All people have the same rights and entitlements to good quality healthcare.

Access
Access to care based on health care needs rather than an individual's capacity to pay.

Equity
Medicare is funded through general taxation and the Medicare Levy. Services should be of a low cost or no cost to patients at point of use.

Efficiency
Administrative costs are kept low by collecting funds through the tax system rather than individual payments. Overheads are kept low through bulk billing and limited advertising.

Simplicity
Claim forms are simple to complete and easy to understand.

A FAIRER MEDICARE: THE FEDERAL GOVERNMENT'S FIRST MEDICARE PROPOSAL

On 28 April 2003 the Federal Government released their package of proposed changes to Medicare. The Federal Government's package was titled *A Fairer Medicare* and was budgeted at $916.7 million.

The Select Senate Committee on Medicare conducted an Inquiry into the proposed changes. The Committee's final report, *Medicare: Health or welfare?*, described the package in the following way:[8]

> *'A fairer Medicare' contains measures that aim to reduce the overall costs of accessing health care, particularly for concession card holders, and additional measures to improve access to health care, particularly in areas of workforce shortage in outer metropolitan and rural areas. The measures fall into three general categories:*
>
> - *Changes to the methods of payment and rebate*
> - *Introduction of new safety nets*
> - *Workforce measures.*

and noted the following concerns about the package:[9]

> *At a practical level policy is focused on guaranteeing' bulk billing of concessional patients in a way that is quite simply unnecessary, since the majority of these people are in all likely hood already bulk billed. The Committee is inclined to agree that the package essentially focuses on a solution to a problem that does not exist.*
>
> *Far more serious though, are the practical ramifications of the proposals. If put into effect, the scheme will trigger a fall in bulk billing for all those who are not concesion care holders. Inevitable problems arise at the boundaries of entitlement, and many Australians in genuine need of bulk billing will fall just outside the threshold of consessional status - including many working families and those with chronic illnesses. These people will face both more gap payments, and overall, a rise in the level of such payments.*

The Federal Government's first Medicare reform proposals outlined in *A Fairer Medicare* were revised in response to the report of the Senate Select Committee on Medicare.

MedicarePlus: THE REVISED PACKAGE

On 18 November 2003 the Federal Government, in response to the report of the Senate Select Committee on Medicare and significant public criticism released their second package of proposed changes to Medicare, *MedicarePlus*.

Key components of the package included:

- Provides opportunities for children under 16 years and Commonwealth Concession Card holders to be bulk billed.
- Makes claiming the Medicare rebate easier for people who are not bulk billed.
- New *MedicarePlus* Safety Net to assist people against major medical costs incurred outside hospital.
- Increases the number of doctors and nurses in the community.
- Changes to access to medical care for residents of aged care homes.
- Under Enhanced Primary Care Program GPs can now involve allied health professionals to develop a multidisciplinary care plan for people with complex conditions
- Costed at $2.85 billion to be implemented by 2007.

The Senate re-established the Committee to examine this second package of proposals. The Senate Select Committee on Medicare produced a second report on the proposed changes, which described the *MedicarePlus* package in the following way:[10]

> *The Committee's second inquiry into the provisions of 'Medicare Plus' discovered mixed reactions across the community. Although in many respects, the new package was considered an improvement on the old, widespread concern remains over the underlying policy directions that remain implicit in the proposals.*

WHERE TO FROM HERE FOLLOWING THE RECENT CHANGES TO MEDICARE?

At present, Medicare is in a state of transition. The Federal Government has succeeded in implementing the majority of the *MedicarePlus* changes as a result of the four Independent Senators joining with the Federal Government in the Senate to pass the required legislation. The analysis presented in this report suggests that these changes have yet to address the concerns many people still have regarding the lack of access to GPs who bulk bill for people on low incomes and those living in rural, regional and outer metropolitan communities.

MedicarePlus IMPROVING ACCESS TO GPs?

The following section outlines some of the key points of the *MedicarePlus* package that will require ongoing monitoring in order to accurately gauge if the *MedicarePlus* changes are making a positive sustainable difference to access to general practitioners (GPs), particularly those who bulk bill.

ENHANCED PRIMARY CARE ITEMS

As detailed earlier in this report, the *MedicarePlus* changes include a range of incentives based on the use of Enhanced Primary Care (EPC) items by general practitioners.

Enhanced Primary Care items are services which have Medicare item numbers, and include allied health services such as physiotherapy, podiatry, speech therapy and dietetics. GPs are able to use the EPCs to obtain these services for their patients. The EPC items both enable the purchase of allied health services and enable GPs to claim the Medicare Rebate for being involved in multidisciplinary care planning and case conferences with other health professionals involved in their patient's care.

Research has indicated that there has been poor uptake by General Practitioners of Enhanced Primary Care items in Victoria. In 2001, the Jesuit Social Services report, *Unequal in Health*, stated that:[11]

> *Extended standard consultations and case conferences were not being provided proportionate to social disadvantage in many of the most needy postcode areas.*

The report goes on to argue that the performance of the enhanced primary care items in Victoria is patchy. Additionally an article in the *Medical Journal of Australia* by Dr John Furler of the University of Melbourne outlined the inverse care law. Dr Furler noted that people living in socioeconomically disadvantaged communities (ie areas with low SEIFA scores) were more likely to have shorter consultations than those people living in more affluent areas:[12]

> *Whatever the underlying reason, it seems that people from disadvantaged areas are less likely to have longer consultations with GPs in their area. This is despite the fact that, as a group, they have significantly higher need for care.*

With the *MedicarePlus* reforms being reliant on the increased uptake by GPs of Enhance Primary Care items and therefore longer consultations, it is probable that those most likely to benefit from these measures are those who are healthier and who have a greater capacity to pay for increased co-payments. *MedicarePlus* will only deliver comprehensive primary care to some chronically ill patients. Put simply, those on low incomes, who are at or just above the poverty line, and who are ineligible for a healthcare card, will be worse off under *MedicarePlus*.

MedicarePlus AND THE SAFETY NET

The *MedicarePlus* package included a range of safety net measures.

The Senate Select Committee on Medicare examining the *MedicarePlus* package expressed a number of concerns regarding the principles underpinning these Safety Net measures. It is worth examining some of the concerns highlighted by the Committee regarding these Safety Net measures as a mechanism to be used in the public financing of primary care.

The Committee noted the following three general concerns about the safety net proposals:[13]

> *The safety net proposal before the Senate contains philosophical and practical problems of sufficient number and gravity to justify its rejection. At a fundamental level, the separation of the proposed safety net into two thresholds creates classes of winners and losers in the proposed health system that offends the principle of universality lying at the heart of Medicare.*
>
> *A more general, though similar, argument was made that the mere fact that uncapped safety nets exist would be a sufficient signal to doctors that a rise in fees could now be more easily absorbed by patients, and that outright financial hardship as a result of high fees was less of a possibility. To quote Professor Deeble: 'If doctors and patients both believed that nobody was going to be really hurt, because the safety net was going to look after them, then there was no reason why the doctors should not just gradually edge fees up. That is the experience in the in-hospital area, where gap insurance and rising fees have gone together.*
>
> *Even for those [patients] who might reach the threshold, the proposal does nothing for them until they reach that threshold. Thus, if they are struggling with costs in January, or June, before they reach the threshold, they may simply delay their visit until desperate, or seek the cheaper alternative at the public hospital emergency department. The concept of a 'safety net' which cuts in after a certain threshold spending requires a capacity to budget for the year. Many of the patients who are struggling financially have trouble budgeting for a week, let alone a year, and will be little helped by this proposal.*

It is clear that *MedicarePlus* is not based on and does not continue the fundamental principle of the original Medicare system of universal health care. *MedicarePlus* creates a two tiered system based on a person's capacity to pay. As noted, the *MedicarePlus* package will require ongoing monitoring to determine whether it does achieve a positive, sustainable difference to access health care for all Australians.

