

# A Free Basic Medical Service for Families Most in Need?

Basic medical care services represent a key support to parents in their task of fostering the healthy development of family members. Ready access to such services when required is thus integral to the concept of equity and social justice. One important element of access is affordability: do families most in need of a free service receive it?

**T**he introduction of Medicare – a universal system of health insurance in Australia – was designed to ensure that all families could afford to consult their doctor when needed. Under the Medicare system, payment arrangements are left to the discretion of doctors. One method of payment is bulk billing (sometimes called direct billing) which provides free services for patients, with doctors claiming fees directly from the Health Insurance Commission and receiving 85 per cent of the scheduled fee. The other method of payment is private billing, whereby patients pay any difference between the fee charged by their doctor and the rebate they receive from the Health Insurance Commission.

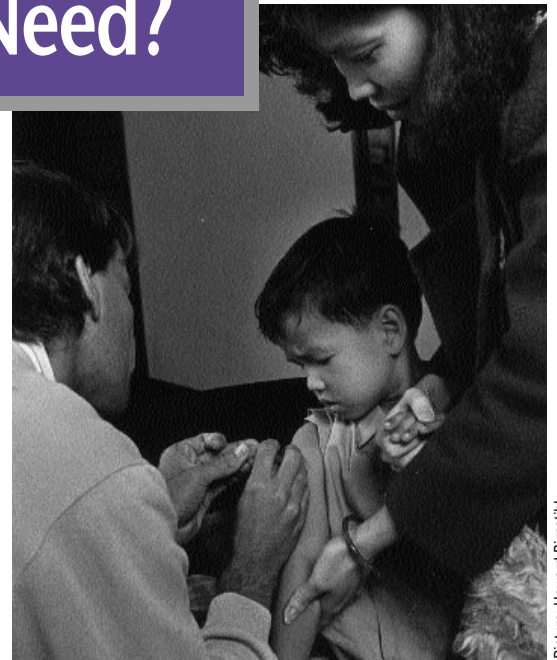
The success of Medicare in removing financial barriers to patients' access to basic medical care thus depends on whether or not families with pressing financial problems live in reasonable proximity to services that offer bulk billing. This raises the issue of whether residential location affects the chances of a free medical service for poor families.

Those doctors who decide to restrict bulk billing to certain groups, including low income families, need to be able to identify which of their families are in financial need. According to Deeble (1991), most doctors bulk bill routinely for Department of Social Security pensioners and beneficiaries ('DSS families') and selectively for others, but how adequate is DSS status as an indicator of financial need? The following analysis is based on data from the Australian Living Standards Study (ALSS), focusing on reports of families in the nine urban ALSS areas and in two rural areas – the Riverland and Roma/Bungil. (A description of the ALSS sample appears on pages 6–7 of this issue.)

## Locational Differences

The majority of families reported that they mostly attended a doctor in private practice or in a private medical centre (78 to 98 per

**RUTH WESTON** examines the level of success of Medicare in enabling low income families to receive free basic medical care.



Picture: Howard Birnstihl

cent in each study area), with all members of most families attending this type of service. Those who did not use a private doctor tended to visit either a community health centre (applying to 14 per cent of Melbourne families and 20 per cent of families in the Riverland) or public hospital outpatient/casualty service (1 to 9 per cent). Few families mentioned other types of services (for example, an employer-provided medical service, naturopath, or homoeopath). Most families in all study areas managed to get to their medical service in less than ten minutes (59 to 73 per cent).

The proportion of all families who were bulk billed varied according to locality. Two sets of figures concerning bulk billing rates for each study area are presented in Table 1. The first refers to Medicare data concerning the proportion of services that were bulk billed in 1993–94 by non-specialist medical practitioners who practised in each study area, while the second refers to the proportion of families who said they were not charged for basic consultations within normal hours.<sup>1</sup>

The Medicare data refer to all services, including those provided to elderly clients, disproportionate numbers of whom would be

pensioners and/or would have health problems requiring frequent visits to a doctor. The ALSS sample of families contained very few elderly people, for this sample was drawn from the population of families with at least one child under the age of 20 years. Furthermore, the Medicare data are based on services of doctors practising in the study area, while some families attended doctors who practised elsewhere (Weston and Lazarini 1995).

