

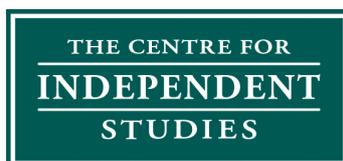
Towards a more competitive Medicare: The case for deregulating medical fees and co-payments in Australia

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Contents

Executive Summary1

Introduction.....3

History: *The Schedule Fee*, Medicare and bulk billing4

Co-payments *versus* bulk billing5

Gap cover for out-of-pocket costs7

Impact of gap cover on fee setting8

The anti-competitive effect of the *Schedule Fee*8

The competitive effect of abolishing the *Schedule Fee*.....9

AMA Fee List and competition policy..... 11

Conclusion..... 12

Endnotes..... 13

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Executive Summary

The complicated and erratic history of the way federal government has attempted to restrict doctor remuneration in Australia has yielded no success in either controlling or influencing what they charge or what patients face in out-of-pocket payments for the cost of their care.

Since at least the 1960s, the issue of medical fees and charges has been a matter of controversy. Under the Australian Constitution, the federal government has no authority to regulate medical fees, and doctors have always had the power to set their own fees.

Lack of ability to set with certainty what doctors charge and what patients pay in all circumstances has long remained a source of political embarrassment because successive federal governments have promised what they have never had the power to deliver.

The origin of the attempt to regulate medical fees dates from the spirit of cooperation that developed briefly between the federal government and the medical profession following introduction under the National Health Scheme of the 'most common fee' in 1970. In response to electoral demands for action to limit out-of-pocket charges for health care, a schedule of medical services was identified with reference to a common fee list produced by the Australian Medical Association (AMA), which later became the *AMA Fee List*.

The Gorton coalition government published its version of the list as the *Schedule Fee*, promising further to an undertaking it had negotiated with the AMA that doctors would accept the *Schedule Fee* to cover all but a small, set proportion of the cost of GP and other medical services paid for directly by patients.

What has now become the *Medicare Schedule Fee* nevertheless remained no more than a 'fee for benefit purposes', since government possessed no constitutional authority to control doctors' fees. Notwithstanding what was originally a 'gentleman's agreement' to abide by the *Schedule Fee*, doctors were never under legal obligation to do so. Unilateral fee increases by the profession quickly ensued and fractured the nexūs between what doctors' actually charged, the *AMA Fee List* and the government's *Schedule Fee*.

Any hope that federal government possessed power to control doctors' fees was finally extinguished during the NSW doctors' dispute in 1984. This was precipitated by the advent of Medicare and the Hawke government's ill-fated attempt to regulate specialists' fees. More recent High Court decisions have since confirmed government's lack of power to control doctors' fees.

Since the early 1980s, federal governments have therefore been loath to interfere with doctors' billing practices, especially those of specialists. Instead they have oscillated between diametrically opposed policies. On the one hand, under the Howard government, the Commonwealth had sought to influence GP billing practices for Concession card holders (by far the

heaviest users of GP services) and patients under 16 by variously relying upon incentives to reward bulk billing at 85% of the *Schedule Fee* since 2003 and at 100% since January 2005. By contrast, both Hawke Labor and Abbott coalition governments have attempted to make patients more sensitive to the cost of care and to contain its financial burden to government by seeking to mandate a statutory GP co-payment.

Doctors' attitudes to medical fees have been as equivocal as government policy has been inconsistent. GPs have been willing to accept the government's bulk billing incentive payments but, where conditions permit, they have been comfortable to charge patients what the market will bear. Specialists have generally opposed bulk billing, except (in some instances) for Concession card holders.

This reflects that in most locations, market power held by most specialists is generally much greater than GPs—at least where GP labour is abundant or where adequate substitute hospital primary outpatient services are available. The AMA, in unison with public health advocates supportive of universal bulk billing for GP services, has nevertheless opposed the GP co-payment proposed in the 2014 Budget on social equity criteria. This is hard to reconcile with an *AMA Fee List* that remains much above the *Schedule Fee*. Specialist fees in particular may exceed the *Schedule Fee* by a factor of many times.

Government has compounded the inconsistency by permitting health funds since 1995 to write no-gap or known-gap cover for private inpatient specialist care underwritten by private hospital insurance tables. As with government paying 100% of GP bills, no-gap and known-gap arrangements for specialists have the same effect of reducing the transparency to patients of fees raised by doctors.

They each run contrary to the intended effect of co-payments and government policies designed to encourage price consciousness and cost-sharing among consumers of health services. Since demand for specialist services is likely to be considerably more price inelastic than for primary care, rather than offering insured patients enhanced access to services—as they would in any case have used them because of necessity—the main impact of no-gap or known-gap inpatient extra medical coverage is to embolden doctors to introduce further increases in their fees. The attempt to maintain or to extend no-gap cover margins, cascading from a benchmark such as the *Schedule Fee* thus becomes self-defeating.

It is paradoxical that the federal government should go to the trouble of setting a fee for Medicare services, when it has no constitutional authority to control fees. The reality is that government strategies to impose either statutory co-payments or to introduce any charging conformity based on the *Schedule Fee* are as limited in 2015 as they were in the 1960s—yet the fiction persists that the

existence of the *Schedule Fee* contributes in some way to public policy. Medicare arrangements should match the constitutional realities.

GPs charge the way they are rewarded to charge. The government should save itself the contradiction and the cost of paying GPs incentives to bulk bill while trying to advocate the virtue of patients becoming accountable for at least some of the cost of their care.