PRIVATE HEALTH INSURANCE REBATE: A CRITIQUE

Although not addressed in the *MedicarePlus* package, one additional consideration open to policy makers in reinvigorating Medicare is the abolition of the 30% Private Health Insurance Rebate (PHI Rebate). This rebate was introduced by the Federal Government in 1999. The Rebate has an annual cost to the community through the Federal Government of approximately $2.5 billion.

There are a number of significant concerns with such a large outlay of public funds on such a Rebate. Of particular concern is that it is extremely difficult to measure its efficacy - ie. its true contribution to the health of the Australian community as a whole.

In an article published in *Dissent*[14] magazine this year, the following arguments were put forward regarding the efficacy and impact of the Private Health Insurance rebate:

- There is no evidence to suggest that there is a relationship between PHI coverage and private hospital demand.
- Private hospitals are substantially the sites of relatively less complex elective procedures. The is little substitutability between the two sectors (although there is some) and those who argue that increasing activity levels in the private sector will decrease pressure on demand in the public sector is simply wrong
- The 30% rebate has failed to take pressure of public hospitals.
- It is highly arguable that the 30% rebate had only the most marginal effect, and represents a serious commitment of public money with little evidence of efficacy.
- It is equally clear that the $2.5 Billion or so being spent on the PHI rebate this year could much more effectively be allocated to improving access and equity to Medicare. Somewhat less than half of the PHI rebate would be more than adequate to improve average GP incomes to levels where bulk billing rates would average more than 75%. The balance could be devoted to direct employment of GPs in areas of need, with funds also available to address hospital funding issues.

There is an urgent need for the Federal Government to undertake a rigorous analysis of the impact on the health outcomes of the

Australian community of the PHI Rebate. Good public policy requires measurement and monitoring of its ongoing efficacy to ensure that public funds are being used in an optimal way for the benefit of the Australian community. The authors of this report argue that the public funds of approximately $2.5 billion used for the PHI Rebate should be redirected to reinvigorate Medicare and restore bulk billing rates to a level above 80%.

The separation of the proposed safety net into two thresholds creates classes of winners and losers in the proposed health system that offends the principle of universality lying at the heart of Medicare

BULK BILLING RATES AND LEVELS OF SOCIOECONOMIC WELLBEING AND DISADVANTAGE FOR VICTORIAN FEDERAL ELECTORATES

MedicarePlus is not based on the fundamental principle of the original Medicare system of universal health care

This section provides the bulk billing rates and level of socioeconomic wellbeing and disadvantage for Victorian communities in each Victorian federal electorate.

The first half of this section includes three tables[15] (Table 1, Table 2, Table 3). Table 1 and Table 2 provide a time series of the declining bulk billing rates for the June quarters 2000 to 2003. Table 1 provides the bulk billing rates in Victorian metropolitan federal electorates, Table 2 provides the bulk billing rates in rural and regional Victorian federal electorates. Table 3 provides the ABS Socio Economic Index for Areas (SEIFA) measures of socioeconomic wellbeing and disadvantage for all Victorian federal electorates.

Victorian metropolitan federal electorate	Bulk billing rate (%) June Quarter			
	2000	2001	2002	2003
Aston	86.2	84.8	82.6	71.5
Batman	92.9	91.0	87.9	84.0
Bruce	86.0	83.6	80.1	76.1
Casey	77.1	75.2	70.7	61.8
Chisholm	83.6	80.9	78.8	73.4
Deakin	80.6	78.5	76.0	66.4
Dunkley	79.4	74.2	58.0	48.4
Flinders	71.5	61.1	54.5	45.6
Gellibrand	94.5	93.3	90.2	85.3
Goldstein	72.1	67.2	61.5	55.8
Higgins	74.0	69.2	65.7	60.7
Holt	91.4	86.9	82.7	76.1
Hotham	87.4	85.5	81.9	76.5
Isaacs	85.3	82.3	76.1	65.4
Jagajaga	78.0	75.0	73.2	69.0
Kooyong	70.8	65.8	64.6	59.4
La Trobe	79.7	73.8	70.0	62.0
Lalor	91.6	89.4	88.7	77.0
Maribyrnong	92.4	90.8	88.3	82.4
Melbourne	89.8	87.4	84.5	79.9
Melbourne Ports	83.8	79.6	73.8	70.7
Menzies	80.7	79.7	77.4	71.1
Scullin	91.0	89.6	88.0	85.5
Wills	90.5	89.1	85.8	79.6

Table 1: Bulk billing rates for Victorian metropolitan federal electorates for June quarters 2000 to 2003

Victorian rural and regional federal electorate	Bulk billing rate (%)			
	June Quarter			
	2000	2001	2002	2003
Ballarat	67.1	64.2	60.5	44.3
Bendigo	52.3	49.4	49.6	49.4
Burke	72.3	71.6	70.3	59.7
Corangamite	56.4	51.0	45.0	41.5
Corio	68.9	65.8	61.4	57.5
Gippsland	56.8	56.6	55.8	46.9
Goldstein	72.1	67.2	61.5	55.8
Indi	42.3	42.0	35.6	32.2
Mallee	56.9	54.7	54.0	55.6
McEwen	73.6	71.7	68.3	61.3
McMillan	68.2	68.5	67.5	67.4
Murray	42.3	39.3	34.3	33.0
Wannon	55.7	55.9	55.2	43.4

Table 2: Bulk billing rates for Victorian rural and regional federal electorates for June quarters 2000 to 2003

	Electorate	Index		Electorate	Index
1	Kooyong	1,121.92	20	Indi	1,003.84
2	Higgins	1,107.60	21	Bruce	1,003.04
3	Goldstein	1,100.08	22	Melbourne	999.36
4	Melbourne Ports	1,089.92	23	Gippsland	998.40
5	Menzies	1,087.68	24	Mallee	998.24
6	Jagajaga	1,065.44	25	Ballarat	996.72
7	Aston	1,057.60	26	Wills	996.72
8	Deakin	1,054.72	27	Murray	990.72
9	Chisholm	1,053.92	28	Hotham	988.56
10	La Trobe	1,046.00	29	Lalor	984.48
11	Casey	1,044.48	30	Bendigo	983.84
12	Corangamite	1,042.16	31	Scullin	980.24
13	Mcewen	1,021.44	32	Mcmillan	980.00
14	Victoria	1,014.56	33	Calwell	967.52
15	Flinders	1,014.40	34	Batman	967.36
16	Dunkley	1,012.24	35	Corio	964.24
18	Burke	1,011.68	36	Maribyrnong	949.84
18	Isaacs	1,010.72	37	Gellibrand	934.72
19	Wannon	1,009.68	38	Holt	932.80

Table 3: SEIFA measure of socioeconomic wellbeing and disadvantage for Victorian federal electorates

The second half of this section provides two maps, each detailing the level of socioeconomic wellbeing and disadvantage of communities in each Victorian federal electorate.