Nevertheless, both sets of bulk billing data suggest that Box Hill and Berwick had the lowest rates of bulk billing for urban local government areas (here called 'low bulk billing urban areas'), followed by Ryde, Werribee and Melbourne ('moderate bulk billing urban areas'). For all other urban areas, over 90 per cent of services were bulk billed, and more than 70 per cent of families reported no charges ('high bulk billing urban areas').

Bulk billing was very unusual in the Riverland, with only 2 per cent of families appearing to be bulk billed, and only 15 per cent of services being bulk billed. In relation to the proportion of families bulk billed, Roma/Bungil is most similar to the moderate bulk billing urban areas, and in relation to

**Table 1** Estimates of bulk billing rates for basic medical services by study area: percentage distribution

	Riv. Roma/ Bungil	Bwk	Wbee	C'town	Pen.	Eliz./ M.Para	Box Hill	Ryde	Melb.	Sth Syd.
Services bulk billed*	15	68	73	79	92	92	66	81	81	95
Families bulk billed	2	53	37	52	76	82	27	45	64	79

\* Source: Department of Human Services and Health – Medicare Claims Data File, 1993–94.

the proportion of services bulk billed, Roma/Bungil is most similar to the low bulk billing urban areas. Unless otherwise stated, the concept of 'bulk billing rates' will, throughout this report, refer to the proportion of families who indicated that they were not charged fees.

### Indicators of Financial Need

Two indicators of financial need are employed in the following analysis: being a DSS family and being financially poor (based on the Henderson poverty line). Families with incomes below the poverty line are called 'very poor', while those with incomes of up to 120 per cent of the poverty line are called 'poor', in line with recommendations of the Commission of Inquiry into Poverty (1975).

When DSS status is used as the indicator of financial status, then Medicare's discretionary system seemed successful in providing a free service to most of those in need, except in the Riverland where 96 per cent of DSS families paid fees.<sup>2</sup> However, there was also variability between other areas in the availability of bulk billing to DSS families. Those in Box Hill, Berwick and Werribee were twice as likely to report payment of fees as families in Ryde (20 to 21 per cent versus 10 per cent), and at least three times as likely as families in the other urban areas to pay fees (where only 2 to 7 per cent paid fees). In Roma/Bungil, 14 per cent of DSS families reported paying fees.

The picture is less rosy when poverty is used as the indicator of financial need.<sup>3</sup> Fifty per cent of financially poor families in Berwick and 44 per cent in Box Hill paid fees. Poor families in these low bulk billing areas were four to five times as likely to pay fees as their counterparts in Penrith or Campbelltown (where around 10 per cent paid fees). In Ryde and Werribee, around one third of the poor were paying fees, while fees were reported by 28 per cent of poor families in Roma/Bungil. In the Riverland, fees were paid by 97 per cent of poor families, 96 per cent of those with household incomes of at least 200 per cent of the poverty line, and all families with incomes between these two levels.

Despite these trends, the likelihood of a family being bulk billed was still greater for disadvantaged families living in most study areas. The areas in which this did not apply (other than the Riverland) tended to be characterised by relatively high rather than low rates of bulk billing for all families. In other words, relatively high rates of bulk billing were likely for the advantaged and disadvantaged in high bulk billing areas, and were more likely for the disadvantaged than advantaged in all other study areas apart from the Riverland.

If Medicare is successful in providing access to basic health services to all people on the basis of need rather than income, then high proportions of poor families would be bulk billed, regardless of where they live. However, because doctors (like many service providers) rely on DSS status as an indicator of financial status, some poor families missed out on bulk billing.

### DSS Status as a Means Test

Figure 1, which refers to families in all areas except the Riverland, suggests that DSS families who were not poor were more likely to be bulk billed than non-DSS families who were poor. At each level of income in which DSS families were represented, these families were more likely to be bulk billed than their non-DSS counterparts. Thus, poverty, *per se*, did not necessarily enable access to a free service.

