Australian Government
Department of Health and Aged Care

Bulk Billing for All Australians

Impact Analysis - February 2025

Contents

Impact Analysis

This Impact Analysis (IA) has been developed in accordance with *The Australian Government Guide to Policy Impact Analysis*.

This IA will be used to inform Government's consideration of options to further Strengthen Medicare through *Bulk Billing for all Australians*.

Executive Summary

Medicare was designed to be a simple, fair and affordable universal health insurance system that provides health cover to all Australians. Medicare subsidises the cost of medical services, prescription medications, and provides free services for public patients in public hospitals. This supports Australians to access the healthcare they need to enjoy good health outcomes regardless of their income or socioeconomic status.

Primary care is generally the first point of contact a patient has with Australia's healthcare system. While it captures a range of services delivered by a variety of medical practitioners, general practitioners (GPs) play a central role. Access to affordable GP services is considered a cornerstone of Australia's universal Medicare system, facilitating patient management, disease prevention and treatment to avoid hospitalisation and ensure good health outcomes. Patients who have regular access to GPs are less likely to be hospitalised for preventable conditions.

In recent years, a decline in the bulk billing rate for GP services and an increase in out-of-pocket costs, coupled with cost-of-living pressures, has meant that more people are delaying or avoiding GP care due to cost. Lack of access to primary care leads to suboptimal patient health outcomes and creates additional pressure on public health services due to avoidable hospitalisations.

After hitting a high-point during the COVID-19 pandemic due to the impacts of mandated requirements to bulk bill certain services[1], the bulk billing rate for GP Non-referred Attendances (GP NRA) has fallen from 88.8% to 77.3% over the last three financial years. Over the same period, total patient out-of-pocket costs more than doubled (from $780 million to $1.66 billion[2]), as has the proportion of people delaying or deferring GP care due to cost (from 3.5% to 8.8%[3]). This has coincided with a 4% decline in GP NRA service volumes, which has been most acutely felt by working-aged people and those living in areas of highest socioeconomic disadvantage. On 1 November 2023, the Government tripled the value of GP bulk billing incentive items. This investment arrested the decline in the GP bulk billing rate, which has improved by 1.9 percentage points between October 2023 (75.6%) and December 2024 (77.5%).

Governments have a unique and important role to play in addressing barriers to accessing healthcare. Through Medicare, the Australian Government plays a crucial role in enabling inclusive, equitable and

[1] The GP bulk billing rate rose in 2020 due to impacts of the pandemic and the introduction of temporary Telehealth items with mandated bulk billing. Reported GP bulk billing rates remained high in 2021 due, in part, to mandated requirements to bulk bill 19.3 million COVID-19 vaccine suitability assessment services.
[2] Analysis includes all GP NRA services, including vaccination and in-hospital services.
[3] Australian Bureau of Statistics. (2024). Patient Experiences, 2023-24 financial year | Australian Bureau of Statistics

cost-effective primary care services which set the foundation for supporting universal, integrated access to health care. Through its oversight mechanism in setting Medicare Benefit Schedule (MBS) fees and funding services, the Government plays a role in ensuring that access to bulk billed primary care remains widely available to Australians as part of our universal healthcare system.

The objectives of the Government's proposed intervention are to: support GPs and GP Practices to provide bulk billed care; reinforce primary care as the first point of contact within the health system; and make it easier for patients to access affordable care where cost is not a barrier to access. In line with these objectives, the Government has considered two main policy options: maintain the status quo (Option 1) or expand bulk billing incentive eligibility to all Australians and implement the *Bulk Billing Practice Incentive Program* – 'the Program' (Option 2).

Bulk billing incentives are additional payments made to medical practitioners when they bulk bill eligible patients for unreferred services. Currently, bulk billing incentives are only available for patients under the age of 16 and those that hold a Commonwealth concession card. Under Option 2, eligibility will be expanded to all Medicare-eligible patients that are bulk billed for a GP NRA service. In addition, under the Program, GP practices and Practitioners will collectively receive a 12.5% incentive payment, based on the MBS revenue from their GP NRA services, if they agree to bulk bill all of their GP NRA services.

Under this option, it is anticipated that an additional 57.6 million GP NRA services would be bulk billed over the forward estimates, with 18 million additional services per year once the program is fully implemented. Patient out-of-pocket expenditure would reduce by $2.7 billion, and the GP NRA bulk billing rate would increase by around 10.5% (from 77.3% to 87.8%). Further, it is estimated that over 4,800 GP practices would join the *Bulk Billing Practice Incentive Program* over time. Collectively, this option would restore to most Australians the genuine opportunity to receive guaranteed bulk billed GP services.

Option 2 is the Government's preferred option as it provides the greater net benefit to patients, GPs and their associated practices. Selection of the preferred option was established through consideration of stakeholder feedback, regulatory impacts, and cost and benefit analysis for affected stakeholders.

Reducing financial barriers through improving access to bulk billed GP care would ensure that healthcare is more accessible. This would safeguard Medicare's founding principle of universality and ensure good patient health outcomes and cost-effective delivery of health services. Affordable access to effective primary care is key to achieving improved health outcomes for the population and reducing pressure on hospital emergency departments.

This IA has been developed by the Department of Health and Aged Care (the Department) in accordance with The Australian Government Guide to Policy IA and in consultation with the Office of Impact Analysis (OIA). It will be used to inform the Australian Government regarding the decision to implement policy initiatives designed to support patients to access the primary care they need without incurring financial hardship.

Background

Medicare

Medicare is Australia's national health insurance scheme. It was established to subsidise the cost of private medical services and approved medications, and to provide free care for public patients in public hospitals. Introduced on 1 February 1984, following the passage of the *Health Legislation Amendment Act 1983*, the then Minister for Health, Dr Neal Blewett, described Medicare as a simple, fair, affordable insurance system that provides basic health cover to all Australians.[4]

The provision of high-quality affordable care to all Australians remains a guiding principle of Medicare.

Medicare Benefits Schedule

The Medicare Benefits Schedule (MBS) is a core component of Medicare. The MBS provides benefits (rebates) to patients for medical services that the Government has agreed to fund. Before being listed on the MBS, new proposed services for MBS rebates must undergo a rigorous assessment and approval process by the independent Medical Services Advisory Committee (MSAC), which determines their suitability for public funding, based on an analysis of safety, clinical effectiveness and cost effectiveness, and provides advice to Government to inform decision making processes.

As of January 2025, the MBS listed over 5,900 medical services and incentives, the majority of which are remunerated on a fee-for-service basis. This includes approximately 340 GP NRA items.

The level of Medicare benefit is calculated as a percentage of a mandated schedule fee, which varies depending on the service setting. Services delivered in private hospitals attract 75% of the schedule fee, while out-of-hospital services generally attract an 85% benefit. For GP NRA services provided outside of hospital settings, the benefit is set at 100% of the schedule fee.

Australia's Primary Care System

Primary care is generally the first point of contact a patient has with Australia's healthcare system. Primary care can include early intervention, diagnosis, treatment, management of long-term conditions, as well as health promotion and prevention services[5]. Services can be delivered by a range of health professionals including GPs, nurses, allied health professionals, and Aboriginal health workers and practitioners. Primary care can be provided across a range of settings, such as in private practices, at a patient's home, residential aged care facilities, and non-government service settings such as Aboriginal Community Controlled Health Organisations (ACCHOs).

Affordability Measures

Affordable access to effective primary care is key to achieving improved health outcomes for the population and reducing pressure on hospital emergency departments. In addition to MBS rebates, a

[4] Biggs, A.(2004). *Medicare – Background Brief.* Australian Parliamentary Library. 8823863.pdf;fileType=application/pdf

[5] Department of Health and Aged Care. (n.d.) About primary care | Australian Government Department of Health and Aged Care

range of Government initiatives work to make primary care, and in particular GP services, more affordable and accessible to Australians.

Bulk Billing

Bulk billing is the key mechanism through which the Government supports patients to access medical services without incurring an out-of-pocket cost. Bulk billing is where a medical practitioner, with the patient's agreement, accepts the patient's Medicare benefit as full payment for the service. When a practitioner bulk bills a patient, the practitioner can receive the Medicare benefit for the service directly from Services Australia.[6] Practitioners can bulk bill any patient for any relevant MBS service, however, the decision to bulk bill, or to charge the patient a fee, is, in most cases, at the full discretion of the practitioner.

Bulk Billing Incentives

Bulk billing Incentives (BBI) were introduced in 2004 as separate MBS items under the *Health Insurance Act 1973* and subordinate legislation. BBIs are additional payments made to medical practitioners when they bulk bill eligible patients for unreferred services. Currently, only children under the age of 16 and Commonwealth concession card holders are eligible for BBIs. BBIs effectively increase the Medicare rebate for the service claimed as a way of incentivising the bulk billing of that service. The value of BBIs differs based on remoteness, with practitioners in regional, rural and remote areas able to claim items worth more than those working in metropolitan areas.

In November 2023, the Government took significant steps to improve healthcare affordability by introducing new higher-value BBI items that can be co-claimed with the most frequently used unreferred services. This provided stronger financial incentives for GPs to bulk bill eligible patients, thereby increasing the rate of bulk billing and making it easier for the eligible population to access the healthcare they need.

100% Benefits for GP Attendances

In 2005, in response to a sustained decline in the bulk billing rate, the Government introduced a policy initiative to increase the MBS benefits for out-of-hospital GP attendance items from 85% to 100% of the MBS fee (known as the "100% Medicare" reforms). In instances where the patient was bulk billed, the GP would receive a higher MBS benefit for the service. In instances where the patient was privately billed, they would receive the higher benefit and, and assuming the GP did not change their billing practices, would have a lower net out-of-pocket cost.

Medicare Safety Nets

There are two Medicare Safety Nets, the Original Medicare Safety Net (OMSN) and the Extended Medicare Safety Net (EMSN). Anyone enrolled in Medicare is eligible for these safety nets with higher benefits automatically paid when the relevant thresholds are reached. While not designed to enable access to bulk billed care, it does seek to increase affordability of services by reducing patient out-of-pocket costs.