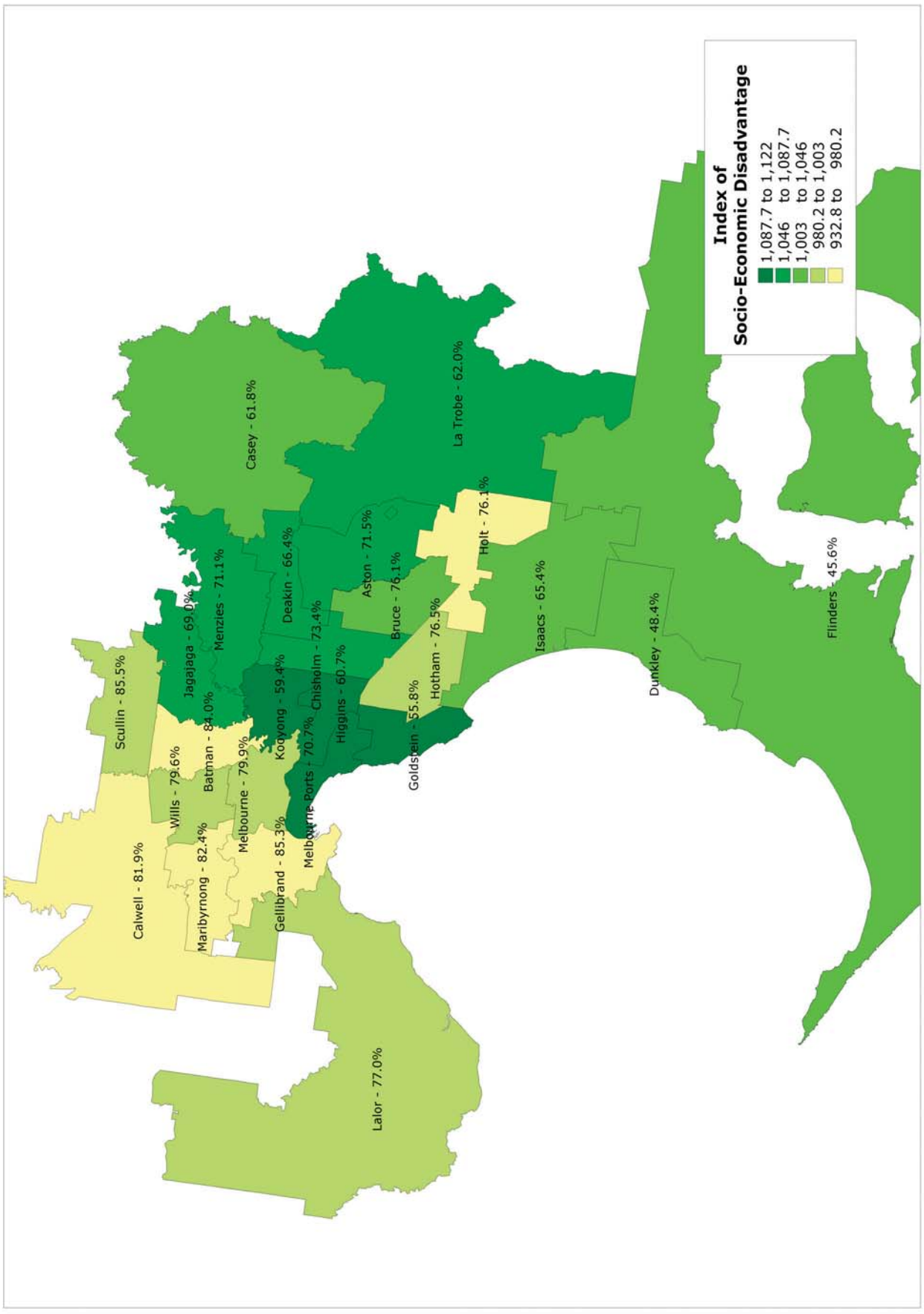
Map 1 (page 17) details the Victorian metropolitan federal electorates, and provides both the 2003 bulk billing rate for each and their respective SEIFA measures of socioeconomic wellbeing and disadvantage. The lighter colours depict the areas which experience the greatest socioeconomic disadvantage (lower SEIFA measures), and the darker colours depict the areas which experience lower socioeconomic disadvantage (higher SEIFA measures).

Map 2 (page 18) details the Victorian rural and regional federal electorates, and provides both the 2003 bulk billing rate for each and their respective SEIFA measures of socioeconomic wellbeing and disadvantage. As in Map 1, the lighter colours depict the areas which experience the greatest socioeconomic disadvantage (lower SEIFA measures), and the darker colours depict the areas which experience lower socioeconomic disadvantage (higher SEIFA measures).

