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Bulky Billing

Missing out on fair and affordable health care

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TAI

Policy Brief

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Summary

When sick, the doctor is the first port of call for most Australians. In 2009-10 one in five visits to a GP resulted in extra fees over and above the Medicare scheduled fee. An estimated $557 million extra were paid for these visits. While the government encourages GPs to charge the scheduled fee (known as bulk billing) many Australians, including Centrelink concession card holders and disproportionately more women, are paying gap fees when they see the doctor.

The cost of health care continues to stack up for those people who leave the doctor with a prescription for medication or a referral for diagnostic testing.

Through the Pharmaceutical Benefits Scheme (PBS) the government subsidises the cost of prescription medications. Within this cap, however, the price of medications can vary widely between pharmacies and between drug manufacturers. Price competition is available when generic medications are able to compete against branded medications, providing the public with a more affordable option. To date increases in the proportion of prescriptions filled with generic medications has occurred despite GP prescribing rates for generic medications remaining consistent at 14 per cent. While the government pays pharmacists an incentive to provide generic medications where possible, Australians still paid $53 million in brand premiums alone in 2009-10.

Referrals for diagnostic testing also come with the chance that additional costs will be charged. Three out of ten referrals for imaging tests resulted in extra fees in 2009-10, as did 15 per cent of pathology referrals. This gap between pathology and imaging is larger now than it was when Medicare was introduced. The lower rate for pathology is likely to be due to the ability GPs have to determine when a test is bulk billed. Interestingly, GPs are more likely to bulk bill a pathology referral than their own services. Despite this, Australians are paying more than $433 million in extra charges.

At the doctor's clinic, the pharmacy counter and in diagnostic imaging rooms and pathology labs, a GP's attitude to patients' rights to access 'fair and affordable' health care can result in a very bulky bill. With Australians paying more than $1 billion in extra charges to access primary and diagnostic medical care it is evident that current health policies are producing an inequitable health care system. The dominance of private providers delivering primary health care, dispensing medication and providing diagnostic services influences this situation.

The government has taken different approaches to funding health services in an attempt to limit the charging of additional fees. The first was the Medicare rebate differential that saw providers who bulk billed receiving a greater payment. The inability of this approach to limit the levying of gap fees has seen the government pay incentives to service providers who bulk bill and the introduction of safety net policies for people with high health care costs. The continuing burden of additional costs for medical services and medication mean that more deliberate policies are needed if the promise of 'fair and affordable' health care is to be realised.

Policy options presented in this paper include:

- automating registration for safety nets and associated record keeping.
- prescription software that uses the active ingredient of a medication instead of a brand name.
- promoting the choice of generic medication.
- mandating the use of government-supplied referral forms for diagnostic tests.

Glossary

brand premium	An additional cost over and above the PBS scheduled price paid by the government. This additional cost does not count toward the PBS Safety Net threshold.
bulk billing	When the provider of a medical service charges the scheduled fee, thereby requiring no payment from the patient, the service is said to be bulk billed.
concession card	Holders of a Centrelink or Department of Veteran Affairs concession card pay a lower PBS co-payment and these cards are *intended* to ensure that the card holder is bulk billed for medical services.
co-payment	A co-payment is the amount an individual pays toward the cost of PBS medication.
generic medication	When the patent for a medication has expired other manufacturers can produce equivalent products, which are referred to as generic versions.
GP	General Practitioner, also known as local or family doctor.
imaging	diagnostic testing such as x-rays and magnetic resonance imaging (MRI).
MBS	The Medicare Benefits Schedule (MBS) is the amount the government subsidises medical services.
Medicare	National health insurance scheme introduced in 1984 and funded from government revenue.
pathology	diagnostic testing such as blood tests.
PBS	The Pharmaceutical Benefits Scheme (PBS) is the system under which the government subsidises the cost of certain medications.
referral	A referral is a request for further medical services that cannot be provided by the referring medical practitioner. For example a GP refers patients for diagnostic testing.
Safety Net	A government policy that provides access to lower costs for people with high medical and/or medication expenses once they reach a threshold.

1. Missing out on 'fair and affordable' health care

Australia has had a system of universal health insurance since 1984. Known as Medicare, it aims to provide 'fair and affordable' access to medical services for all Australians irrespective of their financial situation.[1] Complementing this system is the Pharmaceutical Benefits Scheme (PBS), which provides subsidised prescription medications. Australians are required to make a co-payment for PBS medications that is capped but can vary within this cap depending on the medication purchased. The cap is lower for holders of a Centrelink concession card, cards which are also intended to ensure bulk billing with the government paying an incentive to GPs who do not charge card holders a gap fee.

The spirit of this system's design is that the bill for both professional medical advice and the treatment individuals need is largely funded from public revenue and managed by the government. However, the successful partnership of Medicare and the PBS is undermined when individuals whose needs should be covered have to pay out of their own pockets. Whether it is 'gap fees' for a visit to the doctor or for brand-premiums on medication, health care stops being 'fair and affordable' when individuals have to pay to cover the bill.

In 2010 The Australia Institute released research on the number of Australians missing out on welfare support that they appeared to qualify for. The research found that an estimated 168,000 people were missing out on entitlements across just four Centrelink payments. Revisiting the theme of missing out, The Australia Institute has examined the shortfalls in Medicare and the Pharmaceutical Benefits Scheme which mean that Australians are missing out on universal health cover.

The fairness and affordability of Medicare begins falling short with the charging of gap fees that individuals may be asked to pay on top of the scheduled fee. In such cases Australians are missing out on equitable access to medical care. Although the government sets the scheduled fees paid by Medicare, it does not require service providers to deliver at that price. It does, however, attempt to encourage service providers to keep their fees in line with the bulk billing fee schedule. This occurs in two ways: the Medicare Benefits Schedule (MBS) includes a fee differential that reduces the rebate paid to service providers when they charge a gap fee; and more recently the government has begun paying incentives to GPs and specialists who charge the scheduled fee. Through this 'carrot and stick' approach the government is at least attempting to encourage service providers to moderate their fee schedules whilst allowing them the freedom to run their own businesses. Nonetheless, in 2009-10, one in five people were expected to pay a gap fee for Medicare services rather than being bulk billed (see Figure 1). This figure suggests that, though the government says it is attempting to create a climate that promotes 'fair and affordable' health care for all Australians, the goal is not being achieved.

Unlike Medicare, the government does cap the amount a person is required to contribute as a co-payment to cover the cost of medication provided through the PBS. Despite capping co-payments, it was reported in 2007 that a third of Australians perceived the cost of prescription medications to be a 'moderate to extreme' burden.[2] To some extent this burden may be lifted through choosing more affordable generic medications. Yet the promotion of generic medication options is not being actively pursued by the government. Although the government has begun paying incentives to pharmacists who fill prescriptions with more affordable generic medications the primarily objective is not savings for the individual, but to reduce the cost of the PBS. Yet the government and public have a shared interest in keeping down the cost of medication. For the government (and tax payer) lower prices on high cost medications reduce the PBS bill and for the public it can mean lower prices for medications that come under the co-payment cap.

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1 A Biggs (2004), *Medicare – background brief*.

2 A Searles et al (2007), 'Reference pricing, generic drugs and proposed changes to the Pharmaceutical Benefits Scheme', p.238.

As a result of direct costs over and above Medicare rebates and variable costs for medications there are Safety Net policies to offset excessive costs for both medical services and prescription medications once a patient's costs pass a given threshold. The contradiction of a safety net for a health system that includes universal health insurance and subsidised medication points to the failure health care policy in Australia. Moreover, the systems by which these Safety Net schemes operate are flawed in that not all Australians who are eligible for them are accessing the increased benefits available. So, when there are holes not only in the system but also in the safety nets designed to catch those who slip through, too many individuals miss out on the health care to which they are entitled.

This paper examines the effectiveness of current policy approaches in achieving the government's aim of providing equitable health care for all Australians. The context of this paper is set through an initial analysis of the extent to which gap fees are charged by General Practitioners (GPs). The cost of health care following a GP visit is then clarified through an analysis of premium pricing of medications and, following that, this paper offers an exploration into gap fees for diagnostic testing i.e. blood tests and x-rays. Based on this analysis, a number of specific policy proposals which would reduce the number of Australians who miss out on 'fair and affordable' health care are put forward.

As well as using publically available government data such as Medicare statistics, a survey of 1,411 Australians was conducted in March 2011 in order to gather data for this paper. The survey included questions about health care costs and knowledge of generic medications. For the details of the survey questions, see the Appendix.