Both the *Schedule Fee* and the GP incentive payments it attracts should be abolished simultaneously. Removal of the *Schedule Fee* (by setting it at zero) under the *Health Insurance Regulations* would simply enable publication of a benefit payable on items listed on the *Medicare Benefits Schedule*. And any justification for quasi-statutory GP co-payments or discretionary specialist gaps would fall away, saving government, in the case of the former at least, the political embarrassment of trying to introduce them.

Individual GPs and specialists would retain freedom to set their own fees as they saw fit and their correctly itemised services would continue to attract Medicare benefits. Doctors who had concerns about co-payments creating a barrier to accessing primary preventive health services would remain at liberty to set fees equivalent to the Medicare benefit (but would lose the financial incentive to do so at considerable saving to government). Those accustomed to charging in excess of the benefit benchmark would remain free to compete in the market place, but without the *Schedule Fee* as a background price signal that thwarted price competition. In pockets where lack of competition prevails, any type of public price signal can become a springboard for excessive charging behaviour by GPs with market power, as well as by most specialists.

Even though bulk billing incentives may have been influential in causing some 80% of GP services to be bulk billed at the *Schedule Fee*, free at the point of consumption, significant welfare issues attend the minority of the population who pay in excess of the *Schedule Fee* for their medical care.

Under a simplified and reformed Medicare, co-payments (and the public odium they clearly attract) would henceforth become the business of doctors rather than of governments. This would focus health consumers' minds on what doctors charge instead of what government pays and would engineer a shift towards greater competitiveness in setting medical fees, as in markets for medical services in countries without price signals, such as New Zealand and Singapore.

In the case of specialists, abolition of the *Schedule Fee* would undermine the baseline that accommodates differential gap and no-gap private insurance for inpatient services and thus help create opportunities for a more competitive repricing of specialist services.

Removal of the *Schedule Fee* in conjunction with withdrawing bulk billing incentives paid to GPs would permit an arm's length to develop between fees actually charged and benefits. Without the distortion of a billing incentive attached to an official price signal, GP charges would find their own level, not necessarily linked to the

Medicare benefit, but driven essentially by the extent of local competition, doctors' respective skill sets, and their special interests and professional reputations. It would also direct greater attention to private medical price signals remaining in the market both for GP and specialist services—essentially, the *AMA Fee List*—and create a focus for its ultimate removal.

Competition policy did not originally affect doctors working as sole practitioners or in unincorporated partnerships, but in 1995 the Australian Competition and Consumer Commission (ACCC) gave new guidance to various health stakeholders including individual professionals and associations, advising them that fee setting arrangements with other professionals could put them at risk of contravening the law.

Competition law is intended to prohibit competing doctors from collectively agreeing fees, or participating in agreements that claim to recommend them but which in reality fix them by agreement.

It appears that in setting their fees, even though doctors may freely consult the *AMA Fee List*, they cannot legally discuss them with other doctors or other partnerships. Many doctors and medical practices (and procedural specialists in particular) nevertheless overtly adopt confidential *AMA* list fees privately disclosed between themselves as their own. Although it is silent about doctor fee setting, the *Competition Policy Review Draft Report* (the Harper Review), released on 22 September, 2014 believes that "private disclosure of pricing information has the potential to harm consumer interests as it can facilitate collusion on coordination between competitors..." As things stand, competition law so far as it relates to the pricing of medical services continues to be tested in a series of case-by-case authorisations or Federal Court judgements.

Under the present law it is challenging to disentangle price signalling and possible implicit collusion by way of the *AMA Fee List* from the act of consulting the List to arrive at a fee. Abolishing the *Schedule Fee* hence remains a necessary but insufficient condition for a move toward competitive fee setting for medical services.

While in Australia the ACCC has never made any formal decision on the *AMA Fee List*, in 2007 the Singapore Medical Association by contrast withdrew its *Guideline of Fees* (in force since 1987) to avoid the risk of contravening Singapore's *Competition Act*.

It is ironic that the *AMA Fee List* that originated with the blessing of government for purposes of calculating the *Schedule Fee* and defining the content of the *Medicare Benefits Schedule* now has the potential to encourage medical service pricing quite the opposite to that originally intended. As it has failed its original purpose and much more, the *Schedule Fee* should now be abolished to facilitate greater scrutiny of the effect of the *AMA Fee List* and to begin to allow market forces to play a more decisive role in fee determination and the extent of patient cost sharing.



Introduction

“The increases in Commonwealth benefits, which came into force on 1 January 1960, did not bring about any reduction in the share of the total costs met by contributors [of health funds]—for doctors raised their fees”

So wrote T H Kewley in 1965 of the 1959 Amendment to the *National Health Act 1953* that introduced Commonwealth benefit increases of up to 100% for some 140 services¹. In the quest of public policy to introduce greater certainty to amounts that patients may pay to meet the cost of their medical services, little has changed in the past 50 years. Supported by public funding, doctors have remained committed to fixing fees that suit themselves.

This report proposes a case for abolishing the *Medicare Schedule Fee* in light of its failure to establish a cooperative platform for dealings with the profession over the setting of fees. Well-intentioned interference

in medical services pricing has contributed to supply conditions that are far from competitive; and (in spite of growth in publicly subsidised GP bulk billing) has not fulfilled the promise of universally equitable criteria for patient cost-sharing or service access. Given a specified Medicare benefit payable, each of these failings is best resolved in a market free of government interference.

As this paper went to press, a new chapter in attempts to influence doctor charges and patient payments culminated in government withdrawing its proposal, first announced in the 2014 Budget, for a GP co-payment. As things stand, the majority of patients continue to access their primary medical care from GPs, free at the point of consumption. Government has declared that it will “work with stakeholders” to develop alternative payment policies. In the meantime it has introduced a freeze on benefits for GP services².