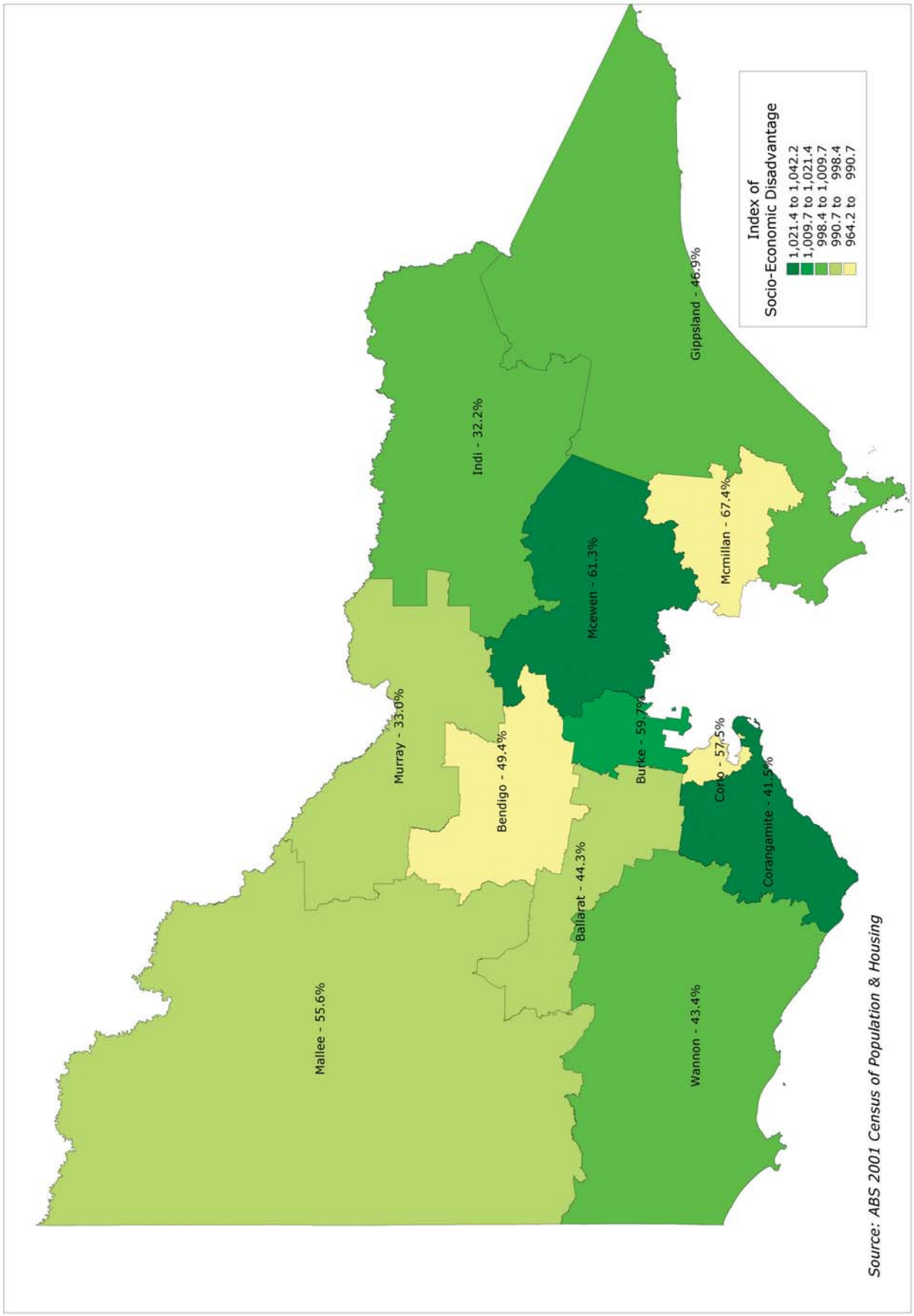
Comment

Tables 1 and 2 plainly demonstrate that many Victorian federal electorates have experienced a sharp decline in bulk billing over the past three years. This decline can be examined in light of high levels of socioeconomic disadvantage, as indicated by low SEIFA measures (presented in Table 3 and in Maps 1 and 2). Such a combination of factors is evident in the electorates of Dunkley, Flinders and Ballarat. Each of these electorates have experienced declines in bulk billing rates of over 20% since 2000, and rank below the Victorian average in their SEIFA measure of socioeconomic wellbeing and disadvantage.

The data presented in Tables 1 and 2 also demonstrate that there is a marked difference in bulk billing rates between rural and regional federal electorates and those in inner and outer metropolitan areas. The lowest bulk billing rates in Victoria are in the rural areas of Indi, Murray and Corangamite. Additionally, there are only two rural Victorian federal electorates that have bulk billing rates above 60%: McMillan and McEwen, which have bulk billing rates of 67% and 61% respectively.



Map 1: 2003 bulk billing rates and SEIFA measures of socioeconomic wellbeing and disadvantage for Victorian metropolitan federal electorates



Map 2: 2003 bulk billing rates and SEIFA measures of socioeconomic wellbeing and disadvantage for Victorian rural and regional federal electorates

SEIFA MEASURES OF SOCIOECONOMIC WELLBEING AND DISADVANTAGE AND VICTORIAN LOCAL GOVERNMENT AREAS

Those on low incomes, who are at or just above the poverty line, and who are ineligible for a healthcare card, will be worse off under MedicarePlus

This section provides two maps detailing levels of socioeconomic wellbeing and disadvantage in Victorian Local Government Areas (LGAs).

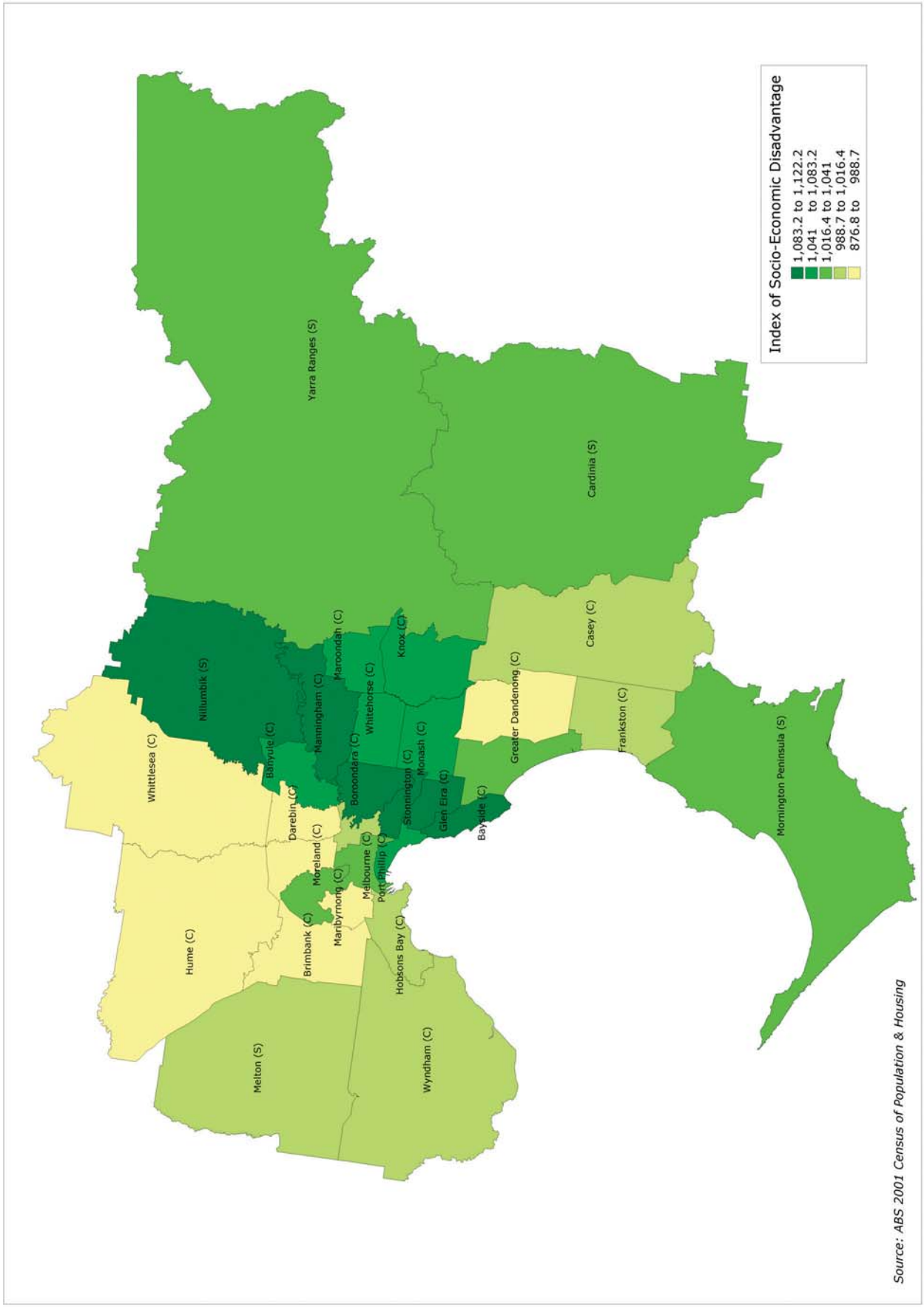
It is of value to gain an understanding of the levels of socioeconomic wellbeing and disadvantage and bulk billing rates at the local government level, as local councils and shires can facilitate many discussions about local issues. The maps included have been provided to allow for a comparison to be made regarding SEIFA scores between federal electorates and local government areas. This contributes to an understanding of the factors that contribute and/or compound disadvantage in different communities.

The first map on page 21 details the ABS Socio Economic Index for Areas (SIEFA) measures of socioeconomic wellbeing and disadvantage for Victorian metropolitan LGAs, and the second map on page 22 details the SEIFA measures of socioeconomic wellbeing and disadvantage for Victorian rural and regional LGAs. For each of these maps the lighter colours depict the areas which experience the greatest socioeconomic disadvantage (lower SEIFA measures), and the darker colours depict the areas which experience lower socioeconomic disadvantage (higher SEIFA measures).