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[6] Department of Health and Aged Care, *Education: Bulk Billing and Additional Charges*, August 2022

The OMSN functions by increasing the benefit a patient receives from 85% to 100% of the relevant MBS fee. As GP NRA services already attract a benefit equal to 100% of the MBS fee, the OMSN has no impact on these services.

The EMSN is designed to provide extra support to those who incur higher out-of-pocket costs for out-of-hospital services received within a calendar year. Once a threshold is met, patients received higher benefits for the rest of the year as a way of reducing any further out-of-pocket costs. Under the EMSN, patients receive up to 80% of any further out-of-pocket costs.

Tripling the rebate for Bulk Billing Incentive items

As part of the 2023-24 Budget, the Government invested $3.5 billion to triple the rebate of existing bulk billing incentive items. This meant that a GP who bulk bills an eligible patient for a standard consultation in a metropolitan area received $20.65 instead of $6.85. In very remote areas the incentive rose from $13.15 to $39.65. The increase in the rebates for a bulk billing incentive items was designed to support GPs to continue to bulk bill 11.6 million children and concession card holders.

Q1. What is the policy problem to be solved?

Overview

Medicare was designed to be a simple, fair, affordable insurance system that provides basic health cover to all Australians. Despite its success, periods of declining GP bulk billing rates have applied pressure on Australia's primary care system and challenged Medicare's founding principle of supporting patients to access healthcare regardless of their ability to pay. The GP bulk billing rate at the commencement of Medicare in 1984 was just 51%[7]. Since then, the rate has steadily increased overall with just two periods in which a significant drop has occurred.

The first of these drops occurred between 1996 and 2003. Over this period, the bulk billing rate fell from 81% to 68%. In response, the Government introduced reforms to incentivise bulk billing through an increase to the amount of MBS rebate available to providers and patients[8] and the introduction of bulk billing incentive items – additional payments available to practitioners when they bulk billed children under 16 or Commonwealth concession card holders[9]. These measures were designed to support patients to access the care they needed while supporting the ongoing viability of GPs.

In the years following these reforms, the GP bulk billing rate climbed steadily from 68% in 2003 to 86% in 2019. The rate further increased to an all-time high of 89% in 2020, however, this increase may have been largely driven by additional Government investment and interventions during the COVID-19 pandemic response. It is important to note that for a short period during the pandemic, many GP attendances were mandated as having to be bulk billed – including Telehealth services and COVID-19 Vaccine Suitability Assessment services. This helped to drive the increase in the overall bulk billing rate.

The second drop in bulk billing began in 2020, from which point the bulk billing rate fell from 89% to 77% in 2023. This fall occurred during a period of significant and increasing cost pressures being felt across the economy, which impacted on the operating costs of primary care practices.

Over the last 15 years, there have been indexation freezes applied to MBS items – including GP NRA services – that reduced the effectiveness of the MBS benefit in covering the cost of medical services. The long-term impacts of MBS indexation freezes, coupled with the recent inflationary economic environment, has caused many GPs and practice owners to revise billing policies – effectively moving away from bulk billing towards charging more of their patients out-of-pocket fees for services.

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[7] Australian Institute of Health and Welfare. (2024). Medicare bulk billing and out-of-pocket costs of GP attendances over time, Patterns in GP bulk billing rates between 1984 and October 2024 - Australian Institute of Health and Welfare

[8] Australian Government. (2004). Health Insurance Amendment (100% Medicare Rebate and Other Measures) Bill 2004 – Parliament of Australia

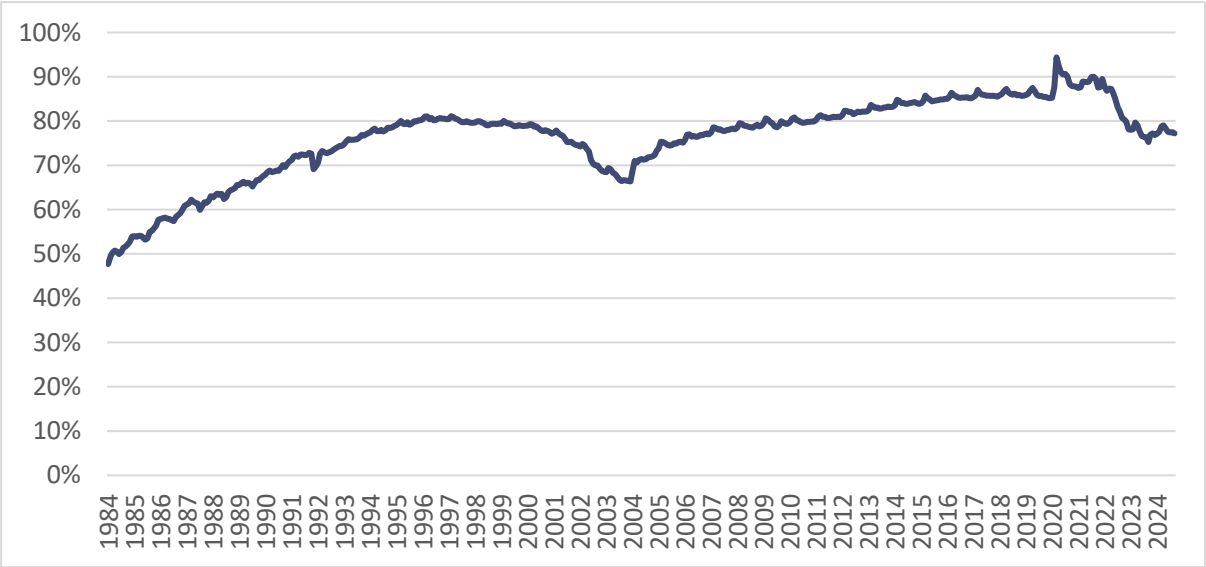
[9] Australian Government. (2003). Mid-Year Economic and Fiscal Outlook 2003-04. 00 Preliminaries.PDF

As part of the 2023-24 Budget, the Government announced changes to the indexation methodology applying to programs, including the MBS, to better align with economic conditions. In addition, the Government applied a one-off additional indexation factor of 0.5% to most general medical service items[10].

During this time, the Government also established the Strengthening Medicare Taskforce to identify and make recommendations to address some of the key challenges facing the healthcare system, with a specific focus on primary care. This included consideration of ways to improve access to general practice, make primary care more affordable, and reduce pressure on hospitals. Following the Taskforce's recommendations, the Government made investments to support primary care reform to ensure high quality, integrated and person-centred care for all Australians[11]. This investment included tripling of the MBS fee for bulk billing incentive items which, coupled with the investment in indexation, were designed to make it easier for eligible Australians to see a bulk billing doctor.

Tripling of the bulk billing incentives on 1 November 2023 for standard GP consultation items provided greater incentive for GPs to bulk bill eligible concession card holders and children under 16. Since the higher-value bulk billing incentive items were introduced, the overall GP bulk billing rate has stabilised at 77.5% (December 2024), Figure 1, and for eligible patients the bulk billing rates has increased to over 90% for children and over 87% for older Australians. However, despite this investment, the GP bulk billing rate for ineligible patients has continued to reduce, dropping to below 70% for working age Australians (Figure 2).

Figure 1: *GP NRA bulk billing rate over time*[12]



[10] Australian Government. (2023). Medicare Benefits Schedule Book. 1 November 2023 Complete MBS Book.pdf
[11] Australian Government. (2022). Strengthening Medicare Taskforce Report
[12] Australian Institute of Health and Welfare. (2024). Medicare bulk billing and out-of-pocket costs of GP attendances over time, Patterns in GP bulk billing rates between 1984 and October 2024 - Australian Institute of Health and Welfare

The decline in bulk billing rates and rise in out-of-pocket costs, coupled with increasing cost-of-living pressures, has presented a barrier for some patients trying to access the care they need. With patients increasingly being asked to contribute to the cost, a greater proportion are deferring or delaying care. Avoiding care often leads to poorer health outcomes for patients and an increase in avoidable hospital admissions, resulting in greater financial pressure on public hospitals.

Access to affordable GP services is a cornerstone of Australia's universal Medicare system, where patients are supported to access healthcare regardless of their income or socioeconomic status. Reducing financial barriers through improving access to bulk billed GP care would ensure that healthcare is more accessible. This would safeguard Medicare's founding principle of universality and would improve good patient health outcomes and cost-effective delivery of health services.

In describing the policy problem and content throughout this IA, we focus specifically on general practices and GP NRA services which encompasses GP consultations in a range of delivery settings. While a wide range of health professionals are involved in the delivery of primary care, GPs play a central role. They are often the point of coordination to ensure patients access the right care at the right time.

Policy Problem

A decline in the bulk billing rate for GP services and an increase in out-of-pocket costs, coupled with cost-of-living pressures, has meant that more people are delaying or avoiding GP care due to cost. Lack of access to primary care leads to additional pressure on public health services due to avoidable hospitalisations and creates suboptimal patient health outcomes.

