Medicare: a quick guide

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Introduction

Medicare is Australia’s national health insurance scheme which subsidises the cost of many medical and allied health services. Medicare commenced on 1 February 1984, following the passage of the Health Legislation Amendment Act 1983 and related legislation in September 1983. At the time, Minister for Health Dr Neal Blewett described Medicare as ‘a major social reform’ which aimed ‘to produce a simple, fair, affordable insurance system that provides basic health cover to all Australians’. Medicare is largely based on the short-lived Medibank scheme, introduced by the Whitlam Labor Government in 1975 but which was later dismantled by the Fraser Coalition Government. Since being introduced, Medicare has undergone some major changes including subsidising expensive new technologies (such as PET scans), adding preventive health checks and funding new ways of delivering health care (such as team care for chronic disease management).

This Quick Guide updates the archived 2004 Parliamentary Library publication Medicare—a Background Brief with a focus on developments over the last decade. It describes the range of services and benefits now covered by Medicare, as well as eligibility requirements, billing practices, financing arrangements, safety nets, statistics on bulk billing and expenditure, significant issues and challenges.

Medical Benefits Schedule

Medicare operates by paying a specified benefit (in the form of a rebate) for a health or medical service for which a claim is submitted. Only services provided by private practitioners (the majority of Australian doctors work in private practice) are covered by Medicare. Services provided in a public hospital only attract a Medicare benefit if the patient elects to be treated as a private patient.

Services covered by Medicare benefits are mandated in specified tables, published as the Medical Benefits Schedule (MBS). Only clinically relevant services are eligible for benefits. A clinically relevant service is one which is generally accepted by the relevant profession as necessary for the appropriate treatment of the patient. Certain services are specifically excluded including medical examinations for insurance purposes, mass immunisations and services for which a state health service or third party insurer is responsible. Regulations can also specify that other services be excluded.

Each service listed in the MBS has an item number, a descriptor which outlines the type and scope of the service and relevant clinical requirements, the Medicare schedule fee, the applicable Medicare benefit, and any additional safety net benefits.

Most items listed in the MBS are remunerated on a fee for service basis. However, in recent years other types of practitioner payment methods (such as incentive payments for managing certain chronic conditions or for bulk billing certain categories of patients) have been introduced.
Medicare benefits

The level of Medicare benefit is calculated as a percentage of a mandated schedule fee for the service, and varies on the setting. A service provided in hospital attracts a benefit equal to 75% of the schedule fee; a service provided out of hospital generally attracts a benefit of 85%. In the case of non-referred attendances (those provided by a general practitioner (GP)) the benefit is set at 100% of the schedule fee. If the health practitioner chooses to bulk bill, they receive the Medicare benefit as full payment for the service and the patient pays nothing (bulk billing is discussed in further detail below).

Medicare claims and payments are administered by the Department of Human Services. The operation of Medicare itself is governed by provisions in the Health Insurance Act 1973 and related regulations. The Minister for Health has overall responsibility for Medicare.

Updates to the Medical Benefits Schedule

The MBS is updated regularly to reflect changes to the scope of services due to changes in clinical practice, the addition of new services or the deletion of obsolete services, as well as to allow for the regular adjustment of fees. Such changes do not require amending legislation but are specified in a regulation which is classified as a legislative instrument and may be subject to disallowance arrangements.

New services and treatments are assessed by the Medical Services Advisory Committee, an independent expert committee which advises the Minister for Health on the comparative safety, clinical effectiveness and cost-effectiveness of any proposed medical service or technology, and recommends the circumstances under which MBS listing should be supported.

The MBS currently contains around 5,754 items and covers a much wider range of services from when it first commenced. Originally limited to professional medical services, pathology, radiology, acupuncture, dental services for palate deformities and optometry, the MBS now includes technologies such as PET and MRI scans, as well as new types of care arrangements such as team care and chronic disease management. Allied health services were added in 2004, nursing and midwifery in 2010 and telehealth consultations in 2011. The Department of Health lists some of these key developments on this webpage.

In the 2014–15 budget, a two year pause in the indexation of the scheduled fee for most MBS services was announced—GP services, pathology and diagnostic imaging were originally exempt. This pause was expanded at the 2014–15 Mid-Year Economic and Fiscal Outlook (MYEFO) to include GP services, and the duration was extended to 2018. Because the MBS benefit is calculated as a percentage of the schedule fee, the pause has the effect of freezing both the patient rebate and the rebate paid to the doctor if they bulk bill.