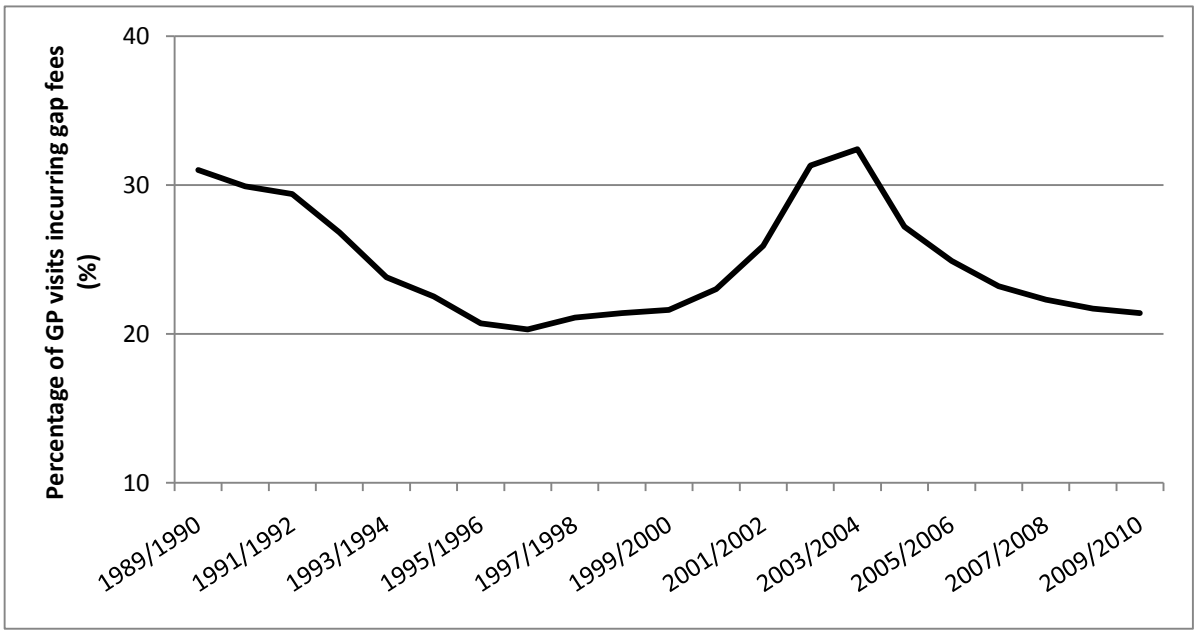
2 The cost of seeing the doctor

GPs, also known as the local or family doctor, are the primary health care providers for most Australians. When Medicare was introduced in 1984, a scheduled fee payable by the Commonwealth was set for consultations with GPs. Though there was initially a limit on how much GPs could charge over the scheduled fee, this is no longer the case. So, while Medicare was designed to provide 'fair and affordable' health care, the gradual acceptance that some health care providers charge additional gap fees has undermined the principles on which Medicare was founded. The government prohibits private health insurance coverage for these fees in order to prevent them from ballooning. In addition to fees for GP visits, seeing the doctor is also the point where further costs can be determined through recommendations, prescriptions for medication and referrals, all of which can potentially lead to further costs.

The percentage of GPs who charged gap fees spiked between 2000 and 2004, generating some talk of Medicare's demise.[3] This rate has since returned to a level evident before this spike (Figure 1).

[3] T Schrader (2003), 'Down the Gurgler?: Howard dangles Medicare overboard'.

Figure 1 GP consultations resulting in gap fees



Source: Department of Health and Ageing (2011), Table B7A.

Figure 1 shows that, at its peak in 2004, gap fees were charged for one in three visits to the GP. Six years later, one in five people were charged gap fees. How the trend will track in the future is unclear; will the rate of gap fees charged for GP services:

- repeat the historical pattern and return to the previous high levels of 2004 and 1990
- continue to decrease albeit at increasingly slower rate, or
- will the government take steps to extend bulk billing for GP services for the 21 per cent of visits missing out?

Medicare statistics show that of the 106.2 million visits made to a GP in 2009-10 gap fees were charged for 22.3 million visits (21 per cent).[4] The average gap fee charged by GPs in 2010 was $25.[5] By multiplying these two figures it can be estimated that Australians paid an extra $557 million (or $33 per adult annually) to see the doctor on top of what the government pays GPs through Medicare.

2.1 Who is paying to see the doctor?

The burden of gap fees charged by GPs is always going to be shouldered by those people who have poorer health. How this burden is distributed demographically shows who suffers most as the government fails to ensure 'fair and affordable' health care for all Australians. In this section age, gender and finally possession of a Centrelink concession card are considered in examining who is paying gap fees to see the doctor.

Up to retirement age this extra cost is likely to be shouldered more by women than men because women under 65 visit the doctor more frequently than do men of an equivalent age.[6] As such

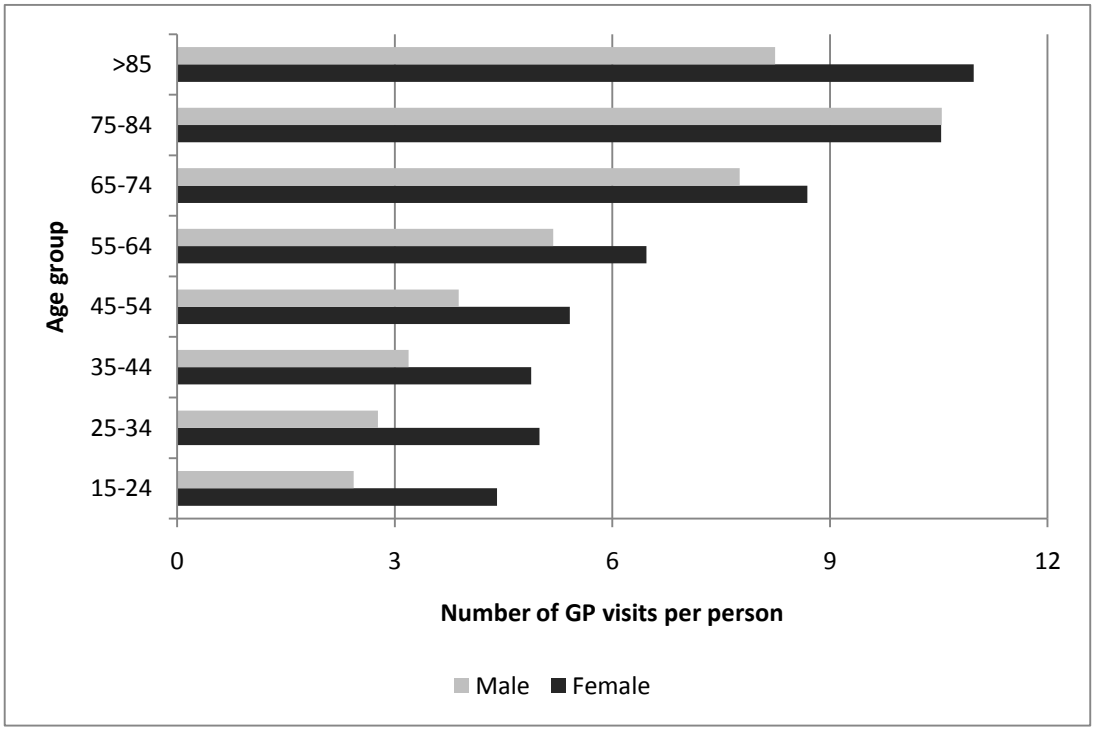
4 Medicare Australia (2011), *Medicare Australia Statistics: Divisions of General Practice Statistics Reports, 2009-2010*.

5 M Metherell (2010) 'Out-of-pocket medical expenses jump 30%'.

6 R Parslow, et al (2004). 'Gender differences in factors affecting use of health services: an analysis of a community study of middle-aged and older Australians'.

women are also more likely to be hit with gap fees. There is a significant rise in the number of visits made to the doctor amongst people aged over 65 years.

Figure 2 Number of GP visits by age and gender in 2009 (per person)



Source: Medicare Statistics, Medicare Group Reports.

As Figure 2 demonstrates, it is likely that women pay substantially more of the estimated $557 million in GP gap fees than men because the number of visits made to a GP is not equally distributed between men and women. Since the proportion of men seeing the doctor increases with age, it follows that younger women pay an even more disproportionate share of the total gap fees being charged. The chances of young women having to pay to see the doctor is further increased by the low number of women (14 per cent) aged 31-36 years who reported having a Centrelink Health Care Card in 2009.[7] This figure suggests that the majority of women in this age bracket would have paid gap fees to see the doctor.

Following the increasing rise in gap fees for GP services in the early 2000s the government introduced incentives in 2004 and again in 2005 to encourage GPs to charge the scheduled fee.[8] The necessity for this kind of policy action on gap fees is evident in statistics from the Australian Bureau of Statistics (ABS), which reports that, in 2008, more than one million Australians aged 15 and over delayed seeing a GP due to the cost of the consultation.[9] Table 1 provides a breakdown of this subset of the population by age.

7 Women's Health Australia (2010), *Data book: for the 2009 phase 5 survey of the 1973-78 cohort (aged 31-36 years)*, p.12.

8 Medicare Australia (2010), *Medicare Initiatives*.

9 ABS (2010), *Health services: patient experiences in Australia 2009*, p.11.

Table 1 Persons 15-64 years who did not visit a GP due to the cost (2008)

	Age					
	15-24	25-34	35-44	45-54	55-64	Total
Estimated number	224,600	272,500	257,200	175,800	107,000	1,037,100
Proportion	8 %	9 %	8 %	6 %	4 %	—

Source: ABS, Health Services: Patient Experiences in Australia, 2009, Table 2.2.
Note: Data for ages 65 and over have been excluded as the relative standard error is between 25% and 50%.

Table 1 shows that younger people are struggling the most with the financial impost of gap fees charged by GPs. When Australians are forced to make health decisions based on the financial impact of gaining medical advice it is clear that the government is still not delivering on the promise of affordability Medicare was intended to deliver for all Australians.