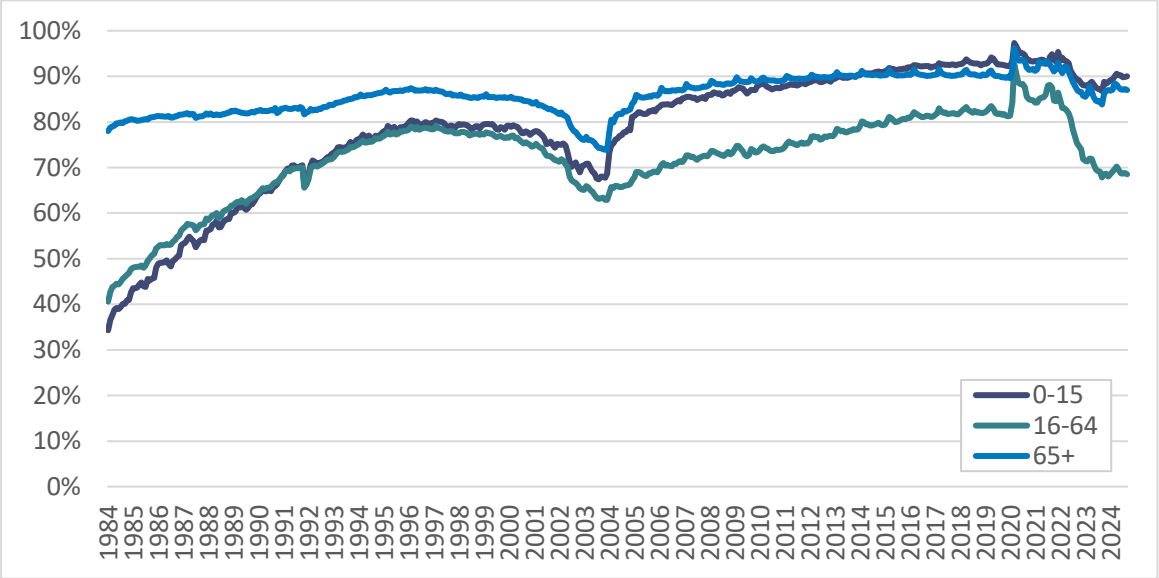
Bulk Billing Rates

After hitting a high-point during the COVID-19 pandemic due to the impacts of mandated requirements to bulk bill certain services, the overall GP bulk billing rate decreased from 88.8% to 77.3% over the last 3 financial years (Figure 1)[13]. MBS data shows that patients who are eligible for a bulk billing incentive are bulk billed at a higher rate than the rest of the population. Recently published data from September Quarter 2024-25 shows that patients under the age of 16 were bulk billed around 90% of the time, and those aged 65 and over – who are more likely to qualify for a Commonwealth concession card – were bulk billed over 87% of the time[14]. People aged 16-to-64, who are less likely to hold Commonwealth concession cards, were bulk billed for 68.8% of their GP NRA services.

[13] The GP bulk billing rate rose in 2020 due to impacts of the pandemic and the introduction of temporary Telehealth items with mandated bulk billing. Reported GP bulk billing rates remained high in 2021 due, in part, to mandated requirements to bulk bill 19.3 million COVID-19 vaccine suitability assessment services

[14] Australian Institute of Health and Welfare. (2024). Medicare bulk billing and out-of-pocket costs of GP attendances over time, Patterns in GP bulk billing rates between 1984 and October 2024 - Australian Institute of Health and Welfare

Figure 2: *GP NRA Bulk Billing Rate by Age Category over time*



Viability of Bulk Billing GP Clinics

The reduction in bulk billing rates appears to have coincided with advice from the leadership of the Royal Australian College of General Practitioners for its members to stop bulk billing and move to mixed billing arrangements.[15]

The shift in GP clinic billing models has been a driver of the reduced bulk billing rates – away from a fully bulk billing model towards mixed or private billing models[16].

The reasons for the Royal Australian College of General Practitioners (RACGP) advice were explained by the then President, Karen Price:

> *By transitioning to mixed billing, not only will GPs earn more, they'll also help to lower the bulk-billing rate. This increases our ability to advocate for higher Medicare rebates, which in turn will also help bulk-billing GPs and those GPs practising in areas of low socio-economic status.*[17]

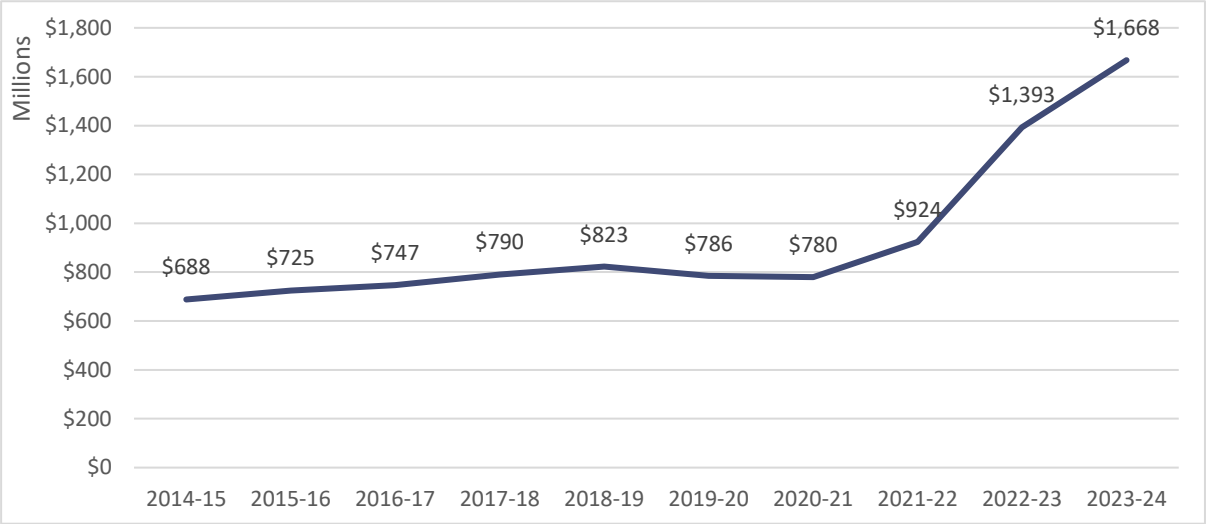
In its 2024 *Health of the Nation* report, the RACGP noted that 81% of GP clinic owners surveyed indicated they were concerned about the viability of their practice, up from 54% in 2021[18]. The report also found the main business challenges facing practice owners were increasing business costs (85%) and business profitability (80%).

[15] AusDoc. (2021). RACGP: 'It is time for GPs to abandon universal bulk-billing'. Article.
[16] Mixed billing practices being defined as those who bulk bill between 50-95% of GP NRA services, and private billing practices being defined as those who bulk bill less than 50% of GP NRA services.
[17] Medical Republic. (2022). Know Your Woth and Bill Accordingly: Price. Article.
[18] Royal Australian College of General Practitioners. (2024). *Health of the Nation*. p.37-38. RACGP - General Practice: Health of the Nation 2024

Out-of-pocket Costs

The recent decline in the GP bulk billing rate has caused a significant increase in the total out-of-pocket costs paid by patients. From 2021-22 to 2023-24, patient out-of-pocket costs more than doubled, from $780 million to $1.66 billion.[19]

Figure 3: *Total Patient Contributions for GP NRA services (out-of-hospital) over years ($m)*



Financial protection is weakened by a health system's reliance on out-of-pocket costs for healthcare[20]. A lack of financial protection can reduce access to healthcare, undermine health status, deepen poverty, and exacerbate health and socio-economic inequalities. While patients with higher incomes generally have higher absolute levels of out-of-pocket costs, the burden of such costs is greater for vulnerable patients including those with chronic medical conditions[21].

Cost-of-Living Pressures

Cost-of-living pressures have risen significantly in recent years, driven largely by persistent inflation. This has placed increased financial pressure on households, with some reports citing that more than half of Australians have experienced increases in housing costs, have missed or eaten a lower quality meal, avoided seeing the doctor or not filled prescriptions[22].

More People Are Avoiding Care

This shift in practice billing, increase in out-of-pocket costs and increased cost-of-living pressure has meant that more Australians are struggling to afford medical care. The Australian Bureau of Statistics' *Patient Experiences Survey* is an annual survey that tracks Australian's experiences with various aspects of the health system. In 2023-24, the ABS report highlighted that 8.8% of people surveyed had delayed

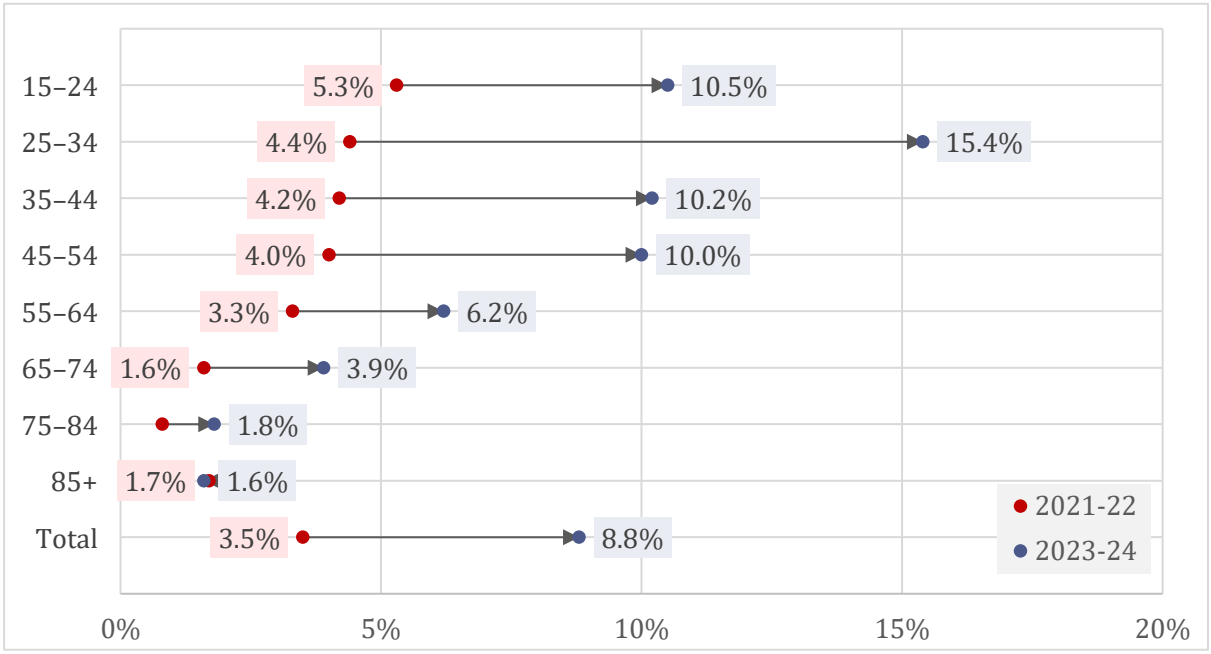
[19] Analysis includes all GP NRA services, including vaccination and in-hospital services.
[20] Organisation for Economic Cooperation and Development. (2023). *Health at a Glance 2023*. 7a7afb35-en.pdf
[21] Angeles, M., Crosland, P., Hensher. (2023). *Challenges for Medicare and universal health care in Australian since 2000*. https://doi.org/10.5694/mja2.51844
[22] Melbourne Institute, Applied Economic & Social Research. (2023). *Taking the Pulse of the Nation*. TTPN May 2023

or deferred seeing a GP due to cost at least once over the course of the year. This was an increase on the 7.0% reported in 2022-23 and the 3.5% reported in 2021-22.[23]

The Australian Bureau of Statistics' *Patient Experiences Survey* has highlighted that 8.8% of people in 2023-24 deferred or delayed care due to cost. This is an increase on the 7.0% reported in 2022-23 and the 3.5% reported in 2021-22.