History: *The Schedule Fee*, Medicare and bulk billing

Past attempts to provide equity of access to necessary medical services have led the Commonwealth to rely on publishing a *Schedule Fee* in the *Schedule of Medicare Benefits* to influence what doctors may charge and to limit the size of the 'gap' paid by patients. Marked at first by a series of 'gentlemen's agreements', these efforts owe their origin to legislation introduced by the Gorton government in July 1970 that introduced what became known as 'the most common fee', later to become the *Schedule Fee*.

Subsequently, medical benefits were established with reference to the common fee list published by the AMA. This represents the origin of the AMA's annual recommended fee list, now simply known as the *AMA Fee List*³, which is indexed for cost and wage increases⁴.

Under the Gorton scheme, a patient was required to meet 80 cents of the cost of a standard GP consultation; for more expensive services or combinations of services, the patient contribution increased but was limited to \$5.00 regardless of cost. Differential benefits were struck for some 300 medical services, to be reviewed biennially. For the first time, there was Commonwealth acknowledgement of a demarcation between the work of GPs and specialists; and this led to a distinction between the fees for GPs and specialists.

Even though the AMA agreed to encourage its members to observe common fees, there was no legal obligation under the legislation for doctors to abide by them.

By February 1971, the AMA was recommending a unilateral fee increase to apply from February 1971—a harbinger of many to follow. Fee discontent continued to simmer throughout the 1970s, fuelled by disturbances to relativities that the Gorton common fee legislation

had created between fees of GPs and specialists.

It gave specialists significantly greater market power than GPs. The realisation by specialists that they could command more than other members of their profession rankled with GPs and fuelled specialist fee aspirations.

The implementation of Medicare in October 1984 formalised a relationship whereby a Medicare benefit became payable at 85% of the *Schedule Fee* as prescribed in the *Medicare Benefits Schedule* (later 100% for GP services). Following the Canadian model, so-called bulk billing enabled patients to assign their Medicare benefit to doctors in full settlement of their liability and for Medicare to pay doctors directly. Doctors at the outset feared that as bulk billing became more widespread, the government-set rebate would effectively become their fee, as perhaps originally intended under the Gorton scheme and as eventually came to pass in the case of GPs in January 2005. This uncertainty created a source of continuing tension between government and doctors that was exemplified by the NSW doctors' dispute during the 1980s.

Preparatory to the implementation of Medicare in 1984, the Commonwealth offered the states untied hospital money on condition that the states persuaded doctors to sign contracts that would control costs and private practice in public hospitals. Doctors recognised this ploy for what it was: an attempt to use Commonwealth-State Medicare Agreements on hospital funding to circumvent the constitutional limitations on the power of government to control their fees.

The NSW Labor government took the lead in implementing the Commonwealth's bidding, with gazettal of an amendment to the *Public Hospitals Act* on

26 March 1983. This gave the NSW Health Minister power to make regulations on the appointment, management and control of visiting practitioners in public hospitals. Regulation 54(a) in particular made the appointment of Visiting Medical Officers (VMO) conditional on their not charging more than the *Schedule Fee*. The NSW dispute effectively became a proxy war for a national one over the power to control doctors' fees. The upshot was a costly and lengthy dispute involving the mass resignation of doctors from the NSW public hospital system. In September 1984, with the Commonwealth's agreement, the NSW government was obliged to capitulate and rescind Regulation 54(a)⁵.

Any vestige of government's power to control doctors' fees was finally extinguished. The NSW doctors' dispute left no doubt that attempts to enforce the *Schedule Fee* as a statutory fee could risk igniting industrial anarchy, in recognition that under the Australian Constitution the government lacks power to control doctors' fees⁶. Recent High Court cases have affirmed that while government possesses constitutional power to regulate the manner in which medical services are provided, it lacks authority to use Medicare as a control on fees⁷.

The *Schedule Fee* thus imposes no obligations upon doctors: it remains simply a 'fee for benefit purposes'⁸. Hence government has resorted to incentive payments to pressure various types of billing practices to accommodate different policies of the day, using the *Schedule Fee* as a reference point.

Despite the equity and service access criteria underlining the declared intention of Medicare, government has been wary, since the debacle in NSW of 1984, of the market power of specialists and therefore loath to interfere with their billing practices. Instead it has oscillated between diametrically opposed policies to influence GP billing practices.

On the one hand, government has courted electoral popularity by seeking to augment the consumption of

GP services. This was the motive behind the so-called *Medicare Plus* program introduced in 2003, whereby so as to minimise the likelihood of Concession card holders and patients under 16 incurring any gap between rebates and fees, GPs were paid a financial incentive to accept 85% of the *Schedule Fee* for services bulk billed to these patients. In January 2005 under the *Strengthening Medicare* program, GPs were further rewarded by being paid an incentive to accept 100% of the *Schedule Fee* for services they bulk billed.

These incentive payments are currently set within the range of \$7.20 and \$10.85 per service (depending on location and type of patient). Their impact (in conjunction with an increase in the GP workforce during the first decade of the century) has been to steadily drive the proportion of GP Medicare services bulk billed from 65.7% in 2003 to 84.3% in the December quarter of 2014⁹. Between 2005 and 2014, Medicare expenditure on incentive payments (Medicare items 10990 and 10991) encouraging GPs to bulk bill at 100% of the *Schedule Fee* accordingly rose in nominal terms from \$337 million to \$560 million¹⁰. Bulk billing incentive payments are currently running at about 9% of all benefits attracted by the services of GPs.