Such trends are consistent with Deacon and Bradshaw's (1983) concept of 'passport benefits': these authors noted that pensions/benefits are used by some service providers in Britain as a passport for eligibility to a range of free services, obviating the need for a separate means test.

Poverty rates and the proportion of poor families who were non-DSS families varied with locality. The highest rates of poverty were found in Elizabeth/Munno Para (45 per cent) and the two rural areas: 41 per cent of non-farm families in the Riverland and 35 per cent in Roma/Bungil were poor. Of all non-farm families who were poor, 62 per cent in Roma/Bungil and 54 per cent in the Riverland were non-DSS families. Thus, non-receipt of a DSS pension/benefit in these areas was by no means a reasonable indication that a family could afford to pay fees. In the urban areas, the proportion of poor families who were non-DSS families ranged from 34 per cent (Elizabeth/Munno Para) to 69 per cent (Ryde).

### Conclusion

In summary, Medicare's discretionary system of fee setting failed to benefit low income families in the Riverland. These families (along with all other families in the Riverland) were very unlikely to receive a free service. In some of the other study areas, a relatively high bulk billing rate applied to the socio-economically advantaged as well as the disadvantaged, while in

others, disadvantaged families seemed more likely than other families to be bulk billed. This is not surprising in urban areas, for most families would be able to 'shop around' for a service which best meets their priorities.

Of the urban poor families who were not bulk billed, some may have had little choice in doctors, owing to lack of private transport, while others may have chosen to pay fees to see a doctor who met other needs (for example, a doctor who understood their cultural background). In other words, different aspects of access may have competed with each other.

Except in the Riverland, bulk billing was particularly likely to apply to families who received DSS pensions or benefits, although some locational differences were apparent. Receipt of a DSS pension/benefit is a convenient method of assessing financial need, but poverty is by no means exclusive to such families. Indeed, in low bulk billing urban areas, a free service was more likely to be reported by DSS families who were not poor than by non-DSS families who were poor.

Thus, where DSS status is being used as a 'means test' for bulk billing, some families with the greatest need will continue to have difficulties using basic medical services. This raises the question of whether there are additional practicable ways by which financial need can be assessed.

### Notes

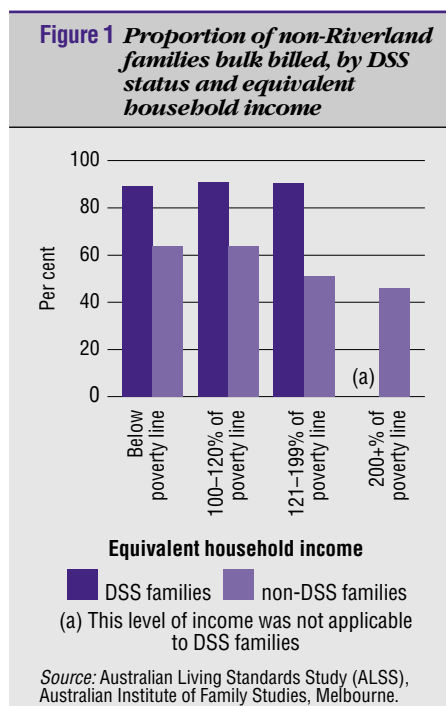
<sup>1</sup> No more than 6 per cent of families in each area mentioned fees of \$2.50, which could be applied from December 1991 to beginning of March 1992, when the Government introduced a 'co-payment' system for non-pensioners/beneficiaries. No information was derived about possible variations in bulk billing or fees charged between family members or across consultations.

<sup>2</sup> Even if fees of \$2.50 are interpreted as the bulk billing plus co-payment that the Government introduced for a short period, bulk billing would have only applied to 15 per cent of DSS families in the Riverland.

<sup>3</sup> Compared with low income non-DSS families, low income DSS families were more likely to be sole-mother families (52 per cent compared with 3 per cent), slightly more likely to have a parent with a poor command of English (12 per cent compared with 7 per cent) and, not surprisingly, less likely to have a parent holding some paid work (10 per cent compared with 86 per cent).

### References

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