This increase has not been evenly distributed throughout the population. People aged 15-to-64, who are less likely to be eligible for bulk billing incentives and who are more likely to be exposed to cost-of-living pressures, have reported delaying care at a far higher rate than those aged 65 and over.

Figure 4: *Proportion of respondents who delayed or deferred GP care due to cost over time and by age category*



Recent literature has also established that patients with chronic conditions are more likely to forego care due to cost, including patients diagnosed with asthma, emphysema or chronic obstructive pulmonary disease - who are six times more likely to skip care[24].

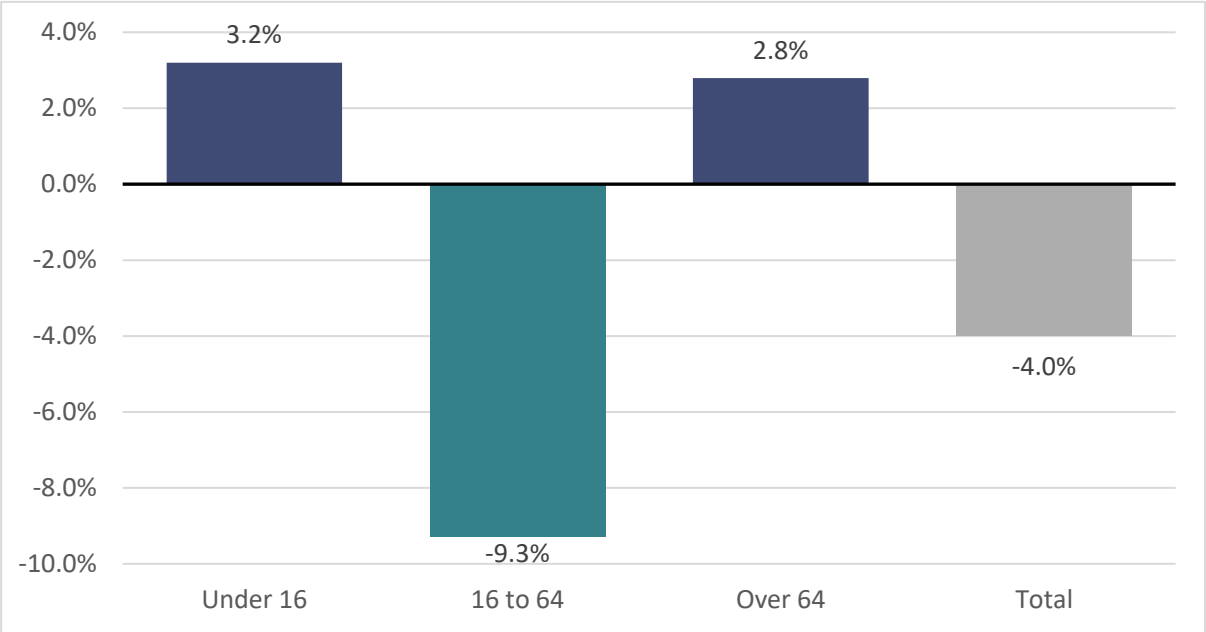
Reduction in GP NRA Services

Over the last three financial years, the number of GP NRA services has declined by 4.0% compared to a historical average annual growth rate of around 3.5%. This decline in GP services has also not been evenly distributed throughout the population. Services for people aged 16-to-64 have declined by 9.3%

[24] Callander, E., Corscadden, L., Levesque. J. (2017). Out-of-pocket healthcare expenditure and chronic disease - do Australians forgo care because of the cost? - PubMed

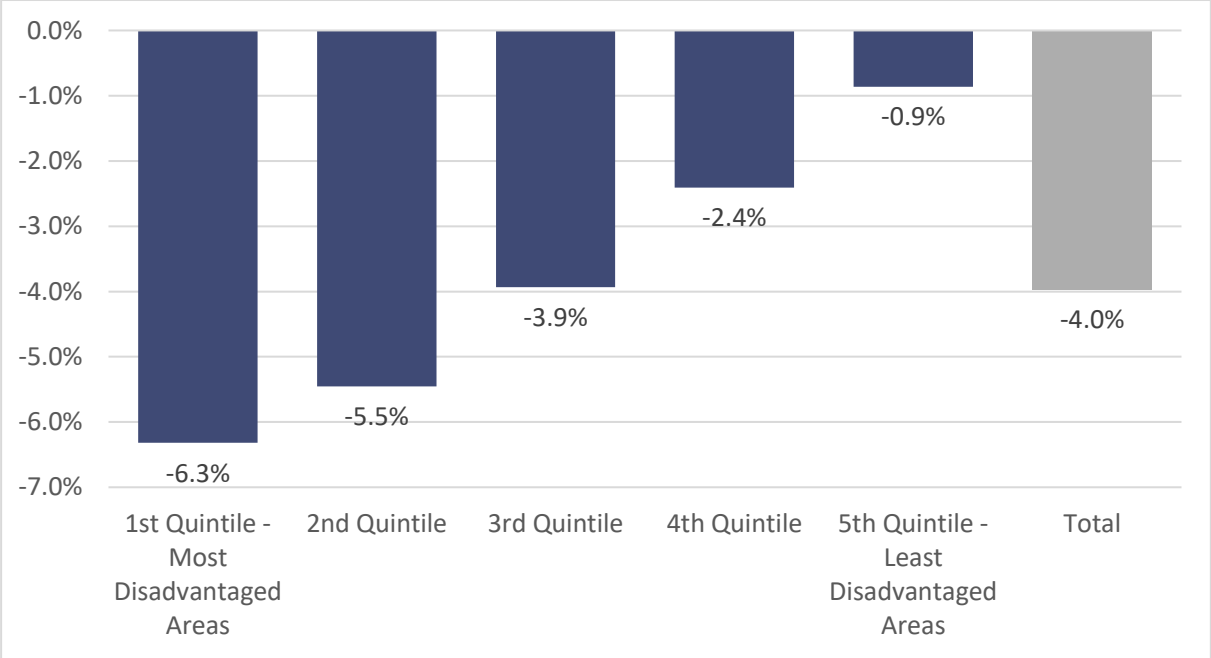
while services for people younger than 16 have increased by 3.2% and services to those aged over 64 have risen by 2.8% (Figure 5).

Figure 5: *Three-year change in volume of GP NRA services by age category*



Similarly, services to people from the most socioeconomically disadvantaged households have fallen by 6.3% while those to the most advantaged households have fallen by 0.9% (Figure 6).

Figure 6: *Three-year change in volume of GP NRA services by patient socioeconomic quintile*



Potentially Preventable Hospitalisations

Delaying care to avoid incurring out-of-pocket costs can have a significant impact on patient health outcomes. The inability to meet the cost of healthcare and tendency to skip care leads to worsening of health conditions over time and an increased likelihood of the patient presenting to a public hospital

emergency department - including as a way to access free primary care treatment. Avoidable emergency department presentations and hospital admissions increase public healthcare costs, divert practitioners from other critical areas, and put strain on public hospital resources. More importantly, if a patient has delayed care to the point that it has become an emergency, this is of significant detriment to the health of that patient and will more than likely result in poorer health outcomes that could have been avoided with appropriate and timely access to primary and preventative care.

Potentially preventable hospitalisations (PPH) are those admissions that could have potentially been prevented through appropriate preventative health interventions and early disease management usually delivered in primary care and community-based care settings (including by GPs)[25]. For example, where a patient presents to hospital for a condition that could largely be prevented through vaccination, treated by antibiotics prescribed by a GP, or managed by primary practice intervention for long term chronic disease.

In 2021–22, there were 11.6 million hospitalisations in Australia. Of these, around 660,000 (5.7%) were classified as preventable[26]. PPH data can provide useful insights as to the effectiveness of health care in the community, as higher rates may suggest a lack of timely, accessible, and adequate primary care.

The risk of PPH is influenced by a multitude of individual, interpersonal, system and environmental determinants[27]. In addition, a higher prevalence of risk factors for poor health, such as smoking and physical inactivity, as well as socioeconomic risk factors, such as income, housing, and health literacy, may contribute to increasing the risk of PPH. Access to affordable and timely GP appointments has been found to be a strong driver in PPH reductions.

International Comparisons

Australia is often considered to have a sound healthcare system that achieves comparatively good health outcomes for its population. In 2024, The Commonwealth Fund ranked the overall performance of the Australian health care system first out of ten high income countries[28]. However, Australia was ranked ninth for 'access to care' which focuses on the affordability and availability of health services at the population level. The report noted that roughly half of Australian patients who do not have voluntary health insurance may have to wait longer to receive services and that affordability is a known problem, although new incentives have led to improvements in recent years.