Even though bulk billing incentives may cause the majority of GP services to be delivered at zero cost, this research report will show that significant welfare issues may be at stake for the minority who pay in excess of the *Schedule Fee*. This in turn brings into play the importance of creating greater all-round competitiveness in the supply of all medical services. Removal of extraneous price signals such as the *Schedule Fee* could make a significant contribution to competition reform. In pockets where lack of competition prevails, any type of public price signal can become a touchstone for excessive charging behaviour by GPs with market power, as well as by most specialists, that can cause significant social costs.

Co-payments versus bulk billing

In a bid to make patients more sensitive to the cost of care, and to contain the financial burden to government by inhibiting the demand for discretionary or unnecessary primary medical services for treating minor problems amenable to self-care or homeostasis, the Commonwealth on different occasions has sought to introduce a co-payment.

In 1991 a Labor administration introduced a \$2.50 co-payment for GP services¹¹ that was revoked after three months, following a change of Prime Minister; and again in 2014 there was an unlegislated Budget measure that included encouraging GPs to collect a \$7.00 co-payment with a \$5.00 reduction in the *Schedule Fee* in conjunction with a 'low gap' incentive reward payment (in lieu of one for bulk billing)¹². This initiative and its watered down variations failed to gain Senate approval and at the time of writing had been abandoned¹³, pending negotiations with the stakeholders¹⁴.

There is plainly an inconsistency in government paying GPs an incentive to bulk bill (or to adhere to any form of prescriptive low cost charging) at the same time as variously attempting a transition into partial measures of patient cost sharing. Even as the inconsistency in public policy remains unresolved, doctors' attitudes towards fees and cost sharing have been as indecisive as the Commonwealth's.

A majority of GPs has embraced the Commonwealth's bulk billing incentive, and this has been conducive in turn to adoption of the Medicare benefit payable at 100% of the *Schedule Fee* as the benchmark for pricing most of their services. On the other hand, where lack of competitive conditions permit, GPs have been comfortable to charge what the market will bear—often in rural locations or in premium, high income metropolitan localities¹⁵. Practices in the Hunter area of NSW are an example of where most GPs routinely charge non-Concessional

Box 1: The welfare burden differential GP charging

Distance between GP practices is significantly negatively associated with the proportion of patients who are bulk billed, and positively associated with the average price paid by patients who are not bulk billed as well as with the average price paid by all patients¹⁷. Because demand for GP services, relative to specialist services (at least), is price elastic (with a coefficient of -0.022)¹⁸, it follows that concentration in undifferentiated service availability, potentiated by bulk billing incentives, increases the likelihood of the bulk billing price constituting a GP service floor price. Some GP services in areas of concentrated availability may command premiums for special skills or professional reputational considerations.

The 'satisfaction' of the majority of Australians who live within relative proximity of a GP practice and who consume at a zero price (whether or not they are Concession cardholders) needs to be qualified by the likelihood of their service use being greater than necessary (since their demand becomes infinitely elastic at zero price).

By contrast, as travel times increase, falls in the quantity of services consumed would be commensurate, *inter alia*, with the probability of fees charged by GPs exceeding the benefit. Moreover, the associated welfare loss could not necessarily be regarded as compensated by the 'satisfaction' of the majority who may pay less or not at all for their GP care (i.e. their capacity as gainers to 'bribe' losers). Their welfare loss, represented by an erosion of consumer surplus given by a Harberger triangle¹⁹, can be quantified in money terms (as $0.5 \times \$ \text{ value of services delivered} \times \text{elasticity coefficient} \times \text{the square of the relative price increase}$).

Any loss so quantified would exclude any person not using GP services by virtue of being 'frozen out' of the market because of monopolistic pricing, excessive travel costs or both—and hence underestimate the extent of the actual loss. The estimate would also exclude the indirect loss of welfare arising from the value of the burden of any preventable illness that those afflicted would be 'willing to pay' to avoid.

patients a co-payment of at least \$30 for a standard consultation¹⁶. Some GP practices are now even charging a practice enrolment fee in addition to fees that exceed the *Schedule Fee*. Specialists have generally opposed bulk billing, except for some Concession card holders.

As Box 1 illustrates, there is a presumption under the *status quo* that diversity in local market conditions for GP services is likely contributing to a net welfare burden. Because it is unequally distributed within the population of GP primary care users, this burden constitutes a deadweight welfare loss of twin opposing dimensions: likely excessive use of care where it is 'free' (sometimes referred to as being indicative of 'supplier induced demand'²⁰), in conjunction with the risk of underutilisation where patients incur uncompetitive prices associated with high doctor charges²¹. Where care is 'free' the extent of the distortion may be exacerbated by government bulk billing incentives.

Market distortions occur because doctors are rational market players. They are conscious that in localities with an abundant supply of GPs or with ready access to hospital outpatient services that may substitute for primary GP care, the overall revenue accruing from the incremental financial gain of government bulk billing incentive payments in conjunction with revenue collected from their charges 'held' at the *Schedule Fee* will exceed the financial reward from setting fees above the *Schedule*. These GPs are content to forgo the prospect of the higher margins available from above *Schedule Fee* charges (at perhaps lower service volumes) and to settle for delivering larger volumes of patient throughput associated with 100% *Schedule Fee* bulk billing—possibly to the extent of excess. This has potential to constitute a social harm associated with inefficiency, with budgetary implications that the

government's cost sharing initiatives have sought to address.

On the other hand, in localities less well endowed with primary medical care, far from anchoring the benefit payable, the *Schedule Fee* has constituted a springboard that could offer incentives for GPs to sacrifice some bulk billing incentive rewards and rather to maximise rent seeking behaviour for which customers (including even some Concession card holders) may be obliged to pay. The premiums that GP services attract where they, or services of outpatient substitute services, are in short supply are analogous to the premiums that most specialist services (also in short supply) command in excess of the *Schedule Fee*²².