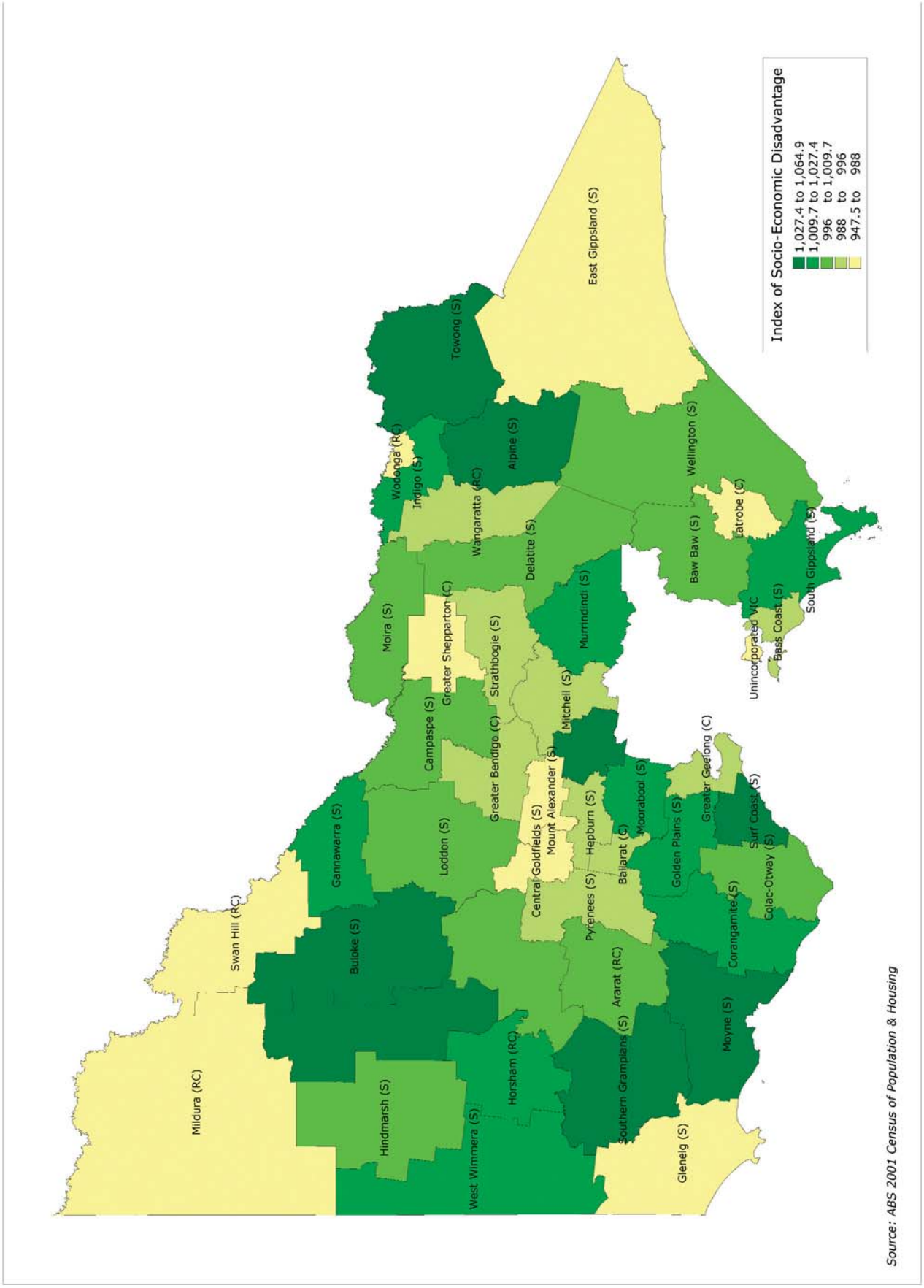
The following table relates to each of these maps, providing the specific SEIFA measure of socioeconomic wellbeing and disadvantage for Victorian metropolitan, regional and rural LGA's.

	Electorate	Index		Electorate	Index
1	Boroondara (C)	1122.16	41	Ararat (RC)	1006.40
2	Stonnington (C)	1108.00	42	Wellington (S)	1006.32
3	Bayside (C)	1107.76	43	Hindmarsh (S)	1005.68
4	Nillumbik (S)	1107.68	44	Northern Grampians (S)	1005.12
5	Manningham (C)	1086.64	45	Warrnambool (C)	1005.12
6	Queenscliffe (B)	1083.76	46	Colac-Otway (S)	1002.80
7	Glen Eira (C)	1083.20	47	Campaspe (S)	1002.08
8	Port Phillip (C)	1078.72	48	Delatite (S)	1001.84
9	Whitehorse (C)	1067.68	49	Melton (S)	997.36
10	Surf Coast (S)	1064.88	50	Loddon (S)	996.40
11	Banyule (C)	1057.92	51	Moira (S)	996.00
12	Macedon Ranges (S)	1057.52	52	Mitchell (S)	994.88
13	Monash (C)	1053.12	53	Wangaratta (RC)	994.32
14	Maroondah (C)	1052.96	54	Hepburn (S)	994.00
15	Yarriambiack (S)	1044.00	55	Casey (C)	993.76
16	Alpine (S)	1042.00	56	Ballarat (C)	993.44
17	Knox (C)	1041.04	57	Greater Geelong (C)	993.12
18	Melbourne (C)	1037.60	58	Frankston (C)	992.72
19	Yarra Ranges (S)	1037.12	59	Strathbogie (S)	991.20
20	Moyne (S)	1031.68	60	Greater Bendigo (C)	990.40
21	Towong (S)	1031.68	61	Bass Coast (S)	988.72
22	Buloke (S)	1030.96	62	Hobsons Bay (C)	988.72
23	Southern Grampians (S)	1029.84	63	Pyrenees (S)	988.00
24	Mornington Peninsula (S)	1027.84	64	Moreland (C)	984.56
25	Indigo (S)	1027.36	65	Swan Hill (RC)	984.32
26	Corangamite (S)	1024.96	66	East Gippsland (S)	984.08
27	Kingston (C)	1024.08	67	Wodonga (RC)	982.16
28	Horsham (RC)	1022.88	68	Glenelg (S)	981.12
29	Cardinia (S)	1018.88	69	Mildura (RC)	979.84
30	South Gippsland (S)	1017.52	70	Mount Alexander (S)	978.00
31	Moorabool (S)	1017.04	71	Greater Shepparton (C)	976.72
32	Gannawarra (S)	1016.56	72	Darebin (C)	966.80
33	Moonee Valley (C)	1016.40	73	Whittlesea (C)	962.40
34	Murrindindi (S)	1016.16	74	Latrobe (C)	960.16
35	West Wimmera (S)	1015.68	75	Hume (C)	954.16
36	Victoria	1014.56	76	Unincorporated VIC	951.12
37	Golden Plains (S)	1014.24	77	Central Goldfields (S)	947.52
38	Yarra (C)	1013.92	78	Brimbank (C)	918.64
39	Baw Baw (S)	1009.68	79	Maribyrnong (C)	915.36
40	Wyndham (C)	1007.52	80	Greater Dandenong (C)	876.88

Table 4: SEIFA measure of socioeconomic wellbeing and disadvantage for Victorian Local Government Areas.



Map 3: SIEFA measures of socioeconomic wellbeing and disadvantage for Victorian metropolitan LGAs



Map 4: SEIFA measures of socioeconomic wellbeing and disadvantage for Victorian rural and regional LGAs

REDUCTION IN PEOPLE ATTENDING GPS

The reduction in bulk billing rates and increases in out of pocket expenses have, from anecdotal evidence, been impacting on the numbers of people visiting a GP. The following table supports this anecdotal evidence, documenting clear evidence that there has been a significant reduction in the numbers of people attending a GP over the past three years.

