The impact of differences in bulk-billing rates: strategies for greater equity in Medicare

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In this issue of the *MJA*, Saxby and Zhang[1] provide more evidence about the limits of Medicare as a universal public health insurance scheme, highlighting deep inequities that mean that access to general practice-based Medicare services depends less on your needs than on where you live.

The authors provide some reassurance in that they report that bulk-billing rates are higher in the most socio-economically disadvantaged regions of Australia (86%) than in the least socio-economically disadvantaged (73%). However, they also identified that mean out-of-pocket costs for general practice services are substantial in many areas, including disadvantaged regions and remote areas. Consequently, people living in remote and socio-economically disadvantaged areas are still likely to be spending larger proportions of their incomes on out-of-pocket fees for primary care health services.[1]

The federal government has recognised the need for solutions to this problem. It increased the bulk-billing incentives for general practitioners in rural and remote areas in January 2022, and subsequently tripled them in November 2023.[2] Nevertheless, Saxby and Zhang found that people pay a mean of $43 for non-bulk-billed general practitioner visits, more than the triple bonus, which means that these incentives are unlikely to be sufficient to reduce out-of-pocket costs, particularly for people in metropolitan areas, where the bonus payments are lowest.[1]

Our own research has found both steep increases and major differences in out-of-pocket costs for health care in Australia.[2] Our findings and those of Saxby and Zhang are consistent with those regarding other critical areas of health care.[3] Using bulk-billing rates as a proxy measure of "good care" is inappropriate and misleading. A key limitation of the analysis by Saxby and Zhang is that they could not consider patient needs. In mental health, the paradox of psychological distress and service use has been understood for some time; that is, we know that more services are provided where they are needed least.[4]

Three key questions must be addressed if we are to reduce growing inequities in Medicare. The first concerns limitations associated with relying on fees for service as our primary payment mechanism, particularly for people with complex needs. Medicare funds teamwork poorly. Sending a young woman with an eating disorder to a psychologist for fifteen (partially subsidised) sessions is unlikely to achieve long term benefits. Instead, in addition to the psychologist, she would probably profit from care provided by a team comprising a general practitioner, a nurse, a dietitian, a psychiatrist and allied health workers, helping her stay connected with school, work, friends, and family.[5] Australia must diversify its funding models to provide effective incentives for professionals to work together effectively. For many conditions, these professionals would span clinical, medical, and psychosocial elements of care.

The second key question concerns the overall absence of workforce design and role delineation. General practice, and primary care more broadly, are under significant financial and demand pressures. Taking mental health care as an example, the role we want general practitioners to play should be discussed.[6] They often function as primary gatekeepers to more specialised care options, but they should be trained, supported, and reimbursed to play broader roles as providers of more complex, team-based care.

The splitting of responsibility for health care funding between federal and state governments means that neither is responsible for community-based and more specialised care.[7] Ready, affordable access to ongoing specialist clinical support in the community is rare, leaving many general practitioners unsupported. Evidence-based roles have been trialled but not implemented to maximum effect.[8] The level of unmet need is alarming.[9]

As Henry Ford is said to have remarked, "If you always do what you've always done, you'll always get what you've always got." Reducing the lumpy distribution of the professional workforce in Australia will begin with a frank discussion about which professionals need to do what and how they can work together.[10]

A third critical factor for greater equity is that teams of professionals providing ongoing, complex care need a new, technology-driven spine. Such systems permit real time information sharing, promote measurement-based care, and can support evidence-based adjunct services. Active, rapid feedback can be derived from patient-reported outcomes. Health planning still operates in a siloed, top–down fashion from capital cities, despite the availability of alternative models.[11] It fails to reflect local community concerns, which even in outer metropolitan areas can be quite different from those in the inner city.

Notwithstanding the problems discussed here and by Saxby and Zhang, equity in health care in Australia remains both desirable and achievable. The authors' findings reinforce concerns that Australians find it increasingly difficult to have even their most basic health care needs met. For people facing disadvantages such as poverty or not living in a metropolitan area, these difficulties increase further as the opportunity to see a general practitioner dwindles. Most Australians associate Medicare with equity and fairness; the findings of Saxby and Zhang challenge this association.

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