Hence the contradiction evident between the AMA's outspoken opposition to iniquities alleged of the proposed 2014 co-payment for GP services,²³ and its silence in the face of rural GP billing practices or specialist charges that—respectively depending upon the locality of their practice or the discipline of their specialism or both—may exceed the *Schedule Fee* by a factor of many times²⁴.

Fear of losing custom—due to the disincentive price effect of a GP co-payment or any form of cost sharing in localities with heavy concentrations of doctors—has readily masqueraded as an argument against risking loss of access to GP preventive health services; and thereby allegedly increasing the exposure of government to downstream costs, and patients to the burden of avoidable hospitalisations and chronic disease.

The AMA has accordingly described the more recent version of the government's co-payment as a "wrecking ball"²⁵. Public health enthusiasts allied with the public health lobby have made common cause with the GPs who oppose the 2014 co-payment²⁶.

Officially the AMA, never an advocate of bulk billing, has long distanced itself from the adequacy of the *Schedule Fee*. Its own Fee List covering all areas of medical practice (and intended to be confidential to AMA members) is substantially higher. In the case of a GP standard Level B consultation (MBS Item 23), for instance, the AMA at the time of writing listed a fee of \$73.00²⁷ compared with a fee of \$37.05 in the *Medicare Schedule*. It is hard to reconcile the AMA's inflated fee list with its public disavowal of a relatively small co-payment.

The AMA's official position is that GPs, as in the case of all doctors, may be obliged to charge increasing patient out-of-pocket costs to avoid erosion of their incomes or deterioration in the quality of the service they provide or both, because of intermittent freezes of the *Schedule Fee* and the reluctance of government to adhere to fee indexation²⁸. The AMA thus encourages doctors to charge a 'fair and reasonable fee' having regard to their practice costs²⁹.

Gap cover for out-of-pocket costs

Some private health insurers seem ready to accommodate doctors who adopt charging practices that pass on to patients what the doctors may consider their unrequited costs. Medibank Private, for instance, is trialling a private insurance model that intersects public Medicare coverage of GP primary care. For persons covered on its hospital tables, Medibank Private's trial is designed to guarantee 'priority' access to out-of-hospital GP services at zero price in south east Queensland at Independent Practitioner Network (IPN) practices owned by Sonic Health Limited. If widely adopted, it would have the potential to neutralise the impact of any government attempts to encourage the implementation of GP cost sharing³⁰.

Besides representing a likely infringement of s126 of the *Health Insurance Act 1973* (which seeks to prevent private health insurers writing cover for out-of-hospital medical services attracting a Medicare benefit)³¹, it remains to be seen whether medical gap cover inherent in the Medibank Private trial will further its stated objective of intercepting otherwise undetectable health problems that will keep patients out of hospital. If hospital drawing rates remain the same, ultimately such a model—although doubtless popular with some doctors³²—could result in health insurance premium increases due to incremental medical costs that could not be debited to the Reinsurance Trust Fund (a risk equalisation scheme to prevent destabilisation of the health insurance industry) and would test the willingness of Medibank Private's contributors to pay for a dubious benefit.

During the lead in to Medibank Private's Initial public offering the Minister for Health did not seek a judgement to test the validity of its trial under the *Act*—very likely for good commercial reasons. Unhappily, this could open the door to other health funds in partnership with competing medical chains with an appetite for market share to emulate Medibank Private's model³³.

Analogous to the Medibank Private trial—and contradicting the principle of cost sharing in a like manner—are no-gap service contracts that health funds have negotiated with hospitals and specialists.

Since 1 July 1995 health funds have been permitted to offer no-gap or known-gap private hospital insurance covering inpatient medical services in excess of the statutory 25% inpatient medical benefit payable on their Basic tables and linked to the *Schedule Fee* (although gaps for some hospital charges may still apply).

Subject to any applicable deductibles, these private hospital tables remove or reduce the risk to private inpatients of a liability for medical cost sharing. No-gap entitlements are available to patients if they use doctors who have entered into Medical Purchaser Provider Agreements with their health fund, provided that fees for their Medicare services, although exceeding *Schedule Fees*, do not exceed fee for gap limits the fund has set. Funds then pay the difference between the agreed no-gap fee and the Basic 75% Medicare inpatient rebate.

Not all doctors participate in such no-gap arrangements, in which case a fund may pay an extra benefit, provided that the doctor beforehand advises the patient in writing of the gap they will face and obtains their informed financial consent. The higher benefit payable for such a known-gap will then limit the patient's liability to a prescribed maximum for each Medicare item (typically \$400 per item). Indeed, the AMA believes it is quite reasonable for privately insured patients to meet the cost of gaps for specialist treatment for cancer and the like if fees exceed the available gap cover³⁴.

During the quarter ending March 2014, medical services paid for by health funds under no-gap and known-gap arrangements averaged 141% of the *Schedule Fee*. These excess fees covered 90% of inpatient hospital medical services that were provided to patients under no-gap arrangements and 3% provided under known-gaps³⁵.

Although these gap arrangements target the services of specialists—and do not directly impinge on the government's declared policy of GP co-payments (as in the case of Medibank Private's GP trial and government 100% *Schedule Fee* incentive)—they analogously reduce the transparency to patients of fees raised by doctors and run contrary to cost sharing principles designed to evoke consumer price consciousness.

Impact of gap cover on fee setting

Since demand for specialist services is likely to be considerably more price inelastic than demand for GP primary care where it is abundant or where there is substitute hospital outpatient care³⁶, rather than giving privately insured patients enhanced access to specialist services—as patients would in any case have used them because of their necessity—the main impact of gap inpatient extra medical coverage is simply to create a vortex for specialist fee increases.