In April 2015, the Health Minister Sussan Ley announced the establishment of a Medicare Benefits Schedule Review Taskforce to undertake a major review of all Medicare items to ensure ‘services can be aligned with contemporary clinical evidence and improve health outcomes for patients’. Many of the items on the MBS have never been assessed or changed since their introduction. An interim report provided to the Minister in December 2015, recommended the removal of 23 services which were regarded as obsolete. A second report is due at the end of 2016.

Bulk billing

Bulk billing is where the practitioner directly bills the Department of Human Services for the service and accepts the Medicare benefit as full payment. Bulk billing is not mandatory; practitioners are free to decide whether to bulk bill or privately bill the patient. If a patient is bulk billed they cannot be charged a co-payment or an additional fee, making the service free to the patient. In 2004 the Coalition Government introduced bulk billing incentives, an additional payment to encourage GPs to bulk bill children and concessional patients. This included a higher incentive to bulk bill these groups in rural and regional areas. Bulk billing incentives for pathology and diagnostic imaging were introduced by the Labor Government in 2009.

A patient who is not bulk billed will be issued an account by their health provider. This usually means the patient must pay up-front and then claim the rebate from the Department of Human Services. Many practices now offer electronic claiming, making payment of the rebate to the patient virtually instantaneous.

Nationally, as at September 2015, across all Medicare services, the bulk billing rate was around 77.4% (Medicare Statistics, Table 1.1). However, for GP services the rate is higher at around 84.0%. The highest level of bulk billing is for Practice Nurse items (99.5%). For specialists, the bulk billing rate is considerably lower, around 30.0% with Anaesthetics recording the lowest rate (10.1%).
Bulk billing rates vary across regions. Generally, higher rates are seen in regions with a higher density of health practitioners, such as metropolitan areas and where competitive pressures apply. But bulk billing rates can be relatively high in areas with significant levels of socio-economic disadvantage. For example, regions of Western Sydney regularly record the highest GP bulk billing rates, while the more affluent suburbs of North Sydney have lower rates, likely reflecting the differing incomes and capacity to pay of residents in each community. The type of practice can also influence bulk billing levels. A number of so-called ‘corporate practices,’ (GP clinics owned by a single company usually employing GPs under contract) often market themselves as exclusively offering bulk billing.

While a $7 patient co-payment was proposed in the 2014–15 budget, it was subsequently ruled out by the new Health Minister Sussan Ley in early 2015, following criticism from medical, health and consumer groups.

**Eligibility for Medicare**

**Patients**

Australian residents are eligible for Medicare provided they:

- hold Australian citizenship or
- hold documented New Zealand citizenship and are lawfully living in Australia or
- have been issued with a permanent visa or
- have either applied for a permanent visa, excluding an application for a parent visa, or have permission to work in Australia or can prove a relationship to an Australian citizen or permanent resident.

Norfolk Island residents, previously excluded from Medicare, will be eligible from July 2016.

In addition, if a reciprocal health care agreement with another country has been signed, residents of these countries who are visiting Australia have restricted access to Medicare.

Medicare benefits are not available for prisoners or those covered by third party insurance arrangements (such as life insurance).

**Provider eligibility**

To be eligible to provide a Medicare service a medical practitioner must meet certain criteria. They must either be:

- a recognised specialist, consultant physician or general practitioner or
- in an approved training placement under section 3GA of the Health Insurance Act 1973 or
- a temporary resident doctor with an exemption under section 19AB of the Health Insurance Act 1973, and working in accord with that exemption.

Non-medical health professionals such as allied health providers, dentists, nurses and midwives must be registered according to State or Territory law or be members of a professional association with uniform national registration requirements, and registered with the Department of Human Services.

All professionals wanting to bill Medicare must also obtain a Medicare provider number from the Department of Human Services.

**Overseas trained doctors**

Section 19AB of the Health Insurance Act 1973 specifies restrictions that limit overseas trained doctors (including New Zealand trained doctors) and former overseas medical students trained in Australia, from claiming Medicare benefits for 10 years. However, an exemption can be obtained by working in a designated district of workforce shortage for a minimum period. In addition, working in designated remote areas can reduce the period of time they would normally have to wait to offer services covered by Medicare.

**How is Medicare funded?**

Medicare is primarily financed through taxation, which includes the imposition of a Medicare levy on taxable income.