Victorian federal electorate	Total number of GP services June Quarter 2000	2001	2002	2003
Aston	189,940	185,779	194,311	172,952
Ballarat	146,758	143,181	144,174	134,825
Batman	231,465	219,070	218,970	201,870
Bendigo	128,812	129,346	136,424	129,647
Bruce	207,911	198,606	203,804	181,229
Burke	179,494	184,065	201,230	180,863
Calwell	255,746	249,597	267,315	234,017
Casey	168,438	162,188	166,619	147,960
Chisholm	185,050	176,979	179,311	159,920
Corangamite	132,424	133,450	139,878	128,286
Corio	148,516	148,962	153,312	142,479
Deakin	178,558	170,550	172,599	154,731
Dunkley	173,108	166,921	163,170	145,428
Flinders	167,951	164,298	170,239	155,158
Forde	182,133	179,733	186,262	172,227
Gellibrand	218,456	200,824	202,209	179,906
Gippsland	123,454	129,966	134,902	129,809
Goldstein	185,950	178,479	191,527	174,358
Holt	225,181	220,245	230,252	205,756
Hotham	200,112	191,332	194,938	171,964
Indi	123,409	128,095	129,305	122,622
Isaacs	185,374	180,867	189,122	167,684
Jagajaga	172,477	167,071	174,152	156,195
Kooyong	149,821	146,597	153,691	137,730
La Trobe	175,552	172,969	185,218	168,688
Lalor	191,521	182,527	189,013	175,580
Lyons	107,816	104,687	107,575	101,168
Mallee	129,672	133,048	134,174	126,117
Maribyrnong	212,844	203,418	207,150	177,524
McEwen	162,123	166,351	177,039	165,162
McMillan	41,630	149,933	54,120	147,977
Melbourne	213,904	204,606	208,270	188,495
Melbourne Ports	188,694	178,461	182,822	168,675
Menzies	164,131	163,313	171,654	153,891
Murray	129,346	127,236	128,467	126,389
Scullin	214,456	210,288	223,390	200,050
Wannon	119,649	123,248	126,480	118,704
Wills	226,034	216,191	217,667	194,940

Table 5: Number of General Practitioner services provided June quarters 2000 to 2003

INCREASES IN COPAYMENTS

The table below details the average out of pocket costs, or the patient contribution, for a visit to a GP in each Victorian federal electorate for the period between June 2000 to June 2003.[16] It is clear from the data that there have been significant increases in out of pocket costs. Such increases will impact significantly on people on low incomes, families with two or more children and older Victorians.

The data presented in Table 6 and the data detailing the numbers of people visiting a GP (Table 5) provides a fuller picture of the patterns of visits to GPs in each local area over the past three years. It is clear that the decline in GPs who bulk bill is reducing access to GPs for Victorians.

Victorian federal electorate	June Quarter			
	2000	2001	2002	2003
Aston	$12.16	$13.62	$14.13	$15.13
Ballarat	$10.08	$9.94	$10.73	$11.07
Batman	$11.60	$12.20	$12.45	$13.62
Bendigo	$7.80	$8.65	$9.73	$11.21
Bruce	$12.17	$13.10	$13.71	$14.39
Burke	$10.42	$11.16	$11.75	$13.46
Calwell	$10.26	$10.90	$12.24	$12.17
Casey	$11.59	$12.78	$13.08	$14.31
Chisholm	$12.90	$13.29	$14.18	$15.70
Corangamite	$9.45	$9.77	$10.70	$12.37
Corio	$8.72	$9.69	$10.13	$11.68
Deakin	$11.73	$12.58	$14.11	$14.79
Dunkley	$11.38	$12.07	$12.11	$13.16
Flinders	$9.51	$9.78	$10.39	$11.64
Forde	$10.13	$10.63	$11.34	$11.85
Gellibrand	$11.99	$12.80	$13.11	$13.39
Gippsland	$8.28	$8.72	$9.17	$10.19
Goldstein	$13.11	$13.81	$15.41	$17.10
Higgins	$14.93	$15.70	$16.73	$18.73
Holt	$10.40	$10.97	$11.70	$11.91
Hotham	$10.28	$10.78	$11.76	$12.72
Indi	$9.12	$9.53	$9.92	$10.89
Isaacs	$10.57	$11.02	$11.73	$12.54
Jagajaga	$11.27	$11.80	$12.87	$14.40
Kooyong	$14.46	$15.58	$16.60	$18.22
La Trobe	$11.25	$11.83	$13.22	$14.64
Lalor	$10.50	$10.55	$11.10	$11.81
Mallee	$9.68	$9.34	$9.78	$11.77
Maribyrnong	$10.60	$11.16	$11.34	$12.44
McEwen	$10.96	$11.33	$11.75	$12.43
McMillan	$8.42	$8.66	$9.66	$11.01
Melbourne	$15.06	$15.62	$16.85	$17.70
Melbourne Ports	$13.98	$15.08	$16.15	$18.24
Menzies	$13.16	$13.68	$14.82	$15.58
Murray	$10.53	$11.32	$12.09	$13.29
Scullin	$9.68	$10.39	$11.57	$12.77
Wannon	$9.17	$9.29	$10.24	$10.52
Wills	$10.81	$12.05	$12.28	$12.60

Table 6: Average patient copayments or out of pocket costs for a visit to a GP by Victorian federal electorate

Comment

The documented increases in copayments, the reduction in numbers of people visiting GPs, and the decline in bulk billing rates are clear evidence of the undermining of universal health care - that clearly, not all Victorians are able to access a GP when they need to.

The data presented contributes to providing a deeper understanding of the links between increased out of pocket costs, the reduction in the numbers of people attending a GP, the decline in the availability in bulk billing, and the anecdotal evidence of people turning to the emergency sections of public hospitals.

There is strong anecdotal evidence emerging that a further result of the decline in bulk billing, is that people are turning to already over-stretched emergency departments of public hospitals.

Public hospitals are not an effective provider of population health, prevention and early intervention services, and are generally more expensive for government to fund. Universal health care is the most effective way to provide services to all members of the community, including those who are on low incomes and who experience disadvantage.

In delaying visiting a GP to seek diagnosis and / or treatment, people are not able to access preventative and early intervention health care treatments. Relying on treatment at later stages of illness will result in significant longer-term social and economic costs. The Federal Government must do more to support the health and wellbeing of all, through ensuring that all members of the community are able to access quality health care services - through ensuring a strong universal health care system.

Universal health care is the most effective way to provide services to all members of the community, including those who are on low incomes and who experience disadvantage

CONCLUSION: KEY FINDINGS AND QUESTIONS TO GUIDE LOCAL DISCUSSIONS

In delaying visiting a GP to seek diagnosis and / or treatment, people are not able to access preventative and early intervention health care treatments

WHERE IS THE GREATEST REDUCTION IN BULK BILLING?

Table 7 below lists the ten Victorian federal electorates that have experienced the greatest reduction in bulk billing rates from June 2000 to June 2003, and lists the increase in out of pocket costs, or the copayment, for that area.

Federal Electorate	Bulk Billing reduction	Increase in co-payment
1. Dunkley	31.0%	$1.78
2. Flinders	25.9%	$2.13
3. Ballarat	22.8%	$1.99
4. Issacs	19.9%	1.97
5. Latrobe	17.7%	$3.39
6. Goldstein	16.3%	$3.99
7. Casey	15.3%	2.72
8. Holt	15.3%	1.51
9. Corangamite	14.9%	2.92
10. Aston	14.7%	2.97

Table 7

WHERE IS THE LARGEST INCREASE IN OUT OF POCKET COSTS?