According to the ABS' *Patient Experiences Survey*, an estimated 8.8% of patients deferred care in Australia in 2023-2024 (7.0% in 2022-23 and 3.5% in 2021-22). In 2018, 13% of adults in New Zealand delayed care due to cost compared to 15% of European citizens, and 13% of patients in the United

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[25] Australian Institute of Health and Welfare. National Healthcare Agreement: PI 18–Selected potentially preventable hospitalisations, 2024

[26] Australian Institute of Health and Welfare. (2024). Potentially preventable hospitalisations in Australia by small geographic areas, 2020–21 to 2021–22, Summary - Australian Institute of Health and Welfare

[27] Ridge, A., Peterson, G., Seidel, B., Anderson, V., Nash, R. (2021). Healthcare Providers' Perceptions of Potentially Preventable Rural Hospitalisations: A Qualitative Study. *International Journal of Environmental Research and Public Health.* https://doi.org/10.3390/ijerph182312767

[28] The Commonwealth Fund. (2024). Mirror, Mirror: A Portrait of the Failing U.S. Health System. Health Care by Country 2024 Report | Commonwealth Fund

States in 2013[29]. Where patients delay or defer access to primary care this can have negative consequence for health outcomes and health care costs through increased rates of complications, specialist care or longer hospital stays. This is particularly pertinent for chronic disease such as diabetes, cardiovascular disease, and hypertension in which early intervention and ongoing monitoring are crucial for appropriate management and avoidance of adverse outcomes such as possible limb amputation and cardiac arrest.

A study by Jatrana and Crampton (2021) sought to generate empirical evidence as to the extent to which cost related barriers were associated with adverse health outcomes, specifically in a New Zealand context[30]. After adjusting for time-varying confounders, the study found that for all outcome measures, health got worse as the proportion of waves in which patient deferral of doctor and dentist visits increased. Waves were the periods of time (2004-2005, 2006-2007, 2008-2009) used for measurement and reporting purposes.

The authors found there was a 48.2% probability of patient populations reporting the deferral of a doctor visit due to cost in instances where that had reported the deferral of care in a previous wave. This suggests that once a patient defers care due to cost, they are likely to defer care over multiple years and, as a result, experience increasingly adverse health outcomes. This finding is of particular concern for people from lower socioeconomic groups who are more likely to have poorer health status.

Information from the United States provides some useful insights into the impact out-of-pocket costs can have on access to healthcare, and the consequences this has for patient health outcomes. The Commonwealth Fund reported that despite significant spending on healthcare, the United States ranked last – including on access to care, administrative efficiency, equity and health care outcomes [31].

In the United States individual patients bear a larger share of health care financing, which disproportionately impacts poor and middle-income households[32]. Cost has a large impact on the under-treatment of health problems, the worsening of health outcomes for patients who cannot afford care, and the prevalence of medical debt. Health care inequities are significant for people in lower income brackets, experiencing homelessness, or who have inadequate wages.

According to the United States Census Bureau, 19% of households had medical debt meaning they could not afford to pay for medical care up front when they received care[33]. The median amount owed was $2,000. Race, ethnicity, age, education and poverty are correlated with whether a household may carry medical debt. For example, medical debt was experienced by 29.7% of households with a Black householder, 24.7% of households with children under 18, and 26.2% of households where no member

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[29] Jatrana, S., Crampton, P. (2021). *Do financial barriers to access to primary health care increase the risk of poor health? Longitudinal evidence from New Zealand.*
[30] Jatrana, S., Crampton, P. (2021). *Do financial barriers to access to primary health care increase the risk of poor health? Longitudinal evidence from New Zealand.*
[31] [31] The Commonwealth Fund. (2024). Mirror, Mirror: A Portrait of the Failing U.S. Health System. Health Care by Country 2024 Report | Commonwealth Fund
[32] Baird, K. (2016). *The financial burden of out-of-pocket expenses in the United States and Canada: How different is the United States?* https://doi.org/10.1177/2050312115623792
[33] Unites States Census Bureau. (2021). Who Had Medical Debt in the United States?

held university level education. Medical debt can lead patients to compromise on health care, potentially having to choose between food and care, which may delay diagnosis and exacerbate health conditions. A clear link has also been established between poor mental health outcomes and financial hardship. Further, wealth, or a loss of it, is associated with a reduced likelihood of recovery from illness and increase in mortality risk[34].

Access to GP services plays a crucial role in facilitating patient management, disease prevention and treatment to avoid hospitalisation and ensure good health outcomes. Patients who have regular access to GPs are less likely to be hospitalised for preventable conditions. Countries with a strong primary health care system generally have more favourable population health outcomes, reduced health inequities across population groups, and less potentially preventable hospitalisations. While Australia has a comparatively strong universal healthcare system, particularly in relation to peer nations, recent trends that see the emergence of cost as a barrier of care threaten the effectiveness of the health system.

Affected Stakeholders

The following stakeholders are currently impacted by the policy problem:

- **Patients** – A decline in the bulk billing rate for GP services and an increase in out-of-pocket costs, coupled with cost-of-living pressures, has meant that more patients are delaying or avoiding GP care due to cost. This is being felt most acutely by younger patients and those living in areas of socioeconomic disadvantage. Lack of access to primary care leads to suboptimal patient health outcomes.
- **GP Clinics** – Rising business costs and business profitability concerns in recent years have contributed to the underlying causes of the policy problem, impacting GP clinics' ability to offer bulk billed services. An increasing number of GP clinic owners are shifting away from fully bulk billing models towards mixed billing models to ensure viability and profitability.
- **General Practitioners** – As more clinics move away from bulk billing models, GPs have been faced with increasingly complex decision making about their own billing policies. Where their patients are unable to afford to pay for care, GPs may not be able to provide the length of care and continuity of care that would achieve the best health outcomes for their patients. This not only adds a layer of administrative complexity but causes a tension between a GP's commitment to their patients and the need to support the ongoing viability of their practice.
- **Governments –** The current policy problem impacts state and territory governments regarding the delivering of primary care services in their jurisdiction. In particular, the flow-on impacts of potentially preventable hospitalisations where patients present to emergency departments but that could have otherwise had their medical needs resolved should they have been able to access appropriate primary and preventative care in the community. This policy problem impact is realised as a cost to states and territories for providing public hospital services, which also increases costs to the Commonwealth through shared public hospital funding arrangements.

[34] Mendes de Leon, Calros., Griggs, J. (2021). *Medical Debt as a Social Determinant of Health*, https://doi.org/10.1001/jama.2021.9011

- **Community Health Organisations** – often receive funding from a variety of sources, including Government funding, that may stipulate certain requirements that need to be adhered to in order to continue to be eligible for funding. GPs and Other Medical Practitioners operating in these settings would be eligible to bill the MBS for GP NRA services, however, the organisation itself may not necessarily be reliant on MBS generated revenue alone. Where patients are increasingly unable to afford to access primary care at a GP Clinic they may seek to access services elsewhere, such as at a Community Health Organisation. This adds pressure to already finite resourcing and may divert practitioners away from the cohort of patients that the organisation was established to primarily support.

Data and Limitations

In undertaking analysis for the proposed options for consideration by Government, the Department interrogated a range of datasets including administrative MBS data, GP practice level data from the Practice Incentive Program, as well as person-level data from the census and taxation data within the ABS' Person Level Integrated Data Asset (PLIDA). The Department has also accessed microdata from the ABS' *Patient Experience Survey*. Collectively, this data is protected by strict privacy and confidentiality measures and is not publicly available in its entirety. As such, the Department has relied on the publicly available aspects of the datasets or proxy data to undertake the analysis as presented in this IA.

Medicare Statistics

The Department publishes Medicare Statistics which are aggregated by geography, age, sex, socioeconomic status and primary care type and which report on measures such as bulk billing rates, services claimed, benefits paid and patient contributions (also known as out-of-pocket costs). This data is collected by Services Australia for each MBS claim that is submitted and processed. It provides an accurate and comprehensive dataset which is used by the Department and other entities as an official source of Medicare data for reporting purposes. The ongoing publication of this data provides an extensive dataset which enables clear and consistent year on year comparisons. The overall quality of this dataset is excellent.

A gap in the publicly available dataset, in the context of analysis required for this IA, is the lack of published information on patient concessional status. This is a central element of the policy options proposed. As such, the Department has used the MBS data available by patient age group (<16, 16-64, and >65) as a proxy for concession card status. Children under the age of 16 are eligible for bulk billing incentives based on age, and those who are over 65 are more likely to be eligible for bulk billing incentives based on holding a Commonwealth concession card. Those aged 16-to-64 are used as a proxy for the non-concessional working age population. This provides a reasonable proxy for bulk billing analysis by eligibility for bulk billing incentive, however there is a portion of the working aged population (<20%) that would qualify for a Commonwealth concession card and that would not be accounted for in the analysis. The proportion of age cohorts that are eligible for Commonwealth concession cards has been verified using publicly available data for the Department of Social Services. While the use of proxy data for patient concessional status reduces the fidelity of the information used here, we assess the proxy data to be of sufficient quality to meet the purposes of this IA.

Australian Institute of Health and Welfare Data Collections

The AIHW has an extensive collection of over 150 datasets. In publishing statistics, the AIHW must ensure that privacy and confidentiality are maintained and the requirements of the *Privacy Act 1998* (Cth) and the *Australian Institute of Health and Welfare Act 1987* (Cth) are met. The establishment of each collection is also approved by the AIHW ethics committee. Due to these strict requirements, not all data is able to be published. However, those that are published are comprehensive and provide a quality and accurate information source for the community, policymakers, researchers and service providers.

However, AIHW reports can often be slightly historical and lacking the most up-to-date year of data. Further, depending on changes in reporting parameters, there may be variances in data from year-to-year or between datasets which can make it tricky to draw comparisons. For example, the potentially preventable hospitalisation data used in the analysis further above reports the latest year of data as at 2021-2022. While this still provides important insights on trends, analysis based on MBS data is much more recent (up to 2023-2024) which makes cause and effect analysis difficult to draw definitive comparisons and conclusions. Regardless, the AIHW data used within this IA is of excellent quality, accurately quantifying trends and illustrating the complexity and the multi-faceted nature of the healthcare system.