In order to better understand the characteristics of those people who were charged a gap fee by doctors The Australia Institute surveyed 1,411 Australians about their health expenses. Respondents who said they had paid to see the GP included a significant number of people with a Centrelink issued concession card which is intended to provide access to bulk billed medical care; two out of every ten Health Care Card holders and almost as many Pensioner Concession Card holders (18 per cent) indicated that they had to pay to see their GP (see Table 2). What is particularly curious about this figure is that the charging of gap fees for concession holders has occurred despite government incentive payments to encourage GPs to bulk bill appointments with concession card holders.[10]

Table 2 Did you have to pay any money for your last visit to the GP? (%)

	Pensioner Concession Card	Health Care Card	Non-card holder
Yes, paid a gap fee	18 %	20 %	43 %
No, was bulk billed	82 %	78 %	55 %
Not sure	—	2 %	2 %
Total	100 %	100 %	100 %

Source: The Australia Institute survey.

2.2 Doctor's charity

Deciding how much to charge patients for the provision of private GP services was a decision doctors made regularly prior to the introduction of Medicare in 1984.[11] The discretion exercised by GPs is referred to as 'doctor's charity'. The continuing prerogative of a GP to levy additional gap fees above the scheduled Medicare rebate means that for some doctors there is still a role for doctor's charity.

[10] Medicare Australia (2010), *Medicare Initiatives*.

[11] As well as a brief period in the 1970's when Medibank (a forerunner to Medicare) provided bulk billing for GP services.

Making a call on whether a person can afford to pay a gap fee is a decision some doctors are happy to make, while others feel 'distinctly uncomfortable'.[12] Although some patients may ask to be bulk billed the stigma attached to receiving charity means others will not. The presence of a Centrelink concession card shows that a person's financial means are limited and therefore require bulk billing for GP services. However, despite incentive payments research by The Australia Institute (see Table 2) has found that 20 per cent of card holders still face gap fees.

The mindset of a GP in relation to who should pay for the provision of health care can have much greater implications for a patient beyond charging an average $25 gap fee. As well as setting the fee for a consultation, a GP can be influential in determining not only the cost of prescription medications but also decisions about whether a patient will be required to pay for pathology referrals. So, although a GPs role may be discretionary, it is pivotal in providing access to 'fair and affordable' health care to patients.

3 The cost of medication

Having possibly paid to see a GP, further costs are faced by the millions of patients (11.3 million in 2009) who leave the doctors surgery clutching a prescription for medication.[13] Of those with a prescription nearly 70 per cent are likely to have repeat prescriptions[14] thereby multiplying the potential cost. The government subsidises the cost of medications listed on the Pharmaceutical Benefits Scheme (PBS), but still requires a co-payment from the public. The amount this co-payment costs can be inflated through the additional imposition of brand premiums and pharmacy mark-ups.

In Australia new medications have a 20 year patent that guarantees profits for the company that develops a new drug. Once this time has passed off-patent medications can be freely manufactured by other pharmaceutical companies. These versions of the drug are referred to as generic medications. A generic medication is a product that contains the same active ingredient(s) as a brand name medication but generally costs less. To be sold in Australia, generic drugs must meet the same government standards as the branded alternatives with which they compete.[15] Although generic options are available for many prescription and non-prescription medications those coming off patent enjoy brand recognition with GPs continuing to discuss and prescribe medication by brand name.[16]

Such prescribing habits may explain in part why generic medications accounted for only a third of prescriptions dispensed in 2008-09[17] even though there are generic options for around 40 per cent of the medications listed on the PBS.[18] The limited uptake of generic pharmaceuticals despite the provision of incentives for pharmacists to supply them suggests that either the incentive is not high enough to offset the profit from branded medication or there is another obstacle to achieving greater take-up of generic options. One such obstacle was only removed in 2008 when the National Health (Pharmaceutical Benefits) Regulations were changed to prohibit a default setting in computerised prescription software that checked the "no brand substitution" box.[19] A study published in The Medical Journal of Australia found that this

[12] Woodruff, T (2003), 'Valuing your worth and fee for service'.

[13] ABS (2010), *Health services: patient experiences in Australia 2009*, p.19.

[14] D Newby and J Robertson (2010), 'Computerised prescribing: assessing the impact on prescriptions repeats and in generic substitution of some commonly used antibiotics'.

[15] NPS (2011), *Different brands are just as good*.

[16] CHF (2007), *Making Consumer Quality Use of Medications Happen*, p.14.

[17] GMiA (2010), *GMiA is your support in matters relating to the generic pharmaceuticals industry*.

[18] H Löfgren (2007), 'Reshaping Australian drug policy: the dilemmas of generic medicine policy'.

[19] This box is available for doctors to check if they believe that changing the colour or shape of a medication may cause confusion for a particular patient.

amendment reduced from 27 per cent down to one per cent the number of prescriptions for antibiotics in which the "no brand substitution" box was checked.[20]

This example highlights the potential that exists for the government to positively affect the amount Australians pay for medication. Yet, for the most part the government is reliant upon people shopping around for the best price. It will be shown in the next section that this approach is proving inadequate, resulting in another layer of personal health costs for Australians.

3.1 The Pharmaceutical Benefits Scheme

The Commonwealth subsidises the cost of prescription medications through the PBS. This subsidy is the difference between the negotiated price paid by the government and the indexed co-payment price charged to members of the public. The maximum co-payment paid by individuals is currently $34.20 per prescription (though not all medications reach this cost threshold) and the co-payment for concession card holders (Centrelink, Veterans' Affairs) is $5.60 per item. Australians paid $1.3 billion in co-payments in the financial year 2009-10.[21]

In an initiative designed to reduce the cost of the PBS the government only pays the price of the cheapest available generic version of an off-patent to every drug company manufacturing that medication. These changes are designed to deliver benefits to the government's budget but not necessarily to consumers. Furthermore, although the government pays a minimum price for non-patent medications, drug companies are permitted to charge the public a brand premium. The PBS structure of capped co-payments does not restrict the amount people are charged through brand premiums and pharmacy mark-ups applied under the co-payment threshold.

In 2009-10, 16.7 million prescriptions where dispensed with a brand premium, at an average of $3.18.[22] This equates to more than $53 million in extra health care costs for Australians. This impost is not equally shared, however, with some sections of the population having a greater need for medication. In other words, individuals remain vulnerable to the high costs of making a profit through pharmaceuticals while the government legislates (on the taxpayers' behalf) to ensure that the PBS benefits from the downward price pressure provided by generic products.

3.2 Achieving everyday savings by buying generic medications

Choosing generic medicines can provide individuals with savings on the cost of prescription medicines – where the price comes under the PBS co-payment. These potential savings are important because, as this paper has already established, the cost of medication can deter some patients from having their prescriptions filled at all.[23] The Medical Journal of Australia reported in 2011 that a third of Australians perceive the cost of prescription medications to be a 'moderate to extreme' burden.[24] ABS data show that, in 2008, almost one in ten people delayed purchasing or did not purchase the medication they had been prescribed because of the cost of that product.[25]

The new survey data collected for this report confirms this: almost a quarter of respondents (23 per cent) said that they had postponed or avoided having a prescription filled because they could not afford to buy it. This suggests that there is a real opportunity for Australians to benefit from the direct savings available from generic medications. Moreover, it reinforces the fact that the

[20] D Newby and J Robertson (2010).

[21] Department of Health and Ageing (2010), *Expenditure and prescriptions twelve months to 30 June 2010, Data and Modelling Section, Pharmaceutical Policy and Analysis Branch*.

[22] Pharmaceutical Benefits Pricing Authority (2010), *Annual Report: for the year ended 30 June 2010*, p.13.

[23] NPS (2007), *NPS News 55: Generic medications: dealing with multiple brands*.

[24] A Searles, et al (2007), 'Reference pricing, generic drugs and proposed changes to the Pharmaceutical Benefits Scheme', p.238.

[25] ABS (2010), *Health services: patient experiences in Australia 2009*, p.12.

onus should be placed on the government to put in place health policies that ensure Australians never feel that they need to forgo treatment because they cannot afford the medication they need. Guaranteeing access to affordable medication will minimise greater long-term social and health costs of not taking medication.

As discussed in Section 3.1, the price of prescription medications can be increased by the charging of brand premiums and pharmacy mark-ups meaning prices for equivalent medications can vary significantly between brands and pharmacies. The following table (Table 3) reproduces selected cost comparisons published by the consumer advocate organisation, Choice. This data illustrates how Australians are potentially missing out on more affordable medication each time they have a prescription filled at the chemist.

Table 3 Price comparisons between selected medications and pharmacies

Drug name	Metformin hydrochloride	Amoxycillin	Codine phosphate with paracetamol	Temazepam
Brand name	Diabex	Amoxil	Panadeine Forte	Normison
Terry White Chemists	$17.55	$12.00	$27.50	$9.95
Roy Yong Chemists	$15.95	$10.40	$17.95	$9.95
Chemist Warehouse Discount Chemists	$10.50	$6.99	$17.99	$6.99
Generic option				
Terry White Chemists	$12.95	$9.45	$7.45	$7.95
Roy Yong Chemists	$14.15	$9.60	$9.15	$8.75
Chemist Warehouse Discount Chemists	$6.99	$6.50	$6.75	$6.50
Largest price difference (%)	60 %	45 %	75 %	35 %

Source: Choice, Discount medicines: Pharmacy price comparison (website).