**Medicare levy**

The Medicare levy is currently set at 2% of personal taxable income (with certain exemptions).
Exemptions from paying the levy are specified in the Part VIIB of the *Income Tax Assessment Act 1936* and include: foreign residents and residents of Norfolk Island (the latter will become liable for the levy from July 2016), certain persons not entitled to Medicare benefits, members of the Australian Defence Force, Veterans entitled to free medical treatment due to disability, age pensioners and those on Disability Support Pensions, and those who meet certain medical requirements. There are also exemptions and phase-in limits for low income earners and pensioners which are adjusted annually.

New Zealand citizens lawfully residing in Australia are liable for the levy.

The rate of the Medicare levy has been adjusted several times, usually to help fund increased Medicare costs. When first introduced it was set at 1% of taxable income. A temporary addition to the levy of 0.2% was imposed in 1996 to help fund the Commonwealth’s gun buy back scheme after the Port Arthur massacre. In July 2014, the levy was raised from 1.5% to 2% of taxable income to help fund the new National Disability Insurance Scheme (NDIS). As a consequence of this latter change, the levy has been renamed the Medicare and DisabilityCare Levy.

Most of the revenue raised by the Medicare levy is not hypothecated and goes into consolidated revenue. A proportion is being directed to the newly established Disability Care Australia Fund which helps fund the NDIS.

**Medicare levy surcharge**

In July 1997, a Medicare Levy Surcharge (MLS) was introduced. This made high income earners who do not hold appropriate private hospital cover liable for an additional surcharge of 1% on their taxable income. The MLS was one of a suite of measures (the others being the Lifetime Health Cover loading and the private health insurance rebate) the Howard Government introduced to try to reverse declining private health insurance membership.

In July 2012, the MLS was raised so that those on the highest incomes (individuals on incomes over $140,000 and families with incomes over $280,000) are now liable for a 1.5% surcharge if they don’t purchase hospital cover.

Consumers who purchase appropriate private hospital cover from a registered insurer may also be eligible for the means-tested private health insurance rebate, which provides a discount on their premium. Appropriate cover must have an excess of $500 or less for individuals or $1,000 or less for couples and families.

**Does the Medicare levy cover the full cost of Medicare?**

Revenue from the Medicare levy and MLS only partially covers the annual cost of Medicare. The remaining cost of Medicare is met through general taxation revenue. In 2013–14, the Medicare levy and the MLS together raised around $10.2 billion according to Australian Taxation Office statistics. In that year, Medicare benefits totalled $19.1 billion, according to the annual Medicare statistics. Together, the levy and MLS met 53.4% of the cost of Medicare. In 1984–85, the first year of Medicare, expenditure totalled $2.27 billion while the levy raised $1.03 billion—around 45% of Medicare’s cost.

In 2014–15, Medicare funded over 373.4 million services and paid benefits totalling around $20.5 billion. The Parliamentary Budget Office (PBO) has forecast that government expenditure on Medicare will grow to $36.6 billion by 2025–26, up from $20.2 billion in 2014–15. While the PBO notes that past growth in spending is attributable to policy changes that broadened Medicare’s scope or increased benefits, future growth is forecast to slow, in part due to the indexation pause that was introduced in 2014–15.

**Safety nets**

Medicare helps fund many services, but patients may still be liable for out of pocket costs when the doctor or practitioner chooses not to bulk bill. Medicare sets a minimum fee for services (the schedule fee) and the rebate amount (see above), but practitioners are still free to set their own fees. Some doctors may set their fees well above the schedule fee particularly where competitive pressures are weaker and bulk billing rates are low. This means that their patients may face high out of pocket costs even after receiving a Medicare rebate.

Patients may be eligible for one or more of the Medicare safety nets. Current Medicare safety net arrangements comprise three components: the Original Medicare Safety Net (OMSN) introduced in 1984, the Extended Medicare Safety Net (EMSN) introduced in 2004 and the Greatest Permissible Gap (GPG) which has been present since Medicare’s inception.

The OMSN reimburses patients when they incur ‘gap expenses’ for out of hospital services above a set threshold. ‘Gap expenses’ are defined as the difference between the Medicare rebate (85% of the schedule fee) and the Medicare schedule fee. Once gap expenses exceed the threshold, patients receive 100%
reimbursement of the schedule fee for the remainder of the calendar year. In addition to this, the GPG ensures the gap between the MBS fee and the 85% rebate for out of hospital services cannot exceed the GPG amount (which is indexed annually to CPI).