Table 8 lists the ten Victorian federal electorates that have experienced the largest increase in out of pocket costs from June 2000 to June 2003, and lists the reduction in the bulk billing rate for that area. The communities in these electorates are bearing the greatest cost in terms of payment for access to General Practitioners - in access to basic health care.

Federal Electorate	Increase in co-payment	Bulk billing reduction
1. Melb Ports	$4.26	13.1%
2. Goldstein	$3.99	16.3%
3. Higgins	$3.80	13.3%
4. Kooyong	$3.76	11.4%
5. Bendigo	$3.41	2.9%
6. La Trobe	$3.39	17.7%
7. Jagajaga	$3.13	9.0%
8. Scullin	$3.09	5.5%
9. Deakin	$3.06	14.2%
10. Burke	$3.04	12.6%

Table 8

Where are the lowest bulk billing rates and greatest levels of socioeconomic disadvantage?

The decline in bulk billing rates has resulted in reduced and uneven access to GP services across Victoria. There is a marked difference between rural, regional and metropolitan rates of bulk billing, and in many communities there is no access to GPs who bulk bill. Access to GPs who bulk bill is particularly limited in many rural and regional areas and some outer metropolitan areas.

A key factor in the health status of individuals is the level of socioeconomic wellbeing and disadvantage experienced by the community in which they live. Socioeconomic status has been documented as the most important indicator of health status among Australians,[17] with Australians of lower economic status being more likely to experience illness and early death than others in the community.[18] As noted earlier, this report uses the ABS SEIFA measure which provides a measure of the level of socioeconomic wellbeing and disadvantage in different communities.

RURAL AND REGIONAL VICTORIA

In rural and regional Victoria, only two out of thirteen federal electorates have bulk billing rates above 60%, with most falling between 40 and 50 percent. The only two rural Victorian federal electorates that have bulk billing rates above 60% are McMillan, at 67%, and McEwen, at 61%. The Victorian federal electorates with the lowest bulk billing rates are all in rural areas. Table 9 below lists these electorates and their respective SEIFA scores. All these electorates, except Corangamite, have below the Victorian average SEIFA measures, indicating higher levels of socioeconomic disadvantage.

Federal Electorate	Bulk billing % 2003	SEIFA Scores
1. Indi	32.2	1003.84
2. Murray	33.0	990.72
3. Corangamite	41.5	1012.16
4. Wannon	43.4	1009.68
5. Ballarat	44.3	996.72

Table 9

MedicarePlus and Bulk Billing Rates

The analysis presented in this report suggests that *MedicarePlus* will do little to improve the rate of bulk billing in many Victorian communities. In *MedicarePlus* there is a lack of incentive for bulk billing many disadvantaged and vulnerable non health care card holders, especially in areas of significant socioeconomic disadvantage where bulk billing rates are already very low and co payments are increasing rapidly.

With the mix of safety nets and provisions to only deliver bulk billing to health care card holders and those under 16 years, it is more than likely that bulk billing rates will continue to decline and out of pocket costs will continue to increase for most Australians. It will be those on low incomes, who are at or just above the poverty line, and who are ineligible for a healthcare card, who will be significantly worse off under MedicarePlus, and will be likely to experience poorer health outcomes than those in the Victorian community from a higher socioeconomic area.

Questions to guide local discussions

This report recommends that local communities throughout Victoria consider the following questions in their discussions about whether the level of bulk billing is appropriate to meet their healthcare needs.

1. Are there enough bulk billing clinics in our local community?
2. What is the level of socioeconomic disadvantage in our community?
3. Will *MedicarePlus* provide appropriate treatment options to those people in our community with chronic and complex conditions?
4. How will people in our community benefit from the safety net proposed in the *MedicarePlus* package?
5. What benefit is our local healthcare system getting from government expenditure on the private health insurance rebate?

APPENDICES

APPENDIX A

PROFILES OF VICTORIAN FEDERAL ELECTORATES FOR REDUCTION IN BULK BILLING, INCREASE IN CO-PAYMENT, TOTAL GP ATTENDANCES AND SEIFA FOR JUNE 2003

Federal Electorate	Bulk Billing % Reduction 2000 – 2003 June Quarters	Increase in co-payment 2000 – 2003 June Quarters	Total GP Attendances June 2003	SEIFA
Dunkley	31.0%	$1.78	145,428	1,012.24
Flinders	25.9%	$2.13	155,158	1,014.40
Ballarat	22.8%	$1.99	134,825	996.72
Issacs	19.9%	$1.97	167,684	1,010.72
Latrobe	17.7%	$3.39	168,688	1,046.00
Goldstein	16.3%	$3.99	174,358	1,100.08
Casey	15.3%	$2.72	147,960	1,044.48
Holt	15.3%	$1.51	205,756	932.80
Corangamite	14.9%	$2.92	128,286	1024.16
Aston	14.7%	$2.97	172,952	1,057.60
Lalor	14.6%	$1.31	175,580	984.48
Deakin	14.2%	$3.06	154,731	1,054.72
Higgins	13.3%	$3.80	157,582	1,107.60
Melb Ports	13.1%	$4.26	168,675	1,089.92
Burke	12.6%	$3.04	180,863	1,011.68
McEwen	12.3%	$1.47	165,162	1,021.44
Wannon	12.3%	$1.35	118,704	1,009.68
Corio	11.4%	$2.96	142,479	964.24
Kooyong	11.4%	$3.76	137,730	1,121.92
Hotham	10.9%	$2.44	171,964	988.56
Wills	10.9%	$1.79	194,940	996.72
Chisholm	10.2%	$2.80	159,920	1,053.92
Indi	10.1%	$1.77	122,622	1,003.84
Maribyrnong	10.0%	$1.89	177,524	949.84
Bruce	9.9%	$2.22	181,229	1,003.04
Melbourne	9.9%	$2.64	188,495	999.36
Gippsland	9.9%	$1.91	129,809	998.40
Menzies	9.6%	$2.42	153,891	1,087.68
Murray	9.3%	$2.76	126,389	990.72
Gellibrand	9.2%	$1.40	179,906	934.72
Jagajaga	9.0%	$3.13	156,195	1,065.44
Batman	8.9%	$2.02	201,870	967.36
Scullin	5.5%	$3.09	200,050	980.24
Bendigo	2.9%	$3.41	129,647	983.84
Calwell	1.5%	$1.91	234,017	967.52
Mallee	1.3%	$2.09	126,117	998.24
McMillan	0.8%	$2.77	147,977	980.00