Table 3 shows that in each case the generic option is cheaper than the brand name alternative. Moreover, the price of medication also varies considerably between pharmacies. For example, the cost for the common antibiotic Amoxycillin[26] ranged between $6.50 and $12.00 in the Choice sample reproduced in Table 3, the average price reported by the PBS was $10.77. In the financial year 2009-10 there were 2.4 million units of this medication dispensed.[27]

Our research found that only four out of ten people (43 per cent) believe that they will receive a financial advantage by choosing a generic medication over a brand-name alternative. Yet, despite the potential savings limited awareness is preventing many Australians from taking advantage of the opportunity to choose generic medications. Although an awareness campaign explaining the equivalency of generic medications was launched in 2007, the initiative was pared back under budget cuts following the Global Financial Crisis.[28] At a time when Australians were

[26] Amoxycillin was the 17th highest volume drug on the PBS in the financial year 2009-10.

[27] PBS (2010), *Expenditure and prescription twelve months to 30 June 2010*, Table 9(b), p.12.

[28] Australian Government (2008), *Budget Paper No.2, 2008-09*, p.394.

already watching their budgets closely, education about the opportunities for them to save on their medical bills was wound back.

In 2010 the government missed another chance to promote the potential financial savings available by buying generic medications. The Generic Medications Industry Association (GMiA) has argued that this outcome was the result of a Memorandum of Understanding (MoU) between the government and the peak body for branded medications, Medicines Australia. In a submission to the Senate Community Affairs Legislation Committee Inquiry into Consumer Access to Pharmaceutical Benefits, the GMiA suggested that this MoU prevents the government from implementing any policies that promote generic medications.[29]

In the Committee's report the Deputy Secretary of the Department of Health and Ageing is quoted as saying: 'We did not start the process with a notion of an MOU or agreement … it was a suggestion from Medicines Australia'.[30] There are conflicting accounts in the parliamentary report with the Department saying they approached GMiA about the MoU 'several days prior to the budget announcement' and the GMiA saying that they only became aware of it on 'budget night'.[31] The report does not resolve the claim by the GMiA that the government has been prevented from promoting generic medicines.

The National Prescribing Service (NPS), a government funded service agency for the National Medications Policy ran an advertising campaign in 2011 that promoted awareness of (a) active ingredients and how to identify their name, as opposed to the medication's brand name and (b) that in some cases you can choose which brand of medicine you buy. The campaign stopped short of encouraging people to switch to a cheaper generic option.

Although research suggests that the public are to some extent aware of both the existence and cost advantage of generic medications, Australians are still not taking-up the savings available to them. The main reason for this missed opportunity appears to be continuing public deference to the advice of their doctors. The Consumers' Health Forum of Australia has reported that consumers receive 'conflicting advice from pharmacists, medical practitioners and the media' about generic medications and are therefore 'reluctant' to choose generic products unless they receive 'specific advice' from their doctors or other prescribers. Compounding this influence is the fact that medication choice is rarely discussed during GP consultations and, when it is, brand names are used frequently – a practice which tacitly reinforces the significance of branding.[32]

The competition provided by generic versions in the off-patent medication market is delivering some savings to the individual but more could be saved. The government, while exploiting the price competition of generics to generate savings for the PBS, needs to do more to promote savings for the individual if health care in Australia is to be fairer and more affordable. Until the government takes deliberate steps to do so almost six out of ten Australians are likely to miss out on readily available price savings. The next two sections of the report look at the role played by GPs and Pharmacists in promoting generic medicines.

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[29] Generic Medications Industry Association (2010) *Supplementary submission to Senate Community Affairs Legislation Committee Inquiry into the provisions of the National Health Amendment (pharmaceutical Benefits Scheme) Bill 2010*, p.9.

[30] Senate Standing Committee on Community Affairs (2010). *National Health Amendment (Pharmaceutical Benefits Scheme) Bill 2010*, p.11.

[31] Senate Standing Committee on Community Affairs (2010). *National Health Amendment (Pharmaceutical Benefits Scheme) Bill 2010*, p.13.

[32] Consumers' Health Forum of Australia (2007), *Making Consumer Quality Use of Medications Happen, Policy Statement*, p.14.

3.3 The role of GPs

As the main providers of primary medical care for most Australians, GPs play an important role in the provision of affordable medication. They are in a position to both educate patients about generic medications and prescribe suitable generic products. GPs do not appear to be taking to this task, however, with the proportion of generic medications prescribed by GPs having varied only slightly in the decade to 2007-08, averaging 14 per cent of prescriptions.[33] This low prescription rate amongst GPs is a significant determinant in the low market share held by generic medications and contributes to higher than necessary medication costs for people.

The issue seems to be that people are not receiving much advice about generic medications from their doctor. Only six per cent of respondents surveyed by The Australia Institute reported first hearing about generic medications from their GP. At the same time, the NPS found that one in two patients would not use generic medication without first checking with their GP,[34] consistent with our figure of 43 per cent reported in Section 3.2. The apparent pervasive nervousness amongst patients about the uptake of generic pharmaceutical products is seemingly not being addressed by GPs.

The likelihood that GPs will raise awareness about generic medications with their patients may be limited by the coercive influence of marketing strategies employed by drug companies. International research cited by consumer advocate Choice found that frequent visits to GPs by drug company representatives are associated with diminished generic prescribing practices. In a survey of 180 Australian GPs, conducted by Choice, drug companies were found to have an inappropriate level of influence over the prescriptions made by some GPs. This influence was found to outweigh the reported reliance on the NPS.[35]

The NPS works with public health professionals and governments to promote the safe and correct use of medication. While the NPS provides GPs with free and current information on pharmaceutical products, many GPs rely more heavily on the information provided by private drug companies when making decisions about what to prescribe for patients. GPs reported using the following information sources:[36]

- only half of GPs surveyed knew about the National Prescribing Service.
- 16 per cent of GPs use drug company information as their 'main source of information'.
- on average, GPs received seven visits a month from drug reps and an average of 10 promotional mailings.
- in the 12 months prior to the survey, four out of ten GPs had been sponsored by a drug company to attend a conference, seminar or training session.

In addition, The Australian Medical Association (AMA) has highlighted the influence of industry relationships with medical students. It found that these relationships can result in 'a preference for brand medications over generics' that persist beyond registration.[37]

GPs have the potential to help Australians save on their health bills by prescribing and promoting generic medications but the influences outlined above appear to be a substantial barrier to realising the potential for such savings. Given that the government aims to provide 'fair and affordable' health care to all Australians and that research indicates this is not being delivered in relation to prescription medication, changes are required to bring the health system closer to that

[33] H Britt et al (2008), *General practice activity in Australia 1998-99 to 2007-08: 10 year data tables*, pp.57-58.

[34] National Prescribing Service (2007), *NPS News 55: Generic Medications: dealing with multiple brands*.

[35] K Bray (2008) *Promotion overdose: Choice GP survey*.

[36] K Bray (2008).

[37] Australian Medical Association (2011), 'Australian medical schools need to improve conflict-of-interest polices'.

vision. While private-sector health providers are business owners with an incentive to maximise profits, the government should ensure this focus does not compromise the affordability and, therefore, fair access to the health care they provide.

3.4 The role of Pharmacists

As the vendors of prescription medication, pharmacists can also directly influence the cost of prescription medication for the public. As trusted experts, pharmacists are in a position to drive an increase in the provision of generic medications, thereby delivering savings to individuals and the taxpayer. The importance of their role is illustrated in the finding that approximately eight out of ten consumers who required medication for chronic conditions trusted the recommendations of pharmacists.[38]

Since 2008 the Government has paid incentives to encourage pharmacists to sell generic medications. On 1 August 2010, the indexed incentive was $1.56 per prescription or just under half the average brand premium.[39] The Auditor-General has reported that targeting an incentive policy at pharmacists as the dispensers of medication has resulted in an increase in the proportion of prescriptions being filled with drugs eligible for the incentive payment.[40] This outcome has occurred despite there being no significant increase in the rate at which GPs prescribe generic medications which has remained steady at 14 per cent of prescriptions.

Research by The Australia Institute conducted for this paper confirms the role played by pharmacists in the promotion of generic medications. More than nine out of ten respondents (92 per cent) answered 'yes' to the question: Do you know what a generic medication is? Interestingly, most respondents (61 per cent) reported that they had first heard about generic medications from a pharmacist. So, though pharmacists essentially operate under the instructions of GPs, they can still encourage patients to embrace more affordable medication options, steering closer to the principles on 'fair and affordable' health care.

3.5 The PBS Safety Net

For those Australians whose medical conditions result in sizeable medication costs, the government provides additional support through the PBS Safety Net. In addition to capping the price of drugs the government has a Safety Net policy that caps annual expenditure. The Safety Net offers additional subsidies for prescription medications once accumulated costs for prescriptions reach an annual upper threshold. The threshold is currently $1,317.20 for non-concession card holders after which the co-payment for PBS medications is reduced to $5.60 (down from $34.20). For concession card holders, the threshold is $336.00, after which co-payments are no longer paid. So, for patients who face the prospect of high medication expenses, there is some hope of an additional government subsidy. Despite the intention of the Safety Net policy these thresholds may in practice be higher as brand premiums are excluded when calculating eligibility for the Safety Net.