As health funds from time to time increase the level of the available gap benefit to compensate for such higher fees, doctors become emboldened to introduce further increases in their fees for inpatient services, and the attempt to maintain or to extend full gap cover becomes self-defeating³⁷.

No-gap and known-gap insurance cover has consequently had a material impact on the cost of health insurance³⁸. During the early years of gap cover's rapid uptake (2002-04), its share of hospital benefits paid by health funds per single equivalent contributor rose at an annual rate of 17.7% compared to 7% for hospital accommodation benefits³⁹. With prostheses, payments for specialist services have thus been a significant factor in the increasing benefit cost of private hospital tables.

No-gap arrangements have contributed to cycles of increases in contributions payable, causing those tables to become less attractive to low risk contributors who may be encouraged to migrate to lower tables or to relinquish their cover.

To the extent that the associated costs of such incremental benefits are debited to the Reinsurance Trust Fund, it contributes to the overall costs of health

insurance over which, because of their lack of power to bargain with doctors, health insurers have little control⁴⁰.

While the *Schedule Fee* provides the benchmark for a statutory inpatient Medicare benefit of 25% for private patients (rather than Medicare's 15% for out-of-hospital care), it also acts as a baseline for underpinning the scope of the margin available to funds (associated with actual specialist charges) to compete destructively with each other in their no-gap and known-gap private hospital insurance offerings. The continuing upward pressure on health insurance premiums that results has progressively adverse cost consequences, which are often referred to as a 'death spiral of adverse selection'⁴¹.

BUPA (Australia's second largest health insurer) goes so far as to argue a case for extending no-gap inpatient cover by further deregulating the private health insurance industry to permit no-gap cover for out-of-hospital specialist services. It claims this would "be consistent with transparency of costs ... (and) inform consumers and improve competition" by delivering "a complete out-of-pocket experience for members for entire episodes of care"⁴².

By shielding patients from the price effects of specialist charging behaviour, BUPA's agenda nevertheless appears less to do with transparency than with underwriting specialists' billing practices and stifling price competition between them. It would compound the problems of no-gap inpatient cover and once again contradict government's cost sharing agenda. To the extent that such no-gap cover were ever incorporated in hospital tables, taxpayers would also pay more via the private health insurance subsidy.

The anti-competitive effect of the *Schedule Fee*

There are many imperfections in the market for medical services in Australia's fee for service environment, including considerable scope for GPs and specialists to set their prices, depending on their geographical location and their area of specialisation⁴³. Aside from rigid demarcations that exist in the labour market for health services and entry barriers to establishing a career in medicine, an underlying contributory factor is the publication of the *Medicare Schedule Fee*.

It is paradoxical that government should go to the trouble of setting a fee for Medicare services, when it has no constitutional authority or power to control fees. The reality is that government strategies to impose either statutory co-payments or to introduce any charging conformity based on the *Schedule Fee* are as limited in 2015 as they were in the 1960s, yet the fiction persists that the existence of the *Schedule Fee* contributes in some way to public policy.

The hierarchy of doctors' fees not paid by government—whether in the nature of a GP co-payment, charges above the Medicare benefit for any other private medical services, or the margin by which medical fees for private

inpatient care exceed the threshold set by the Basic inpatient medical rebate—ultimately derives from formal acknowledgement of the vestigial *Schedule Fee* in the *Health Insurance Act 1973*.

A climate of expectation ensues whereby the *Schedule Fee* becomes the first rung in the hierarchy: it is useful to government to help anchor higher GP charges through bulk billing incentives; and it can also act as a general spur for any doctors with sufficient market power to calibrate additional tiers of charging according to local market conditions, having regard as well to the *AMA Fee list*—with the destabilising corollary, in the case of private inpatient care, of driving the amount of available gap cover increasingly higher in a continuing upward spiral.

Besides their direct burden upon consumers, doctor charges based on market power are costly (via higher premiums) to households contributing to higher private hospital tables. They also have an impact on state governments meeting the cost of contractual VMO work in public systems (via either individual employment contracts or other agreements).



The competitive effect of abolishing the *Schedule Fee*

The *Schedule Fee* should be abolished hand-in-hand with abolition of GP bulk billing incentive payments for which GPs received a government subsidy of some \$0.6 billion in 2014. Abolition of the *Schedule Fee* in conjunction with its GP incentives would create an arm's length between fees actually charged and benefits that could be claimed. Without the distortion of a billing incentive attached to an official price signal, GP charges would gradually find their own level, but not necessarily linked to the Medicare benefit—as indeed would tend to occur for all doctor charges. Instead, government could simply publish a standalone benefit payable on items listed on the *Medicare Benefits Schedule*. The notion of quasi-statutory co-payments would then fall away and save governments the political embarrassment of trying to introduce them. This change could be accomplished under the *Health Insurance Regulations* without legislative affirmation.

Individual doctors would retain freedom to set their own fees as they saw fit according to local market conditions. Their correctly itemised services would continue to attract Medicare benefits. Those GPs with concerns about co-payments creating a barrier to their patients' accessing primary preventive health services would remain at liberty to set their fees at the Medicare

benefit and to absorb the loss of the bulk billing reward payment on their own account.

In the case of specialists, abolition of the *Schedule Fee* would undermine the baseline that accommodates differential gap and no-gap private insurance for inpatient services and help create thereby opportunities for a more competitive repricing of specialist services.