ABS' Patient Experiences Survey Data

The ABS Patient Experiences Survey has been a particularly important source of information in analysing the proportion of people delaying care and the drivers behind this behaviour. The survey is conducted every year by the ABS and collects information from people about their experiences with aspects of the health system, including access and barriers. The survey is restricted to those aged 15 years and over and who were usual residents of private dwellings. This excludes persons living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, nursing homes, homes for people with disabilities, and prisons. In the 2023-2024 survey, information was collected from 26,176 fully responding persons, including 2,501 proxy interviews for people aged 15 to 17 and those aged over 18 but were not able to answer due to illness, injury or language problems.

While the Department has access to more granular microdata via the ABS DataLab, the analysis used in this IA is based on the public available information. With over ten years of comparable data year-on-year, this dataset provides a solid source of reliable information that provides insights into trends relating to barriers to accessing care, including cost as a barrier.

While surveys introduce a higher level of subjectivity, the comprehensive nature of the survey data used and the structure of the questions has minimised this impact and provides a good quality reference point for comparison year-on-year. The survey format also enables consideration of patient and practitioner sentiment and perception, which is important in informing the development of health policy.

Royal Australian College of General Practitioners' Health of a Nation Data

The IA has used the RACGP's *Health of the Nation* 2024 report to outline the main concerns faced by GPs and practice owners. This report is informed by an online survey of 3,006 practicing GPs and GPs in training and 180 non-practicing GPs. The survey has been run over eight years and is used to examine

the current state of general practice and track changes over the short and medium terms as well as to forecast possible longer-term trends and consider the implications for patients.

Again, reliance on data collected via a survey is open to response bias, sampling issues, and measurement error through inconsistent interpretation. It is also important to note that the Department reported 40,347 primary care GPs in the 2023-24 financial year[35] meaning that the sample size for the survey represents just 7.9% of the workforce.

Further, the data is reported on a GP level basis rather than at a practice level. While the Department would generally consider bulk billing rate data at a practice level, the RACGP provides data at a GP level which provides more granular insights and trends regardless of whether the GP works in a small family business or as part of a corporation.

Despite these gaps and variances, the RACGP's reported data provides sound insights into sector trends. As the survey has been conducted over eight years, this provides confidence that any consistency issues in the design and interpretation of questions and answers would likely have been addressed. Further, great care has been taken to highlight the demographics of the participating GPs which helps to contextualise any diversity issues in the interpretation of data.

Organisation for Economic Cooperation and Development Data

The data collected and used in reports by the OECD, such as for their *Health at a Glance* report, provides useful information for international comparison purposes. However, a limitation of the data presented is its self-reported nature and varying recency with which each country provides their latest dataset. This means that countries may be using different base years, providing a gap in establishing clear comparisons on a like-for-like basis. For example, analysis of catastrophic expenditure showed the most recent Australian data as at 2016. While still useful, this provides a gap in understanding trends across the most recent years. As such, the analysis based on this data is limited in nature and has been supplemented with the results of independent studies.

Further, metrics used for analysis may be based on differing definitions depending on the country. For example, 'healthcare coverage' is defined as the share of the population covered for a core set of health services, and is used as an initial measure of access to care and financial protection. However, there may be variation between countries as to what types of services are included. Despite this, it is largely accepted that core health services include consultations with doctors, tests and examinations and hospital care. This broad standardisation provides a reasonable set of data for comparison for the purposes of this analysis.

Literature and Limitations

A range of literature has been sourced to support the analysis in this IA. This includes primary research, government reports, industry reports, and secondary research such as meta-analysis.

[35] Department of Health and Aged Care. (2024). General Practice Workforce providing Primary Care services in Australia

A key limitation of this IA is the difficulty in comparing trends, statistics and insights reported across the literature given the variance in date ranges used. This presented a challenge when attempting to compare like-for-like resources, with some literature using dated information. While this is a limitation for the purposes of our comparisons, the literature itself provides detailed and comprehensive information that has provided a sound base to draw conclusions and create a foundation of evidence to support the analysis presented. The IA clearly identifies the date ranges referred to, as appropriate, to ensure the avoidance of misinterpretation.

A range of Government resources have been referenced, including Australian Government reports and information published by the United States Government Departments. Official government websites generally provide a reliable and authoritative source of information that is generally frequently updated with the latest available evidence and provides a good source for policy and demographic information. The reports published by the Australian Government are often co-authored by independent experts, adding to the high level of credibility. The information cited in this IA has provided a sound source of statistics, trends, stakeholder feedback, and policy effectiveness insights.

Research in other first world countries with similar, albeit not identical, healthcare contexts has been cited in this IA. One example is the study by Jatrana and Crampton, which investigates healthcare avoidance trends in New Zealand. While sourcing an article based on primary research in an Australian context would be ideal, this article provides a good source of empirical evidence that seeks to link the avoidance of care due to cost with poorer health outcomes. This is highly relevant to the analysis undertaken for this IA and have been caveated appropriately to ensure the avoidance of any doubt by the reader. While there are some limitations to the literature cited in this IA, the broad range of research and reports presented provide a sound foundation of evidence to support the analysis presented.

Q2. What are the objectives, why is government intervention needed to achieve them, and how will success be measured?

Rationale for Government Intervention

Medicare is Australia's universal health insurance scheme that provides free treatment for public patients in public hospitals and provides 'benefits' for services listed in the MBS[13]. Benefits are paid to the patient, unless the patient assigns them to the practitioner as is the case when being bulk billed for a service. This reinforces the notion that Medicare benefits are patient benefits, in place to support patients to access the medical care that they need, and patient choice in where they seek medical care.

The Australian Government is responsible for administering this public funding, including making decisions about what medical services will be listed in the MBS, the fees for services, and any associated affordability measures. While the Government does not regulate the fees of medical practitioners, it does indicate the relative cost for services through the setting of MBS fees. In designing Medicare, the Government sought to apply competitive pressures against fee increases[36]. Bulk billing encourages competition as many patients prefer seeing a bulk billing GP. While GPs are free to decide what they charge for their services, where they charge a private fee (rather than bulk bill) the total cost is paid directly by the patient, who then claims the MBS benefit – with the difference between the fee and the benefit representing the out-of-pocket cost. The additional cost and complexity of private billing applies pressure on the pricing behaviours of clinics and practitioners.

In 2017, the World Health Organisation's Director General Dr Tedros Adhanom Ghebreyesus said that 'The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'[37]. Universal health coverage means that everyone should have access to the health services they need, when and where they need them, without suffering financial hardship. This is enshrined in the 2030 Agenda for the United Nations' Sustainable Development Goals (Target 3.8). Protecting people against having to pay out-of-pocket costs for healthcare, such as by using up life savings or borrowing money, reduces the risk of people being pushed into poverty.

'The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'.
(Dr Ghebreyesus, 2017)

Governments have a unique and important role to play in the establishment strong, efficient and equitable universal healthcare systems. The Australian Government is committed to the Sustainable

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[36] Boxall, M., Gillespie, J. (2013). *Making Medicare*. UNSW Press.
[37] World Health Organisation. (2017). Health is a fundamental human right

Development Goals, as one of the 193 countries that signed on to the 2030 agenda, including ensuring access to a world-class health system built on the foundation of universal health coverage. The Government's voluntary 2018 report reiterated the commitment to providing access to timely, high-quality health services delivered without discrimination. It also highlighted the importance of collectively working with civil society organisations and health providers to address gaps in addressing the underlying mechanisms that contribute to poor health outcomes within the Australian community[38].

Through Medicare, including the MBS, the Government plays a crucial role in enabling inclusive, equitable and cost-effective primary care services which is fundamental to supporting universal, integrated access to health care.

Objectives of Government Intervention

There are three main objectives that underpin the Government's proposed intervention to increase access to bulk billed GP services:

Objective 1 - Support GPs and Practices to provide bulk billed care.

I. Intended Outcome/s
    i. To increase the proportion of general practice clinics that fully bulk bill GP NRA services to all patients.

Objective 2 - Reinforce primary care as the first point of contact within the health system.

I. Intended Outcomes/s
    i. To support patients to access the primary care they require via the right services at the right time through the right health practitioner.
    ii. To support all Australians to be healthy and well, through access to equitable, affordable, person-centred primary care services, regardless of where they live and when they need care, with financing that supports sustainable primary care.

Objective 3 - Make it easier for patients to access affordable care where cost is not a barrier to access.

I. Intended Outcome/s
    i. To support patients to access bulk billed GP services, ensuring that patients do not need to avoid care due to cost.

Success Factors

The following table outlines the factors that will make this proposed policy change a success, along with measurable targets. Each target is set for no more than four years post-implementation, unless otherwise specified, with interim results measured throughout the proposed evaluation process to inform future policy direction.

[38] Department of Foreign Affairs and Trade. (n.d.). 2030 Agenda for Sustainable Development. Australia's Report on the Implementation of the Sustainable Development Goals | Australian Government Department of Foreign Affairs and Trade

Table 1. *Correlated success factors and targets for three Government objectives.*

Objective	Success Factor	Success Metric / Target
1. Support GPs and Practices to provide fully bulk billed care.	• Increased proportion of GP NRA services that are bulk billed.	• 87.8% of GP NRA services bulk billed by 2028-29.
	• More GP clinics provide fully bulk billed care for GP NRA services.	• 3,600 GP practices sign-up to Clinics Program over the first 2 years (noting 4,800 are expected to sign up at full implementation).
2. Reinforce primary care as first point of contact with the health system.	• Increased proportion of people who receive an MBS service from a GP.	• Over 90% of the eligible population receives an MBS service from a GP.
3. Make it easier for patients to access affordable care where cost is not a barrier to access.	• Increased bulk billing rate for GP NRA services.	• 87.8% of GP NRA services bulk billed by 2028-29.
	• Decrease in total patient contributions for GP NRA services.	• 50% decrease in total out-of-pocket costs for GP NRA services.