Furthermore, some citizens are likely to miss out on the available benefits of the Safety Net because they must both register with the PBS and keep a record of the prescription medications they purchase on the official Prescription Record Form in order to be eligible for the Safety Net. This record stays in the possession of the individual and should be handed over to be updated by a pharmacist each time a prescription is filled. Pharmacists are permitted to charge a non-compulsory fee for entering a prescription into a patient's Prescription Record Form.[41] While a

[38] National Prescribing Service (2007).

[39] Medicare Australia (2011), *PBS Reforms*.

[40] Department of Health and Ageing (2010), *The Impact of PBS reform: report to Parliament on the National Health Amendment (Pharmaceutical Benefits Scheme) Act 2007*, p.41.

[41] Medicare Australia (2011), *Explanation of PBS pricing*, pp.9, 8.

pharmacist may keep an electronic record of patients' purchases, this list pertains only to purchases made at that pharmacy and will not include medications purchased elsewhere, hence the need for individuals to present their Prescription Record Form each time they have a prescription filled. Though this is a somewhat inconvenient process, it empowers individuals to keep records of purchases made at any number of pharmacies rather than being reliant on the database at a specific pharmacy, thereby giving patients greater freedom to choose where they have their prescriptions filled.

There is some reason to question the success of this largely self-managed policy. Whilst around a quarter (27 per cent) of PBS medications are dispensed through the PBS Safety Net,[42] the Auditor-General reported in 2010 that up to 144,000 people who were eligible for the Safety Net in 2007 did not apply and as a result missed out on accumulated savings estimated to be as much as $10.8 million.[43] Such unnecessary costs compound the extra money paid for brand premiums and pharmacy mark ups which mean that Australians are still a long way from receiving the kind of 'fair and affordable' health care the PBS was designed to provide.

4 The cost of diagnostic testing

When GPs seek additional information about a patient's condition through diagnostic testing, they request testing through a referral. There is a Medicare fee schedule for diagnostic testing, but as with GPs there are currently no limits on what patients may be charged for these tests.

The cost implications of this for patient health care are substantial. A 2001 study found that more than one in ten Australians (1.95 million people) did not undergo a recommended test, treatment or follow-up during the previous year due to the cost of that procedure. Amongst Australians with a below average income, the proportion was closer to two out of ten people.[44] In other words, ten per cent of Australians are forced to compromise on the health care they need because they cannot afford to pay for it. Early detection of health problems through 'fair and affordable' diagnostic testing will limit the possibility of greater problems down the track, for both the patient and the public health system.

The ABS has reported that, in 2008, referrals from health professionals led 8.4 million Australians aged 15 and over to have a pathology test and 5.4 million to have an imaging test.[45] Although the likelihood of being referred for imaging was lower the chance of being charged gap fees was higher. Figure 3 shows the proportion of diagnostic tests billed at the scheduled fee since the introduction of Medicare.

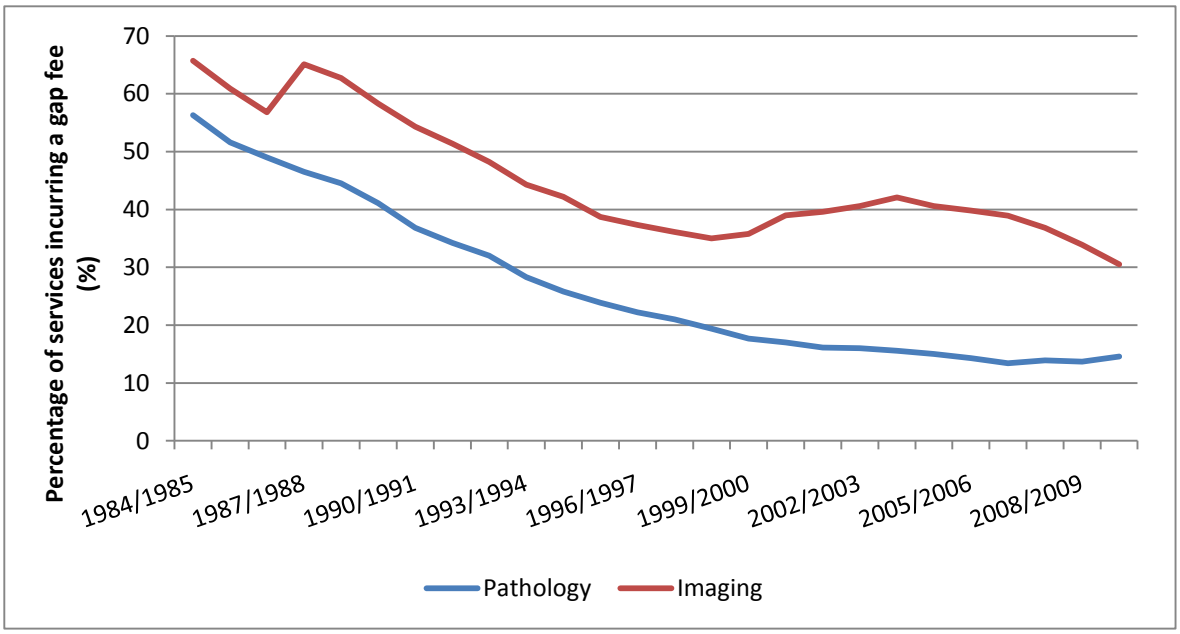
[42] Medicare Australia (2011), *Medicare Australia Statistics: Pharmaceutical Benefits Schedule Group Reports*.

[43] Australian National Audit Office (2010), *Medicare Australia's Administration of the Pharmaceutical Benefits Scheme*, p.106.

[44] R Blendon et al (2002), 'Inequities in Health Care: a five-country survey', p.185.

[45] ABS, *Health services: patient experiences in Australia*, pp.28-9.

Figure 3 Patients paying gap fees for pathology and diagnostic imaging since the introduction of Medicare



Source: Department of Health and Ageing (2011), Table B7A.

Figure 3 shows that since the introduction of Medicare in 1984 the bulk billing of pathology had until recently been declining. The rate of decline had been slowing since the mid 1990s, more so since 2000 before creeping up marginally in the last few years. At the introduction of Medicare ten per cent more imaging tests resulted in gap fees than did pathology tests. Yet after only a few years a sharp increase in gap fees for imaging tests meant that this differential approximately doubled. Another increase in the rate of gap fees occurred around 2000 which then reversed in 2004-05; by 2009-10 the difference between imaging and pathology was 15 per cent. The short story is that proportionally more imaging tests are incurring gap fees in 2010 compared to when Medicare was introduced.

In order to encourage diagnostic imaging professionals to bulk bill patients, the MBS includes a rebate differential, similar to the system which applies to GPs who bulk bill. The government also provided funding for incentive payments for service providers who bulk bill as part of the 2009-10 Federal Budget. The funding allocated for these incentives was $948.7 million over four years, of which approximately two thirds was assigned to imaging services.[46] The purpose of paying incentives is to further increase the bulk billing rate for diagnostic testing as part of the ongoing policy pursuit of fairer and more affordable medical care. The pursuit is continually hampered, however, by the open ended pricing private providers are permitted to charge.

Following reviews of both the funding and fee setting arrangements which 'ensure that the Government is paying the right amount in the right way to support access for patients',[47] changes to the financing of diagnostic testing were included in the 2011-12 Budget. These modifications included $550 million in savings to the government over five years through changes to the MBS.

[46] Department of Health and Ageing (2009), *Health Budget 2009-2010: more support for bulk billing pathology and diagnostic imaging tests*.

[47] Department of Health and Ageing (2010), *Detailed review of funding for diagnostic imaging services, Discussion Paper*, p.2.

There is also $104.4 million over four years to expand the provision of diagnostic imaging services, in particular Magnetic Resonance Imaging (MRI). The majority of this funding ($75.5 million) is designated to allowing GPs to refer patients for MRI services, a decision which until now, could only be made by specialists. A predicted increase in MRI referrals by allowing GPs to refer patients is evident in the simultaneous increase in the number of MRI machines eligible to provide Medicare funded services and in increase in the Medicare rebate for bulk billed services to 100 per cent of the scheduled fee.[48] Time will tell how effective these budget measures are but, as documented in this report, the MBS rebate alone has not proved sufficient in limiting the charging of gap fees by service providers.

The government has allocated substantial spending to increase the provision of diagnostic testing. These budget measures include reforms to the supply of both pathology and imaging services. While funding and reforms are intended to increase the availability of services there is a lack of emphasis on new measures to ensure the fair and affordable delivery of these services.

4.1 The role of GPs in deciding how much we pay

As this paper has already noted, GPs use referral forms to order diagnostic tests for their patients in the same way they prescribe medications. The concerning feature of current practice is that referral forms, that is, the actual form informing people what they need to do, are usually provided to GPs by private providers of diagnostic service whose goal is to promote their business. This effectively channels patients to a particular private provider simply because the logos and addresses on the referral documents they receive imply that the test should be performed by a particular company. Any subsequent gap fees the company providing pathology or imaging charges are unlikely to be questioned as the patient is following “doctor’s orders”.

Public awareness about the role of GPs in determining whether an individual pays gap fees for diagnostic tests is low. Survey respondents who had had a medical test within the last year were asked: As far as you know, who decides whether you pay any money for a medical test? Table 4 lists the results of this survey question.

Table 4 Public awareness about who determines the cost of a diagnostic test (%)

Who determines the cost of pathology tests	Proportion of survey respondents
My GP	17 %
The clinic/service I go to for the test	37 %
The government	31 %
Not sure	15 %
Total	100 %

Source: The Australia Institute, n=936.