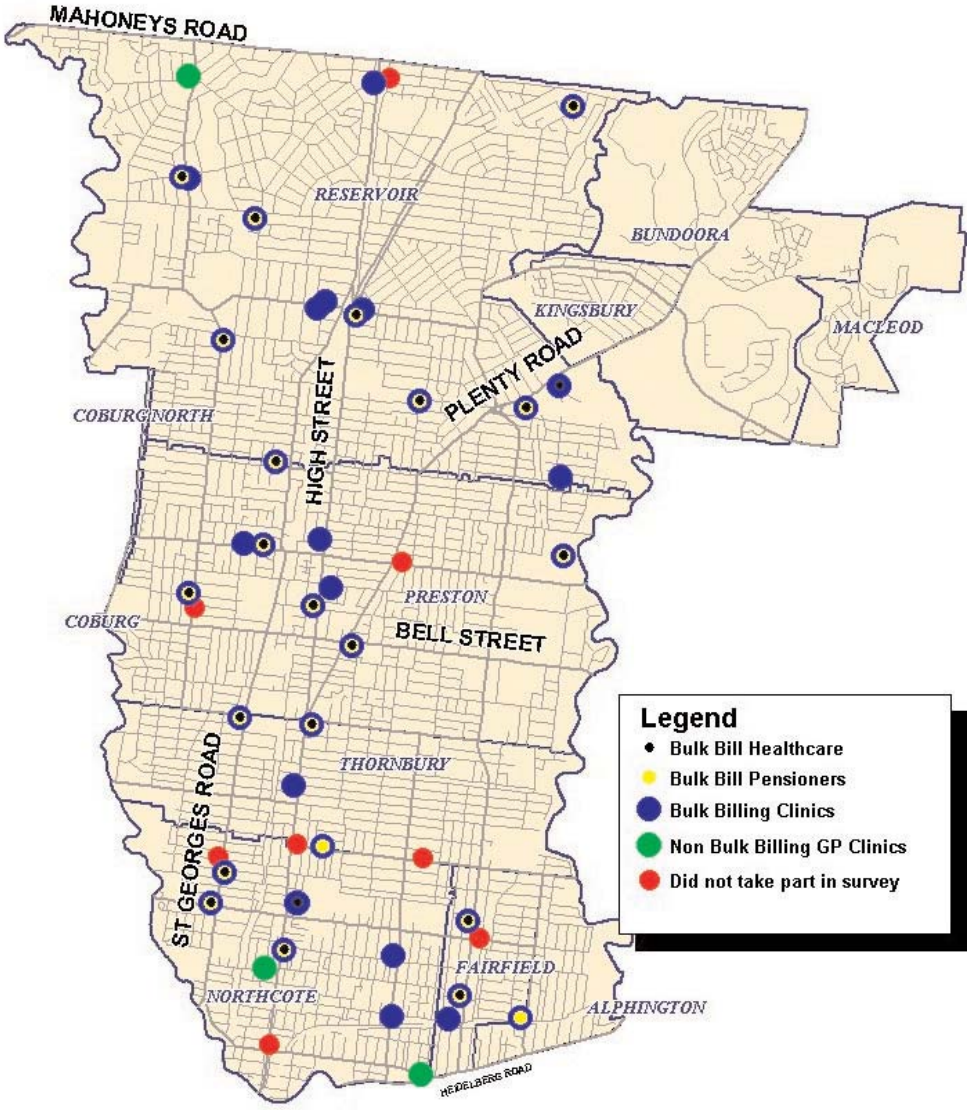
APPENDIX B
DAREBIN BULK BILLING SURVEY 2004

BACKGROUND

The City of Darebin Community Services Department has conducted a survey of General Practitioners as part of council's ongoing involvement in the campaign to save Medicare. The survey supports the report *'The Bulk Billing Crisis: A Victorian Perspective'* also developed by the City of Darebin in partnership with a coalition of agencies and gives greater insight into the issues surrounding bulk billing across the state.

ANALYSIS

There are a total of 53 practices in Darebin who are members of the Northern Division of General Practice. *The Darebin Bulk Billing Survey 2004* indicated that 13 of the 45 GP Practices who agreed to take part in the survey provided a bulk billing service.



General Practice Type	Number
Bulk Billing	13
Bulk Billing Health Care Card Only	3
Bulk Billing Pension Only	4
Bulk Billing both Pension / Health Care Card	22
Non Bulk Billing	3
Did not participate in survey	8
Total	53

Table 1: City of Darebin Bulk Billing Survey 2004 Results

The majority of clinics surveyed believe that the opportunity for patient's to be bulk billed has had no change over the last 12 months indicating that despite the government introducing initiatives to change Medicare, it has had little effect in Darebin.

The survey also indicated that there are only 22 practices of the 45 surveyed who bulk bill pensioners and health care holders alone. A general theme from the information gathered in the survey is that it is increasingly difficult to determine who exactly is being bulk billed in Darebin due to the wide variability within General Practitioners bulk billing practices. Such variability includes:

- Bulk billing occurring at the discretion of the general practitioners, regardless of whether people hold a health care card or concession.
- Bulk billing only being available within business hours, resulting in limited access.
- The limited number of practices open after hours and the availability of bulk billing on weekends.
- Some GPs bulk bill people if they have a chronic illness and frequently visit the practice.

General Practitioners from clinics within Darebin appear to have a range of methods for bulk billing patients. For example, one practice provided a bulk billing service to people with a valid Medicare card, only after an initial annual fee of $30 was paid for adults and $20 for juniors.

Although the Government's new $5 bulk billing payment to General Practitioners introduced February 2004 is limited to children and card holders only, it is difficult to determine its impact on bulk billing figures since this inclusion. With this in mind it should be noted that in Darebin there are only 22 of the 45 practices surveyed that bulk bill for pensioners and health care card holders. In an article published on Saturday 15th May in The Age, the Australian Medical Association vice-president Mukesh Haikerwal predicted that the increase in bulk billing rates would level off over the next two quarters before decreasing again once the increase is absorbed through the high cost of running a practice.

CONCLUSIONS

The Darebin bulk billing survey presents an interesting depiction of bulk billing in the municipality. It appears that the general rate of bulk billing across the municipality is quite low. It is difficult to determine the impact of MedicarePlus given the increasing complexity of many GPs billing practices. Overall the following conclusions can be drawn.

- Due to the extent of variability between General Practitioners methods of billing, it indicates that Medicare is now very complex and highlights a significant shift from the principles of Medicare which are:
  - Universality
  - Access
  - Equity
  - Efficiency
  - Simplicity
- The limited availability of Bulk Billing in Darebin may place pressure on local hospital emergency departments. A recent discussion paper by Darebin Council titled 'Complex Needs in a Complex System' highlights the fact that Darebin's service system is complicated by fact that Darebin is equidistant to three major metropolitan hospitals. Residents are likely to travel to the Northern, Austin or St. Vincents Hospital to use the emergency

department. In the context of limited availability of bulk billing and almost non existent after hour's services it can be argued that Darebin residents may choose to access all three emergency departments for conditions that could be treatable by a bulk billing GP clinic. Table 2 outlines the data relating to emergency department presentations for the three Metropolitan Health Services most used by Darebin residents.

Austin Hospital	19.06% of all hospital activity is to Darebin – Preston SLA residents 9,000 ED presentations by Darebin residents in 2001/02
Northern Hospital	17.38% of all hospital activity is to Darebin – Preston SLA residents 7,000 ED presentations by Darebin residents in 2001/02
St Vincent's Hospital	9.07% of all hospital activity is to Darebin – Northcote SLA residents 6.01% of all hospital activity is to Darebin – Preston SLA residents 4,500 ED presentations by Darebin residents in 2001/02

Table 2: Emergency department presentations and hospital activity for the three Metropolitan Health Services most used by City of Darebin residents*

*Source: Victorian Department of Human Services (2003). Directions for your health system - Metropolitan Health Strategy: Ambulatory Care Services. Victorian Government Publishing Service 2003

- The number of practices that restrict bulk billing services to pensioners and health care card holders is less than half of those surveyed at 22 out of 45 practices. This may be an indication that a large number of practices throughout Darebin are now charging a co-payment to see a doctor.
- Medicare Plus is increasing the complexity of GPs billing structures and provides little relief for people on low incomes. It appears that MedicarePlus is developing two classes of patients with a move away from a universal system that allows access to all.

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Endnotes

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