GPs with market power, and most specialists, who are accustomed to charging fees exceeding the benefit, would remain free to compete in the market place but without the *Schedule Fee* as a background price signal or as a benchmark for Basic inpatient medical benefits (which insurance funds would competitively determine without government regulation). In the case of GPs, individual doctors (if they felt it necessary) would have the inherent capacity to privately recoup, to the extent possible in the free market, the equivalent of the GP billing incentive subsidy they had lost. Co-payments (and the public odium they clearly attract) would hence nevertheless become the business of doctors rather than of governments.

GPs could continue to accept assigned benefits and charge patients for any residual privately determined 'out-of-pocket costs' that prevailed—although it is likely

that legislation would be required to permit a benefit to be assigned if gaps charged exceeded the amount of the assignment[†]. If legislative change proved a barrier, alternative administrative arrangements for paying benefits could be adopted, such as those currently used for specialists whereby patients pay in full, with the doctor's practice simultaneously claiming a benefit on behalf of the patient through a Medicare EFTPOS link and directly crediting the patient's benefit to their bank account. In any event, the inherent driver of medical fees in most situations would be a shift towards greater competitiveness and a distancing of government from fee setting arrangements.

Of course, removal of the bulk billing subsidy may not be popular with GPs. They cannot, however, have it both ways. It will always remain their prerogative to advocate for remuneration exceeding the benefit to compensate their loss of incentive payments. But rather than continuing to shift their business risk on to third parties, they should wear this risk by testing the market for themselves as any other small business are bound to do, without the umbrella of public patronage. The incentive was after all first introduced quite suddenly as an outright windfall to GPs without regard to scope either for congruent productivity gain or for the attainment of new standards of quality assurance.

Abolition of the *Schedule Fee* would have systemic implications not just for GP co-payments. Its abolition would have ramifications, for instance, for operation of indexed Medicare Safety Net thresholds⁴⁴. These are designed to provide relief for individuals and families with 'unusually' high out-of-pocket out-of-hospital medical services costs. The 2015 baseline (or 'Original') Threshold provides 100% of *Schedule Fee* cover for out-of-hospital medical services once the sum of the series of a person's gap payments to doctors exceeding the *Schedule Fee* reaches \$440.80 in a calendar year⁴⁵. Formalisation of such gaps by way of the *Schedule Fee* creates further avenues mainly for specialists to raise their fees above the *Schedule Fee* and defeats the purpose of the Safety Net.

Extended Medicare Safety Nets (EMSN) rely on higher thresholds and refund 80% of all out-of-pocket costs for out-of-hospital Medicare services above the threshold in a calendar year—\$638.40 for Concession card holders and \$2,000.00 for the general population for 2015⁴⁶. EMSNs create a further layer of subsidy to accommodate what are often prohibitive specialist out-of-hospital charging practices. A 2009 study found that because the EMSN simply targeted a doctor's bill, nearly 80% of its cost went towards higher specialist fees⁴⁷. The competition effect of removing the *Schedule Fee* would

reduce the need for all routine Safety Nets. If instead the government were to introduce a modified and carefully targeted Safety Net to cover for chronic and catastrophic health events affecting the poor, it would reduce at least the extent of its moral hazard exposure.

Although Australia is not the only country to publish an official fee list for medical services, some countries recognise fee lists as potentially anti-competitive. In Singapore, a country with health outcomes comparable with Australia, doctors charge patients without reference either to fee lists or indeed to any list of service definitions. Free market pricing of medical services in Singapore not only plays a role in encouraging health consumers to make discriminating choices; it also constitutes an incentive for practitioners to keep their costs down and to maintain affordable charging practices within the means of patients⁴⁸. The market for medical services in New Zealand bears more resemblance to Australia's than to Singapore's. GPs are contractors to New Zealand's public health system but they independently set the fees they collect from patients over and above their public remuneration without reference to government or other fee lists⁴⁹.

Even if Australia were to abolish its *Schedule Fee*, the move to a free market for medical services under Medicare in Australia would be constrained by the continued existence of the list of Medicare item numbers; defining the services for which a benefit was payable, and the restrictions applying to their use. This would thwart scope for competition in new product service offerings. The main competitive driver would be price competition centred upon Medicare service definitions with a capacity to charge fees ranging between the benefit payable and various levels above, depending upon local market conditions, doctors' respective skill sets and their special interests and professional reputations.

This would nevertheless at least create greater opportunities for doctors to more aggressively advertise their fees and to create greater price transparency as occurs in the case of dentists and optical dispensers. It could encourage the adoption of voluntary peer review mechanisms (as sanctioned by antitrust authorities in the United States⁵⁰) to handle complaints about doctor overcharging. It may also offer scope for GPs to offer their regular patients increased service content for the service definitions.

A further step in moving towards a more competitive Medicare would be to refine the definitions of Medicare item numbers so as to introduce greater flexibility in the service descriptions, including greater scope for blended payments and for care perhaps involving term contracts covering one or more item numbers.

[†] Section 20A (1) (b) of the *Health Insurance Act 1973* limits bulk billing to situations where no additional charges are raised.

AMA Fee List and competition policy

Abolition of the *Schedule Fee*, and as a corollary the related fee list maintained by the Department of Veterans Affairs[‡], would serve to focus attention on the private medical price signals remaining in the market: the *AMA Fee List* and other derivative lists that the industrial wings of some specialist disciplines maintain, such as the *Relative Value Guide* of the Australian Society of Anaesthetists⁵¹. Although the AMA claims that its fees are “only a guide” and not recommended fees, it is clear that many doctors and medical practices (and procedural specialists in particular) overtly adopt confidential AMA list fees privately disclosed between themselves as their own. Practice web sites are legion allowing, for example, that “consultation fees are at the rate prescribed by AMA”; or that the doctor “bills at the recommended AMA fee”; or that fees “are guided by the AMA”, etc.