The EMSN was introduced to provide an additional benefit to families and individuals experiencing high out of pocket costs due to the growing gap between the Medicare schedule fee and fees charged by doctors, particularly specialists. The EMSN benefit (which is in addition to the Medicare benefit) applies when a patient’s out of pocket expenditure on out of hospital services exceeds an annual threshold. Once this threshold is reached, patients are reimbursed 80 per cent of any further out of pocket costs they incur on out of hospital services for the rest of the calendar year.

In 2009, a review found that EMSN expenditure was growing at a faster rate than Medicare spending and was contributing to a significant increase in average provider fees, particularly for some specialities. It found that the majority of EMSN benefits were being distributed to the more socio-economically advantaged and had little impact on the most disadvantaged. Some 55% of EMSN benefits went to the top income quintile, while the lowest income quintile received less than 3.5%. Consequently, the Government introduced caps on EMSN benefits for selected out of hospital MBS items identified as having excessive average fees (initially obstetrics, pregnancy related ultrasounds, cataract surgery, hair transplantation, and varicose vein procedure). Capping now applies to most out of hospital services, with the cap amounts specified in the MBS. For capped EMSN services, reimbursement is the lower of the specified benefit cap or 80% of any subsequent out of pocket costs for the remainder of the calendar year once the EMSN threshold is reached.

In the 2014-15 budget, it was announced that from January 2016 the existing Medicare safety net arrangements comprising the OMSN, the EMSN and the GPG would be replaced by a new simplified safety net. The new Medicare Safety Net would have lower out of pocket expenditure thresholds—$400 for concessional singles and concessional families, $700 for non-concessional Family Tax Benefit-A families and non-concessional singles, and $1000 for non-concessional families who do not qualify for FTB-A. The total benefit payable (rebate plus safety net) would be capped at 150% of the MBS fee. Legislation to enact this measure was introduced to Parliament, but lapsed with the prorogation of Parliament.

**Medicare statistics**

A range of statistics on Medicare is available.

The Department of Health produces quarterly and annual statistics on bulk billing rates, including by broad type of service (for example, GPs, specialists and pathology). The release also includes data on the number of Medicare services claimed, total benefits paid and the average patient contribution for these services (or average out of pocket cost). Data is broken down by state and geographic classification (that is, remoteness), but not by electorate.

In addition, data on individual Medicare item numbers (services claimed and benefits paid) is also available from the Department of Human Services. Data can be disaggregated by patient demographics (age and gender), by state and by time period (monthly, quarterly, annually) and as a per capita figure. Also available is data on number of services and benefits by broad category of service. The website also hosts historical Medicare data on bulk billing by electorate and safety net benefits (although not current figures).

Other agencies also report Medicare data. The Productivity Commission’s annual Report on Government Services reports a range of Medicare statistics, for example, details of MBS funded primary care and mental health services, and use of Medicare by Aboriginal and Torres Strait Islanders.

Data on the My Healthy Communities website uses Medicare data for many of its reports, including reports on the average number of GP and specialist attendances and average Medicare benefit paid per person, broken down by Primary Health Network.

Occasionally, Medicare data is provided in response to Parliamentary questions on notice. This is usually provided through the Senate Estimates process, with the answers appearing on the relevant Committee’s webpage.

**Challenges**

While all Australians are eligible for Medicare and most pay a Medicare levy, ensuring that all can access Medicare benefits when they need to remains a challenge. For example, people in some rural, regional and outer metropolitan areas face barriers due to a lack of Medicare funded services resulting from the distribution...
of the medical workforce. This has a particular impact on Aboriginal and Torres Strait Islander people, who may also face cultural and language barriers.

Another issue is rising patient out of pocket costs in the form of co-payments. Nearly ten percent of adults living in some parts of Australia reported delaying or avoiding seeing a GP due to cost. Accessing affordable specialist care where co-payments are more common, remains problematic particularly for those on low incomes. Some specialists’ fees are set well above the Medicare Schedule fee, while bulk billing rates are low. As the indexation pause introduced in the 2014-15 budget continues, stakeholders such as the AMA have warned that GPs may have to abandon bulk billing and pass costs on to patients as co-payments.

Other challenges include managing the cost implications associated with the rise of chronic diseases and the ageing of the population, funding innovative but sometimes expensive new therapies, improving integration of services across multiple settings (eg primary care and acute care) and maintaining health care quality. Emerging issues include ‘diagnosis creep’, personalised medicine and the role of private health insurance in primary care.

Further reading
Department of Health, ‘History of key MBS primary care initiatives 1999-2013’.