Less than two in ten people (17 per cent) surveyed for this paper were aware that GPs can have a determining influence over whether or not they pay for testing. Table 4 shows that most people think that it is the clinic providing the test that determines what patients pay. This is indeed the case if the referring GP has not ticked the bulk billing box. By checking a box on a pathology referral form, a GP can ensure that a patient will not be charged any gap fees at all; if a referral indicates that the service is to be bulk billed, a private provider may, however, still overrule this

[48] Australian Government (2011), p.217.

aspect of the referral. Three out of ten respondents mistakenly believed that the government made the decision.

The fact that GPs have the capacity to determine whether their patients have to pay for pathology services is not widely known. At present, the experience of many patients is that they are told how much they need to pay only when they present for a test, at which point the inconvenience and embarrassment of cancelling the appointment and going elsewhere is likely to result in patients acquiescing and paying the additional cost out of their own pockets.

In some cases, GPs request bulk billing for all their patients.[49] This may account for the high rate of bulk billing for pathology services compared to imaging tests (see Figure 3). In fact, data collected by The Australia Institute indicate that the rate of bulk billing for pathology was higher than it was for GP visits. This disparity is also evident in Medicare Statistics reported earlier in this report. This incongruity suggests that some GPs are willing to charge gap fees for their own services yet are happy to stipulate that their patients should be bulk billed for the pathology tests to which they refer them.

A lack of awareness about a GP's prerogative to determine bulk billing by simply ticking a box means that patients do not realise that they can potentially curb their own medical costs in regards to diagnostic testing by asking their GPs to tick-the-box. It could be argued that a lack of awareness about this tick-the-box system is necessary because, if it were a widely-known fact, individuals might take it upon themselves to tick the boxes on their own referral forms. How many patients would do this is unknown, but given the extent to which Australian patients defer to GPs decisions (as is illustrated in Section 3.3), it is fair to assume that the rate would be fairly low.

So, if GPs continue to use the branded referral forms supplied by pathology and imaging companies and the public remains largely unaware that their GP decides whether a pathology referral is bulk billed, patients are unlikely to seek out affordable diagnostic services. The dilemma faced by doctors in determining who is entitled to be bulk billed, addressed in Section 2.2, is also a factor in determining the personal cost of referrals for medical testing. While the government cannot control the referring practices of GPs it can implement a policy to prohibit branded referrals, removing the coercive influence these forms can exert. Such a policy would go some way to increasing access to 'fair and affordable' health care.

4.2 Private profits versus equitable access

The gap fees charged for diagnostic testing are indicative of the kind of profit-based motives which undermine the provision of 'fair and affordable' medical care in Australia at present. The enduring debate between private providers and the government over the cost of medical services is regularly aggravated by private providers, who clamour for increases to the MBS. For example, following changes made in 2009-10 which reduced the Medicare rebate for the collection of pathology specimens, the three largest private pathology companies wrote to GPs to ask that 'in future, they request a patient have their pathology tests bulk-billed only if they consider them to be in genuine financial hardship'.[50] That is, for-profit pathology companies are directly lobbying doctors to not use the full public subsidy for their patients.

For the most part the public is oblivious to this to and fro over how much they will pay should they need a pathology test. If members of the public were more aware of the role played by GPs, would they or consumer groups, like pathology and imaging service providers, lobby GPs to act in their interest by always selecting the bulk billing option on a referral form? Evidence from the analysis of the doctor-patient relationship in terms of compliance with GPs instructions in relation to prescription medications (see Section 3.3) and the stigma of such requests (Section 2.2)

[49] K Bray (2010) *Pathology gap fees: mind the gap*.

[50] A Cresswell (2009), 'Pathology labs avoid bulk-billing'.

suggests that patients are unlikely to directly make such a request of their doctors. Therefore, so long as Australians are largely ignorant of how the cost of diagnostic tests are determined whilst also deferring, on the whole, to their GP it is likely that many individuals will continue to pay more than they should have to.

Current practices in relation to charges for pathology tests indicate that this dimension of health care is far from 'affordable' for some. Although many patients are bulk-billed for pathology work, those who are not face sizable gap fees. For example, the AMA recommends that the fee for pathology tests be charged at almost twice the rebate provided by Medicare.[51] Gap fees currently charged for pathology services range from $50 up to $190.[52] Medicare statistics show that, of 103.7 million tests in 2009-10, more than 1.5 million incurred gap fees.[53] Therefore, the estimated value of annual gap fees lies somewhere between $75 million and $191.5 million.

Compared with pathology testing, the likelihood of being charged a gap fee for diagnostic imaging is twice as high. Of the 18.1 million Medicare imaging tests conducted in 2009-10, gap fees were incurred for just over 30 per cent.[54] The peak body for private providers of diagnostic imaging, the Australian Diagnostic Imaging Association, reported that the average gap fee for diagnostic imaging is $66.[55] Based on these figures, it can be estimated that $358 million in gap fees were levied in 2009-10 for diagnostic imaging tests. Some indication that the public is not satisfied with this cost for diagnostic imaging is evident in a report, for the government, into the quality of diagnostic imaging services which found that '[c]onsumers wanted informed financial consent before accessing diagnostic imaging'.[56] Evidently many Australian's are paying much more than they need to for diagnostic testing requested by their GP.

4.3 Branded health care and the public alternative

As this paper has already discussed, the phenomenon that most diagnostic tests ordered by GPs are performed by private operators is underpinned by the use of branded medical referral forms. Moreover, the use of branded referral forms means that patients receive a selective list of addresses which guide the patient to a particular provider. Indeed, following recent reforms patients are now free to make appointments at any testing facility. Yet, Choice magazine has reported that GPs 'almost never discuss' either the choice of service provider or the costs involved with patients.[57] In many instances diagnostic services can be accessed at no personal cost by going to publically funded providers, including public hospitals.

Research by The Australia Institute has found that the majority of survey respondents knew where to go for their diagnostic test because:

- they found the address on the back of the referral form (33 per cent).
- they already knew where to go (33 per cent).
- the GP told them (25 per cent).
- they looked up the address themselves (three per cent).

[51] K Bray (2010) *Pathology gap fees: mind the gap*.

[52] K Bray (2010) *Pathology gap fees: state-by-state pathology snapshots*.

[53] Medicare Australia (2011), *Medicare Australia Statistics: Medicare Group Reports*; and Medicare Australia (2011), *Medicare Australia Statistics: Monthly and Quarterly Standard Reports*.

[54] Medicare Australia (2011), *Medicare Australia Statistics: Medicare Group Reports*; and Medicare Australia (2011), *Medicare Australia Statistics: Monthly and Quarterly Standard Reports*.

[55] Australian Diagnostic Imaging Association (2010), *Detailed Review of Funding for Diagnostic Imaging Services: response to discussion paper*, p.11.

[56] Consumers Health Forum of Australia (CHF) (2010), Quality Use of Diagnostic Imaging: Final report, p.6.

[57] K Bray (2010) *Pathology gap fees: How the proposed legislation effects you*.

The fact that few people independently identified where to go for their pathology test underlines both the impact of branded referrals and the influence of what GPs discuss with their patients.

The influence of branded referral stationary may be diminished following legislative amendments passed in 2010. The *Commonwealth Health Insurance Amendment (Pathology Requests) Act 2010* facilitates increased choice of pathology service providers for patients by removing the limitation on freely attending any pathology provider. Prior to this act, referring GPs were required to specify a pathologist in a referral request. Though this requirement did not prevent an individual from then making an independent choice about which service provider to use, GPs were permitted to overrule such discretionary choices.

Until the revision of the *Act*, the requirement that a GP specify the pathologist a patient was to consult was easily met through the use of branded referral forms. As this paper has already outlined, these forms, provided as a 'service' by the pathology companies, are emblazoned with logos, company names and location details. While this allowed GPs to easily meet legislative requirements, it also facilitated the soliciting of patients by private pathology companies. The new legislation gives individuals the freedom to take a pathology referral to any registered provider. However, with only a small minority of people looking for a pathology clinic independent of the marketing influence of branded referral forms the recent changes are unlikely to have any real effect unless branded referrals are also removed. In other words, because research suggests that patients will continue to be directed towards whichever service provider offers its referral forms to their GP, unless the actual referral forms change, patients are unlikely to be aware of and hence take-up the freedom of choice the *Act* provides.

At present, private pathology companies provide almost 90 per cent of Medicare funded pathology services.[58] The combined after tax profit of the three dominant pathology companies in Australia prior to these deregulatory changes was $424 million. The government has, as part of reforms to the pathology sector, deregulated the collection market which has resulted in the opening of 'more than 1,000 new pathology collection centres' since July 2010.[59] Although this increase has been welcomed by the government, it means that the proportion of public providers has shrunk, bringing the very real possibility that more people will have pay gap fees in the future. We cannot yet know what effect the recent changes to referral form requirements will have on this market dominance but the removal of restrictions on the number and location of private pathology collection centres provides an opportunity for the market share to become more imbalanced.

Whilst all state and territory governments provide pathology services, the proportion of services they provide varies significantly. For example, in Tasmania, public pathology is limited to public hospital clinics; a similar situation exists in Queensland, which has only four additional shop-front collection points. In Western Australia there are around 100 collection centres and South Australia is also well-serviced by public collection points. In Victoria, the supply of pathology services is predominantly private, with only limited public collection points outside of public hospitals but St Vincent Health (located in Victoria) also provides bulk billed pathology services at 32 collection centres.[60] Closest to the spirit on which Medicare was founded, private providers in the Northern Territory charge the scheduled fee for all pathology services.