Where competition is jeopardised through access issues or the risk of cartelisation because of professional entry barriers, the market becomes progressively receptive to extraneous price signals such as published (government or private) fee lists.

Although it is silent about doctor fee setting, the Competition Policy Review Draft Report (the *Harper Review*)⁵², released on 22 September 2014, believes that “private disclosure of pricing information has the potential to harm consumer interests as it can facilitate collusion on coordination between competitors...”

As things stand, medical services are subject to competition policy, adjudicated by the ACCC, administering the *Competition and Consumer Act 2010*—previously the *Trade Practices Act 1974* (TPA). Part IV of the TPA (dealing with restrictive trade practices) applied originally only to professionals working in incorporated business structures. The TPA did not affect doctors working as sole practitioners or in unincorporated partnerships. This may have represented some sort of implicit acknowledgment of a special relationship claimed to be inherent between doctors and patients, based on quality of service and ethical criteria. This changed in 1995 when, under the aegis of Council of Australian Governments (COAG), the states and territories enacted their respective *Competition Policy Reform Acts*, incorporating provisions of the TPA and extending its reference to “persons”. In November 1995, the ACCC gave new guidance to various health stakeholders, including individual professionals and associations, advising them of issues such as fee setting and arrangements with other professionals that could put them at risk of contravening the law⁵³.

Competition law in relation to the practise of medicine as it stands nevertheless remains anomalous. It is intended to prohibit competing doctors from collectively agreeing on the fees they will charge patients, or participating in agreements that claim to recommend prices but which in reality fix prices by agreement. However, since 2002 the ACCC has issued various authorisations[§], including consent to “capped fee structures”⁵⁴ as well as permission for doctors working in partnership in the same practice to discuss and agree fees. In 2013 the latter type of authorisation was extended to allow GPs practising in a partnership to collectively bargain with public hospitals for public medical services such as after-hours consultations⁵⁵.

GPs working in associateships meeting certain criteria, including accreditation by The Royal Australian College of General Practitioners (RACGP), may also discuss and agree fees⁵⁶; but surgeons who work as associates evidently are regarded as practising as individuals and cannot discuss fees⁵⁷. Moreover, in setting their fees, even though doctors may freely consult the *AMA Fee List*, they cannot legally discuss their fee policies with other doctors or partnerships.

Whilst there have been isolated cases where the ACCC has secured judgements against individual doctors⁵⁸, it is evident that competition law as it relates to the pricing of medical services continues to be tested in a series of case-by-case authorisations or Federal Court judgements. This is far from satisfactory. Under the present law it appears challenging to disentangle price signalling and possible implicit collusion by way of the *AMA Fee List* from the act of consulting the List to arrive at a fee. An amendment of *The Health Insurance Regulations* to abolish the *Schedule Fee* hence remains a necessary but insufficient condition for a move toward competitive fee setting for medical services.

While in Australia the ACCC has never made any formal decision on the *AMA Fee List*, by contrast in 2007 the Singapore Medical Association (SMA) withdrew its *Guideline of Fees* (in force since 1987) to avoid the risk of contravening Singapore’s *Competition Act*. In 2010, in recognition of the harm that fee recommendations can do to competition, the Competition Commission subsequently affirmed the SMA’s action.⁵⁹ The Commission found that the *Guideline* infringed section 34 of the *Competition Act* by breaching prohibition of agreements that have as “their object ... restriction or distortion of competition within Singapore” and that the *Guideline* delivered no net economic benefit.

‡ Other statutory medical fee lists are maintained by various workers compensation jurisdictions, accident compensation schemes, etc.

§ An authorisation permits anti-competitive conduct where the public benefit outweighs any public detriment.



Conclusion

It is ironic that the *AMA Fee List* originated with the blessing of government for purposes of calculating the *Schedule Fee* and defining the content of the *Medicare Benefits Schedule*. Both became integral to the *Health Insurance Act 1973*. The public policy environment has since changed dramatically. High expectations that an *AMA List* would harmonise with a *Schedule Fee* on a gentlemen's agreement were quickly dashed. The nexus that existed between them was lost a year after it was forged and has never been re-established.

Where, due to lack of competition, doctors do not bulk bill, the *Schedule Fee* has the potential to encourage medical service pricing by some GPs and most specialists in a way quite the opposite of what was originally intended. Since it cannot control what doctors charge, the *Schedule Fee* has no intrinsic public policy worth in determining patient out-of-pocket payments—except in situations where, at much additional cost to government, doctors are paid to observe it. As a corollary, it therefore fails as

an efficient anchor for any official co-payment policy; neither is it recognised by the AMA, because doctors are always free to set their charges in the manner of their choosing at or above the statutory benefit payable. Where doctors exert market power, the *Schedule Fee* becomes a baseline that brings an inflated *AMA Fee List* into play, inviting GPs and specialists alike to set fees that risk becoming a charge against consumer welfare.

The primary concern of funding agencies (government and health funds) should thus be the setting of benefits—and in the interests of efficiency, at levels that leave room for a more effective market, free of the burden of bulk billing subsidies or no-gap insurance, to arbitrate co-payments and out-of-pocket specialist charges. The *Schedule Fee* has become redundant: it has failed its original purpose and much more; and should accordingly be abolished to permit more competitive market forces to play their part dispassionately in determining fairer fees.

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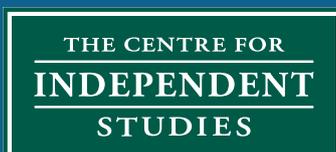
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