This IA places emphasis on an increase in the GP NRA bulk billing rate and the percentage of fully bulk billing clinics as the most important measures of success. Relative to the other targets, these two measures are crucial in indicating that patients can access the primary care they need when they need it. The achievement of these key measures will naturally support flow on benefits in achieving the remaining targets, including a decrease in average out-of-pocket costs.

The above success factors have been set in a manner that is realistic, time bound with the majority based on the analysis of MBS statistics to provide an objective, consistent and accurate measurement of success. This ensures that the Government has high confidence in their achievement. Overall, the Government has high confidence in the achievement of these targets which will form part of the evaluation of the chosen option and will be updated as required to ensure they remain appropriately aligned to the policy implementation.

Key assumptions

A key assumption to Government intervention and the achievement of these success factors is the passage of legislative amendments needed to enact the changes. Without successful legislative amendment and within the timeframes outlined, the preferred option will not be able to be implemented as proposed.

A second key assumption is that the Government will be able to deliver necessary payment systems and IT changes to enable the changes to start on time. Without this, the program will be delayed and proposed benefits would be deferred.

Another key assumption is that the Government can effectively communicate policy changes to the GP sector and the public. Without this, the program risks being undersubscribed.

Achievement of these success factors is also heavily contingent on GP clinics and Practitioners responding to incentives in way similar to Departmental modelling. If the sector is less responsive to incentives, then positive impacts may be reduced.

Limitations to Government Intervention

A key limitation to intervention is the extent to which Government can influence charging behaviours of private businesses. A long-standing view of the medical sector is that the Government is unable to regulate the fees charged by practitioners, due to the civil conscription provision in the Constitution which provides that:

> *The Parliament shall, subject to this Constitution, have power to make laws for the peace, order, and good government of the Commonwealth with respect to:--*
>
> *….*
>
> *(xxiiiA.) The provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription), benefits to students and family allowances:*
>
> *…..*

Contemporary health policies and programs continue to align with this approach and use financial incentives as the key mechanism to influence and shape behaviour[39]. As such, the Government's proposed intervention relies on the approach of encouraging behaviour, through additional MBS and incentive funding arrangements, rather than the direct regulation of charging practices.

However, the extent to which Government can continue to intervene through the expenditure of funds does also present a key consideration. Although Australia's health system rates well domestically and internationally, it is important to continue to consider its future fiscal sustainability. Health funding across the system has consistently increased, including MBS specific expenditure. In 2022-23, the Australian Government spent $101.5 billion on health[40]. More than one third (36.3% or $36.8 billion) of this was directed towards primary care, comprising $11.1 billion for unreferred medical services (mainly GP services). In the same time period, spending for MBS benefits reached $27.1 billion, compared to $20.2 billion in 2014-2015 and $24.1 billion in 2018-2019[41]. While this is an increase in nominal terms and on an overall basis, when considered in real terms and on a per capita basis, the

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[39] McDonald, F., Ducket, S., Campbell, E. (2023). *Commonwealth Power to Improve Access, Quality, and Efficiency of Medical Care: Does section 51 (xxiiiA) of the Constitution Limit Politically Feasible Health Policy Options Today?* https://doi.org/10.1177/0067205X231165872

[40] Australian Institute of Health and Welfare. (2024). Health expenditure Australia 2022–23, Government sources: Australian Government spending - Australian Institute of Health and Welfare

[41] Australian Government. (2020). MBS Review Taskforce Final Report. An MBS for the 21st Century Recommendations, Learnings and Ideas for the Future

growth in spending for MBS benefits is broadly in line with both population growth and CPI[42]. Australia's population was 23.8 million people in 2014-2015[43], 25.4 million people in 2018-2019[44] and 26.6 million people in 2022-2023[45].

As highlighted in the Treasurer's 2023 Intergenerational Report, long-term spending pressures are rising across a number of sectors, including health. An ageing population coupled with a declining birth rate is a contributor to this pressure, with Australians expected to live longer and therefore use government-funded services for longer. The Intergenerational Report forecasts that Australian Government payments for health care, aged care and the NDIS are projected to increase as a share of GDP from 6.2% in 2022-2023 to 10.7% in 2062-2063[46].

Healthcare is just one of many areas that is funded by the Government. External pressures can limit Government spending and constrain the ability to invest to achieve certain health related outcomes. While Government has decision-making power in the amount and allocation of funding for measures, it is also accountable to the Australian public for the appropriate expenditure of public funds. Investment of funds into healthcare initiatives must be weighed up with value for money and net benefit to the Australian public.

Alternatives to Government Intervention

Government intervention to increase bulk billing rates is needed to achieve better health outcomes and reduce long-term healthcare costs by preventing the escalation of health issues that often lead to expensive hospitalisations and specialist care. By ensuring that more people can access primary and preventative care through bulk billing, the government can facilitate early diagnosis and management of conditions, preventing or reducing the need for costly, long-term interventions. Without intervention, overall bulk billing rates for GP services are likely to continue to decline, making basic healthcare less accessible for many Australians.

In the current Australian context and existing structure of the healthcare system, achieving the stated objectives without Australian Government intervention would require significant additional investment from entities that have little reason or ability to intervene in primary care provision. While technical advancements, such as Artificial Intelligence (AI) may provide some positive efficiencies, they are not sufficiently developed to meaningfully support the objectives.

Reliance on GPs to bulk bill more patients without further investment

As noted earlier in this IA, the decision to bulk bill ultimately rests with the treating Practitioner. It is possible for the bulk billing rate to increase without further Government assistance if Practitioners decided to bulk bill more services. However, without further Government assistance or increased market competition, it is unclear why large numbers of GPs would return to bulk billing more of their services.

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[42] Australian Bureau of Statistics. (2025) Consumer Price Index, Australia
[43] Australian Bureau of Statistics. (2015). Australian Demographic Statistics, Jun 2015
[44] Australian Bureau of Statistics. (2019). Australian Demographic Statistics, Jun 2019
[45] Australian Bureau of Statistics. (2023). National, state and territory population, Jun 2023
[46] Australian Government. (2023). Intergenerational Report 2023: Australia's future to 2063

Increased primary care investment from State and Territory or Local Governments

It is the view of state and territory governments that responsibility for funding primary care services rests with the Commonwealth Government, as the majority of these services are provided by private businesses and funded through MBS patient rebates. While state, territory and local governments may provide public primary care services (for instance to provide an alternative to higher cost hospital care for people who cannot afford to seek primary care from the private MBS market, this is not widespread. Any state, territory or local government funding for primary care services that are also billed to the MBS could contravene section 19(2) of the *Health Insurance Act* which prohibits Practitioners from receiving funding from multiple layers of Government for the same service.

Increased reliance on Private Health Insurers

In Australia, private health insurers are unable to provide funding for services that are available on the MBS. This limits their ability to contribute towards the Government's objectives. Even if this restriction were to be lifted, any contribution from private health insurers is likely to exacerbate access issues for people who do not hold private health insurance policies and undermine the principle of universality.

Some insurers offer GP telehealth services for their members, however this occurs only when no relevant MBS item applies.

Artificial Intelligence

Technologies are rapidly evolving. AI describes the machine simulation of human cognitive capabilities such as learning, reasoning, problem-solving, and self-correction. It includes machine learning, robotics, chatbots, image recognition, and voice recognition.

AI solutions are becoming increasingly of interest in the healthcare space as a possible tool in addressing challenges to primary care access. While there is limited appetite for AI to replace the patient-practitioner relationship, the RACGP has acknowledged that there are opportunities in helping to fill service gaps, particularly in remote areas, and as a way to increase patient access to care between GP appointments[47]. Such tools may reduce the burden of lower value routine administrative and clinical tasks on GPs, increasing their availability for the delivery of high-value primary care.

Several challenges would need to be addressed prior to any consideration of addressing primary care access issues with reliance on AI. These include issues such as privacy and security for sensitive patient health data, preventing the potential for bias in algorithms, the establishment of standards and regulatory oversight to ensure any tools adopted are safe, ethical and effective, as well as integration with traditional systems to ensure that AI complements Australia's highly skilled primary care workforce.

As such, while there is promise in the future application of AI to support healthcare access, ongoing research is required to determine the impact in achieving better access and better health outcomes before it is considered a viable alternative intervention.

[47] RACGP. Artificial intelligence in primary care

Potential Barriers to Achieving Success

As with any large-scale health reform, a barrier to achieving the Government's objectives is the extent to which the Government can influence charging behaviours of private providers. As previously canvassed, the Government does not currently regulate the setting of medical fees, nor does it regularly mandate bulk billing of services. Medical practitioners are currently free to set their own fees for the services they provide. As such, the overall success of the Government's proposed intervention is largely dependent on the sector's willingness and commitment to participate and transition to bulk billing a larger portion or the entirety of their patient base.

There is a risk that regardless of implementing the proposed initiatives, GPs and practices decide not to bulk bill a greater proportion of their services. This is more likely to happen in areas where there is limited competition between practices or in higher socioeconomic areas where medical fees are comparatively high, and a larger proportion of the population have greater financial means or where the GP or practice wants to retain the ability to bill some patients. Lower or absent market pressures may mean that practices do not change their billing behaviour, resulting in a continued lack of or limited bulk billed services.

To overcome this, as part of the proposed intervention, the Government will undertake a communications campaign as well as implement transparency measures to increase public awareness of the bulk billing options available in their area. This presents an appropriate approach in a context where there is limited ability or desire for the Government to mandate particular fees for medical services.

Educating GPs and practices as to the benefits of joining the Program and the availability of expanded bulk billing eligibility will be key to ensuring early adoption and the achievement of anticipated uptake. The Department will engage with GPs and their employers and representative bodies and provide factsheets containing details of the changes which would be published on the Department's MBS Online website. The Department would host information sessions with providers and their representative groups to ensure that changes to MBS items are well understood. Providers, practice managers and their representatives will be engaged early to answer any questions as to how the Program will work. This will be an important opportunity to build awareness of how practices can support their patients to access services whilst understanding how the initiatives will support the ongoing viability of primary care businesses.