Public pathology services provide more affordable health care to Australians and recent amendments to referral requirements make it easier for patients to access public pathology. That being said, the ease with which individuals can exercise choice depends on the state or territory in which an individual lives, as this determines the availability of public services. But the low level of general awareness of the financial benefits an individual can receive by using public pathology

[58] M Sweet (2009), 'Pathology and Government sums don't quite add up: industry insider'.

[59] N Roxon, *Pathology Services to the Better Managed and Funded, Delivering $550 Million Saving to Taxpayer*.

[60] K Bray (2010) *Pathology gap fees: state-by-state pathology snapshots*.

services means many individuals do not seek out these savings. Furthermore, it is a barrier that will not be overcome so long as GPs continue to use branded referral forms. While the dominance of private pathology continues, so too will the charging of more than $430 million in gap fees which Australians are paying to private companies. So, if the government is serious about providing universally equitable health care then requiring unbranded referral forms is an important step.

4.4 The Extended Medicare Safety Net

This paper has already argued that the existence of the PBS Safety Net is silent admission by the government that the mounting burden of additional fees denies Australians access to 'fair and affordable' medical care. Because of the inability of Medicare to provide real access to affordable health care the government has been forced to establish a Medicare Safety Net (as it has for the PBS). The current threshold for the Medicare Safety Net is $1,157.50, after which 80 per cent of gap fees are reimbursed by Medicare. For concession card holders and recipients of Family Tax Benefit Part A, the threshold is half this amount, $578.60.

Following the introduction of the Medicare Safety Net in 2004, there were some concerns that the policy may have predominantly subsidised specialists' services and that 'residents of high income areas' appeared to benefit more from the policy.[61] Subsequently, alterations were made in 2009 in order to address these concerns that the Safety Net had exacerbated an already undesirable situation, leading to increased profits for medical specialists instead of reducing costs for patients.[62] Although, under the current system, certain medical services are targeted explicitly, the Safety Net continues to include visits to GPs and diagnostic testing.

A notable difference between the two Safety Net systems is that, unlike the PBS Safety Net, Medicare keeps a tally of accumulated costs once an individual or family has registered. While individuals are required to register before they are eligible, the difference in record-keeping practices mandated under each system indicates that the PBS Safety Net could easily be improved. By increasing the automation of recording PBS purchases, the government would go some way toward reducing the number of Australians who miss out on the benefits of this policy. If the system in place for keeping records of individuals' medical expenses was streamlined, it would further reduce the number of people who are paying more than they need to for medical care and prescription medications.

5 Policy options

At present, Australians miss out on 'fair and affordable' health care because they pay more than $1 billion per annum over and above the public subsidy for GP visits, prescription medications and diagnostic testing. This cost is disproportionately borne by those with poor health. The government's current initiatives aimed at righting the situation are Safety Net policies that limit the accumulation of these fees and incentive payments designed to discourage the charging of such fees in the first place. However, because these measures are somewhat ineffectual, individuals are stilling missing out on affordable health care. The following section proposes more prescriptive policy options aimed at reducing the financial burden of health care placed on individuals in Australia.

Both the universal health insurance system (Medicare) and, to a lesser extent, the associated subsidy of prescription medications through the PBS fail to provide 'fair and affordable' medical care, as they were intended to do. This is the result of reliance upon market based pricing of medical care. Despite its potential to ensure fairness and affordability by setting a scheduled fee

[61] K van Gool et al (2009), 'Who's Getting Caught? an analysis of the Australian Medicare Safety Net', p.149.

[62] N Roxon, A sustainable Medicare Safety Net, media release, 12 May 2009.

for medical services and a cap on the public's co-payment for prescription medications, under the current system, Australians often pay gap fees for medical services and additional costs at the chemist including brand premiums for medication and pharmacy administration fees. All of these extra costs add up and shortfalls in the lengths the government will go to, to improve the equity of health policy in Australia.

The government allows private providers of medical services to set the charges for the services they provide. Then, in an attempt to limit the extent to which these charges exceed the Medicare rebate, the government not only pays incentives to providers in order to discourage them from charging gap fees but also tacitly admits to the ineffectiveness of this measure by offering Safety Net schemes, which further subsidise private profits.

The government could do more to ensure that reform measures bring down the cost of health care for individuals as well as the government's budget bottom line. For example; the government has used the cheaper prices of generic medications to save the PBS money yet has not made any real attempt to help members of the public realise the personal savings which are available to them through these products. More recently, the government reformed referral requirements for pathology services but it has not made sufficient changes to bring about a meaningful shift in the fairness and affordability of pathology services. Until the government prioritises the fairness and affordability of public access to health care over the fostering of private enterprise to provide these services then Australian's are going to continue to miss out.

The following policy improvements point to how the Australian government could do more to ensure that members of the public are not missing out on 'fair and affordable' medical care.

5.1 One Safety Net

A shortcoming of the existing Medicare and PBS Safety Net policies is the requirement that individuals register before they are eligible for support; therefore, the ability to take advantage of the benefits of these safety nets is dependent on their awareness of the schemes. Furthermore, the PBS Safety Net includes a further obstacle in that individuals are required to keep a record of the expenses they incur, whereas eligible expenses for the Medicare Safety Net are automatically registered by Medicare when a rebate claim is lodged. Creating a single integrated and automated Safety Net would improve the level of support Safety Net policies are intended to provide.

The government has acknowledged that individuals are missing out on the intended benefits of Safety Net polices because they have neither enough information about either their eligibility to apply for them nor a clear understanding of how to keep the required records.[63] This lack of awareness of Safety Net schemes is likely to contribute to the government's failure to deliver legislated benefits to which individuals are entitled.

Low public awareness of social welfare benefits was identified as being a significant barrier for individuals who are eligible to access welfare support in a previous paper from The Australia Institute: *Missing Out: Unclaimed government assistance and concession benefits*. One policy solution that was proposed to overcome this barrier was the automation of government benefits. Again, in this case, automating registration for an integrated Safety Net would be a straightforward policy improvement that would ensure that more Australians receive the benefits they should be receiving, according to current legislation.

Another problematic aspect of the current system is that, while a record of prescription purchases may be kept on file by a pharmacist, this is likely to have the effect of tying individuals to a single

[63] Australian National Audit Office (ANAO) (2010), *Medicare Australia's Administration of the Pharmaceutical Benefits Scheme*, p.106.

pharmacy and, therefore, limiting the potential that they may actively source cheaper options for their prescription medications from other pharmacies.

An integrated Safety Net would also allow for the extension of the existing automatic Medicare Safety Net system to include the purchase of PBS medications from any chemist. If this were achieved through the existing Medicare card infrastructure, pharmacists might only need to swipe Medicare cards at the point of sale for their prescription purchases to be logged. Such a system would facilitate better record keeping, especially if individuals choose to purchase their prescription medications from more than one pharmacy.

An integrated Safety Net with automatic registration and logging of medical services received and prescriptions filled would ensure that more Australians benefit from the 'fair and affordable' health care the health system is intended to provide.

5.2 Savings through generic medications

While the government benefits from savings through PBS reforms which take advantage of the lower prices of generic medications, there has been little policy focus on realising the potential of direct savings for the public. Although there has been some success in this matter through the existing incentive payment for pharmacists who offer patients generic alternatives to the branded medications prescribed by their GPs, there is still considerable competition to this from the potential profits available to pharmacists who sell branded medication. Moreover, research suggests that, as Australians place great trust in the advice of GPs, they are unlikely to ask for a pharmaceutical product other than the one named on their prescription.

Current government advice to Australians is that they ask their GPs to prescribe a generic medication where possible or, alternatively, to ask the pharmacist for a generic product when the prescription is being dispensed. However, survey findings show that, at best, less than half of those respondents who believed they could save money by purchasing a generic alternative actually requested such an option from their pharmacists. This finding indicates, therefore, that lack of awareness is not the main barrier to raising the rate of generic medication use in Australia.

The limited focus of government policy on delivering personal savings to Australians through the promotion of generic medications means that this role has fallen to GPs and pharmacists. However, although pharmacists appear to have taken on this role in responding to incentive payments offered by the government. Whereas GPs who are not offered such incentives do not appear to have done so.

The kinds of computer-generated prescriptions used currently by many GPs provide a means of increasing the rate at which generic medications are prescribed. Some existing prescription programs have 'equivalency' functions that will list all medication options that contain a specific active ingredient. This function could be automated so that it is the active ingredient which is prescribed rather than brand name of a medication – except in instances in which the "no brand substitution" box is marked. This process would not alter the existing processes followed by GPs, pharmacists or the public. The government set a precedent for this type of change in 2008 when it prohibited default settings that checked the "no brand substitution" box. Furthermore, automatically prescribing medications by their active ingredient would reduce reliance on consumer awareness to secure for themselves the more affordable health care which legislation is designed to provide but does not.

In the interim, an explicit, government-funded publicity campaign could be launched as a way of educating members of the public about the savings they can make by opting for generic medications. A requirement to post large signs in GP waiting rooms, surgeries and on the desks of GPs and in similar positions in pharmacies, encouraging individuals to ask for generic

medications. A simple message such as “same drug – different price” would help prompt patients to ask that their prescriptions be for generic products, thereby reminding them both in the surgery and at the point of sale that they can to some extent reduce their medical costs in this way.

5.3 Standard referral forms

The use of branded pathology referral forms was an easy way for GPs to meet an earlier legislative requirement, now amended, that they refer patients to a particular service provider. The only remaining purpose these branded forms serve is to capture market share for private medical service providers by making it easy for GPs to refer patients on stationary that list the addresses for businesses which could perform the tests. So the government could make standard referral forms mandatory as a way of reinforcing recent legislative changes and in doing so remove the tacit instruction that patients use particular service providers for their pathology and imaging tests. Such a form would provide the address details for a range of public and private providers, thereby increasing patient understanding that the choice of service provider is theirs to make.

The new forms should also include a prominent field in which GPs would enter an estimate of the cost which is likely to be incurred if the patient does not go to a public provider or is not bulk billed. This requirement would go some way to highlighting the fact that it is the prerogative of GPs to determine whether diagnostic services are bulk billed. The impact of this increased transparency would hopefully encourage patients to question the cost of tests, should GPs fail to broach the topic. It is certainly preferable that patients be well informed about their capacity to choose health care providers for this kind of testing and particularly that they are able to inquire about the costs they will incur ahead of time so that they can factor those costs into their personal budgets.

So, rather than viewing the referral form as an order for a test at a specific location, this change would mean that patients would still see a referral form as an instruction to undergo a test but not an instruction to undergo that test at a particular business. The expected costs would be made clear on the document and patients would be able to discuss these costs with their GPs, enabling them to better understand the billing system and foregrounding the extent to which the health care a patient anticipates receiving will be ‘fair and affordable’.

6 Conclusion

It can no longer be assumed that Medicare provides all Australians with a universal health insurance scheme and that the Pharmaceutical Benefits Scheme (PBS) ensures affordable prescription medications. While these two structures are in place to deliver equitable access to medical care for all Australians, many are missing out on receiving care which is genuinely ‘fair and affordable’. Whether it be the 22.3 million times Australians paid extra money to see the doctor in 2009-10 or the three out of ten imaging tests that resulted in gap fess being levied for the 5.7 million tests conducted in the same year, this paper shows that the government needs to be more focused on patients and less on providing a market for medical services and medication when developing health funding policies.

Unfortunately, private providers applying additional costs such as gap fees and mark-ups on pharmaceuticals undermines the equitable access to medical care that Medicare is intended to provide. The freedom which allows business owners to charge fees in excess of what Medicare covers for GP visits and routine diagnostic services as well as brand premiums and pharmacy profits on prescription medications add up to more than $1 billion a year in extra health care costs for Australians. Though it is fair to allow business owners the chance to set their own profit margins, when this freedom affects the extent to which Australians can access health care, the government is obliged to make changes that will ensure the equity of access to health care.

These figures are also concerning because research suggests that, when health care costs are too high, some Australians will simply not seek this care when they need it. Prohibitively high pricing can be such a financial burden that, in some cases, patients who would like to seek medical advice, have prescriptions filled or follow up referrals choose to postpone these things or even to abandon them entirely. In other words, a health funding model which purports to make health care universally available yet allows private providers to charge an additional fee is failing to achieve this aim.

The favourable rebates offered as part of the MBS were designed to encouraging GPs to bulk bill patients. At present, however, this system does not function as intended because, in practice, many GPs and specialists charge higher rates which exceed the Medicare rebate, requiring that a gap fee be paid by patients.

To counteract this practice, the government has already introduced targeted incentive payments that aim to increase the rate at which GPs bulk bill concession card holders. At present, one fifth of visits to the doctor incur gap fees, adding up to an estimated $541 million per annum. Incentives for GPs to bulk bill concession card holders also appear to be limited in their effectiveness with 18 per cent of card holders reporting that they had to pay for their last visit to a GP. As a result, these high additional costs result in one in twenty people postponing visits to the doctor. The inadequacy of this measure has been reported in this paper and is also evident in the instigation of Safety Net policies for patients who incur sizeable medical costs.

A similar amount of money is paid in gap fees for diagnostic testing by Australians. The charging of gap fees for pathology sits between 15 and 18 per cent of referrals and twice as many imaging referrals incur these additional charges. The fact that 90 per cent of diagnostic services are currently provided by private companies goes some way to explaining why half a million dollars is being paid by members of the public to cover the fees which exceed the government-funded Medicare rebates.

A similar situation exists in relation to policies surrounding prescription medication: pharmacists are paid an incentive to provide premium-free or generic medications and there is a safety net for individuals whose medication costs are high. Despite these policies, the flaws in the current systems mean that many Australians still pay unnecessarily high medical costs when there is an opportunity for much of their expenses to be covered by the government.

Despite the availability of subsidised prescription medication, almost a quarter of survey respondents reported they had put off or avoided having a prescription filled. The combined cost to individuals of brand premiums on pharmaceuticals and instances of patients neglecting their own eligibility for Safety Net savings add another $64 million to the already high out of pocket health bills of Australians. Furthermore, even though there is moderate awareness about the savings available by selecting generic medications over branded alternatives, these opportunities are not yet being taken up by Australians. This can be explained by the high degree of trust patients place in GPs who, in the past decade, have not increased the rate at which they prescribe generic medications. Indeed, because of general compliance with ‘doctors’ orders’ policies which focus on consumer contact with pharmacies to achieve greater up-take of generic medications are limiting the potential to bring about the kind of change the government desires to see.

More action is needed in order to reduce the financial burden placed on individuals for their own health care. Government policy should change its incentive-based approaches which supposedly lure GPs, pharmacists and private diagnostic testing companies towards the ‘fair and affordable’ provision of health care and start to insist upon it through better legislation. Evidence reported in this paper point to the following policy options:

- automating Safety Nets in order to enable members of the Australian public to take advantage of the savings to which they are entitled.
- requiring prescription software to default to the active ingredient and not a brand name (except where the “no brand substitution” box is checked) as a way of improving the low rate at which GPs prescribe generic medications.
- instigating a publicity campaign to inform patients about the choices they can make in regard to medication with prominent signs which would be displayed in GP offices, encouraging patients to ask for generic medications.
- mandating the use of government-supplied referral forms for diagnostic tests which require an estimate of the likely cost of the procedures and provide a variety of public and private locations at which the tests may be undergone in order to reinforce and extend recent legislative changes.

Appendix: Survey questionnaire

The survey for this paper was conducted online using a geographically based representative sample. The survey was conducted in March 2011 and asked people about both their health care costs and knowledge about generic medications and bulk billing. Findings from this survey were used throughout the main section of this paper. The survey questions are included below.

Q1. Please think about the last time you went to a GP. Did you …?

- Have to pay money
- Not have to pay any money (because your consultation was 'bulk-billed')
- Not sure

Q2. In order to see a GP who would not charge you for a consultation, how long would you have to travel from home? Please make your best estimate.

- Less than 10 minutes
- 10 to 20 mins
- 20 – 30 mins
- Between half an hour and an hour
- More than an hour
- Not sure

Q3. In the past month, how many prescriptions have you had filled at a pharmacy?

- None
- 1
- 2-4
- 5-10
- More than 10
- Not sure

Q4. In the past year, have you put off or avoided buying prescription medicine because you could not afford it?

- Yes
- No
- Can't remember

Q5. Do you know what a generic medicine is?

- Yes
- No

Q6. How did you first find out about generic medicines?

- From a doctor
- From a pharmacy
- Saw an advertisement/promotion
- Brochure from the GP
- Brochure from Medicare/government
- A family member or friend told me
- Other

- Can't remember

Q7. To the best of your knowledge, in the past 12 months has a GP deliberately prescribed you a generic medicine rather than a brand-name medicine?

- Yes
- No
- Not sure

Q8. How did you know that the medicine was generic rather than brand-name?

- The GP told me
- I worked it out myself
- I asked about the medicine I was prescribed
- The pharmacist told me
- It was cheaper
- Other reason

Q9. In the past 12 months, has a pharmacist offered you a generic alternative to the medicine a GP prescribed?

- Yes
- No
- Not sure

Q10. In the past 12 months, have you asked a pharmacist for a generic version of the medication you have been prescribed by a GP?

- Yes
- No
- Not sure

Q11. If you choose a generic medicine rather than a brand-name medicine, who do you think receives the biggest financial benefit?

- Me
- The government/taxpayers
- The pharmacy
- A pharmaceutical company
- Not sure

Q12. When were you last sent somewhere else by a GP for a medical test? (e.g. a pathology clinic)

- Within the past month
- Within the past six months
- Within the past year
- More than a year ago
- Not sure

Q13. How did you know where to go for the test?

- The GP told me where to go
- I asked the GP's receptionist where to go

- The address was on the form the GP gave me
- I already knew where to go
- A friend or family member told me where to go
- I contacted a hospital
- Looked it up in the phone book or on the internet
- I rang Medicare to find out where to go
- Other
- Not sure

Q14. What type of test was it?

- Pathology (e.g. blood test)
- Diagnostic Imaging (e.g. x-ray, ultrasound, MRI)
- Other kind of test
- Not sure

Q15. Did you have to pay anything for the test?

- Yes
- No
- Don’t remember

Q16. As far as you know, who decides whether you pay any money for a medical test?

- My GP
- The clinic/service I go to for the test
- The government
- Not sure

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