As part of the Government's investment in a communications campaign, the Department will consider appropriate channels to promote awareness of the changes to the public. Increasing awareness of where patients can go to seek primary care support is crucial to a well-functioning and effective health system. Formative research will be used to determine attitudes and behaviours for varying audience demographics, including research in regional, rural and remote areas as well as for First Nations peoples. Additionally, given the diversity of the Australian population, concept testing will be used to ensure that the message is framed in a way that is easily understood. This includes having regard to Culturally and Linguistically Diverse audiences and to adapt and translate information as required. Channels that will most effectively reach audience targets will be sought and may include television, social media, advertisements, and announcements. These communication activities would occur prior to implementation of any changes as well as after implementation to maintain awareness and support the ongoing transition of patients once changes have commenced.

In thin markets, such as more remote areas of Australia, the Government provides a higher rebate for bulk billed services through scaled benefits. Bulk billing incentive benefits vary based on the MBS service provided and remoteness of the practice as determined by the Modified Monash Model. Practices in Modified Monash 2 areas receive around 150 per cent of the rebate compared to those in metropolitan areas, increasing to 190 per cent of the metropolitan rebate in very remote (Modified Monash 7) areas. Providing higher rate bulk billing incentives in more remote areas is a way in which the Government helps support bulk billing of patients in thin markets, while recognising that a higher level of competition will influence provider behaviour in metropolitan areas. This approach will work to overcome the success barriers outlined above, including in more remote areas.

Q3. What policy options are being considered?

This IA considers the following policy options to address the policy problem:

- Option 1 – Status Quo.
- Option 2 – Expand eligibility for bulk billing incentives to all Australians and implement the *Bulk Billing Practice Incentive Program*.

These options have been brought forward as best practice reform options that seek to restore Medicare's original intent of supporting universal access to healthcare, where all patients can access the primary care services they need regardless of their financial circumstances.

Option 1 – Status Quo

Under this option, patients currently eligible for bulk billing incentives (children under the age of 16 and those who hold a Commonwealth concession card) would remain eligible. There would be no expansion to eligibility, no changes to existing incentive benefits, and no additional incentive payments would be introduced. GPs and practices would continue to apply their billing policies and retain discretion as to which patients they bulk billed. In instances where eligible patients were bulk billed, GPs would continue to be able to claim the relevant bulk billing incentive in addition to the standard MBS benefit for the GP consultation service.

The Department would remain responsible for overseeing the operation of the MBS and Services Australia would remain responsible for administering payments in response to claims for MBS services, including bulk billing incentives.

The Department would continue to engage with the sector regarding the ongoing operation of MBS items and any policy initiatives that sought to amend MBS items or introduce initiatives to support GPs and access to GP services.

How does Option 1 meet Government objectives?

Maintaining current policy settings is not likely to achieve the Government's objectives. With no major changes to the current arrangements or the emergence of unforeseen health emergencies, the bulk billing rate trajectory will likely follow recent trends.

As of October 2024, the bulk billing rate was 77.3% compared to 75.6% in October 2023 (up 1.7% in one year). This increase has been largely attributed to the higher bulk billing rate for those patients that are eligible for bulk billing incentives.

Prior to the introduction of the triple bulk billing incentives, the bulk billing rate had dropped to 77% in 2023[48]. Following the Government's intervention, analysis of the bulk billing rate for age groups shows that, in the first 10 months of 2024, the bulk billing rate for those aged 0-15 increased from 88% to an average of 90% and those aged 65+ experienced an increase from 86% to an average of 87%.

[48] Australian Institute of Health and Welfare. (2024). Medicare bulk billing and out-of-pocket costs of GP attendances over time, Patterns in GP bulk billing rates between 1984 and October 2024 - Australian Institute of Health and Welfare

Those aged 0-to-15 qualify for bulk billing incentives based on age, and those aged 65+ are more likely to qualify for a bulk billing incentive via holding a concession card, for example due to receiving the aged pension.

Comparatively, those aged 16-to-64 experienced a decrease in the bulk billing rate from 70% to an average of 69%. As those aged 16-to-64 make up the greatest proportion of all GP attendances (54.2%), the relatively lower bulk billing rate for this aged group has a significant impact on lowering the overall bulk billing rate. People aged 16-to-64 do not automatically qualify for bulk billing incentives due to their age and are significantly less likely to hold a concession card[49].

As a result, while the bulk billing rate for patients eligible for bulk billing incentives is expected to remain relatively stable, without intervention, there is a risk that the bulk billing rate for ineligible patients may follow the recent historical trajectory and decline further. Should the bulk billing rate for eligible patients remain relatively stable, this may result in a small decline in the overall bulk billing rate attributable to a possible decline for ineligible patients. This is likely to further exacerbate affordability and access issues and be criticised as undermining the intended universal nature of Medicare. This does not align with the Government's intended objectives and does not address stakeholder feedback, as outlined in Question 5.

The short-term benefit of Option 1 is that no changes to legislation or IT systems would be required and stakeholders would not incur any costs to implement changes but rather continue with existing systems, processes and billing practices.

Overall, Option 1 would not deliver the same benefit that patient and practices would otherwise receive under an expansion of bulk billing incentive eligibility and the introduction of an incentive program for GP services as proposed under Option 2.

Option 2 – Expand eligibility for bulk billing incentives to all Australians and implement the *Bulk Billing Practice Incentive Program*

Option 2 would expand eligibility for bulk billing incentive items to all Medicare-eligible patients and implement the *Bulk Billing Practice Incentive Program*. This option promotes the Government's objectives to support GPs to provide bulk billed care, to make it easier for patients to access affordable care whilst supporting the ongoing viability of GP practices, and to reinforce General Practice as first point of contact with the health system.

Practitioners would be able to claim a bulk billing incentive in instances where they bulk billed a Medicare-eligible patient for any GP non-referred service provided, regardless of the patient's age or concessional status. Bulk billing incentives are a long-standing feature of the MBS and are well understood by GPs. This proposal represents a simple change to the patient eligibility of existing MBS items. It is easy to implement and would simplify billing procedures for GPs and administrative staff – who would no longer need to check the eligibility of patients before lodging a bulk billing incentive

[49] Analysis of publicly available data from the Department of Social Services suggests that only 20% of people aged 16-to-64 hold a Commonwealth concession card.

claim. Implementation would follow standard processes via amendment of the *Health Insurance (General Medical Services Table) Regulations 2021*.

In addition, this option would introduce the *Bulk Billing Practice Incentive Program* which would provide an additional incentive payment to the value of 12.5% of MBS benefits from GP NRA services each quarter if participating practices (and their GPs) opt into the Program and commit to bulk bill all of their GP NRA services. The Program would be rolled out in two phases:

- Phase 1 – GPs at *participating clinics* would receive payments equivalent to 12.5% of the revenue from MBS fees billed in the previous quarter for all GP NRA services. A portion of this incentive would be paid directly to the practice at which the GP is associated, so that both GPs and practice owners are incentivised to register with the Program. Practices and providers would be encouraged to register their patients with MyMedicare to enable a potential shift towards patient-centred blended funding reforms during Phase 2 of the Program.
- Phase 2 – subject to an internal review, the Program could support reforms to provide blended funding models, linked to MyMedicare reforms.

Practices will need to be registered with MyMedicare to participate in the Program. In order to broaden participation, practices that do not meet current accreditation requirements will be permitted to register with MyMedicare in order to join the Program. While participation in the Program is voluntary it is expected that a significant proportion of existing practices will opt-in to the Program. Practices will have the discretion to opt-out of the Program at any point. Under Phase 1 of the Program, patients will not be required to register with a specific practice – although voluntary registration will be encouraged.

Clinics will be required to advertise their participation in the Program, and the ability to search for these clinics via the HealthDirect website, would further assist patients in finding bulk-billed services when and if they need them.

How does Option 2 meet Government objectives?

Option 2 aligns with all three of the Government's objectives. It would support GPs to provide bulk billed care whilst providing a mechanism for practices to sustain their ongoing viability, would reinforce General Practice as the first point of contact within the health system, and would make it easier for patients to access affordable care where cost is not a barrier.

Expanding bulk billing eligibility to more Australians would support greater access to primary care without the burden of out-of-pocket costs. Reducing financial barriers to care ensures that healthcare is more accessible, regardless of income and employment status. Timely access to primary and preventative care can support earlier diagnosis, treatment, and management of conditions, reducing the long-term burden on the healthcare system.

Implementation of the Program would increase the bulk billing rate by supporting GP practices to transition to or otherwise adopt a fully bulk billing model, increasing the number of GP practices available that bulk bill all of their patients. This would provide a measure of certainty for patients – who will know they will be bulk billed if they attend a Bulk Billing Practice.

Introduction of the Program would enhance the viability of the bulk-billing practice model and encourage practices to shift back to being fully bulk billed. The Program would re-introduce stronger competition into the GP clinic market – as many patients are likely to favour bulk billing clinics.

Encouraging providers and practice owners to return to – or otherwise adopt – a fully bulk billing model would ensure more patients had an option to receive primary care without incurring an out-of-pocket cost.

This option ultimately achieves the overarching aim of supporting GPs to provide bulk billed care, making it easier for patients to access primary care without incurring an out-of-pocket cost.

Disregarded Options

The Government had regards to the possibility of considering other options such as:

- Expansion of bulk billing incentive eligibility as a standalone measure.
- Introduction of the Bulk Billing Practice Incentive Program as a standalone measure.

However, in choosing the options to analyse for this IA, we chose to weigh up the preferred Option 2 against the status quo of Option 1 as this delivers the greatest combined benefit to patients, GPs and the GP practices.

Q4. What is the likely net benefit of each option?

In its final 2022 report, the Strengthening Medicare Taskforce noted the importance of reform to ensure Australia's primary care system can meet the current and future challenges and reflect the new models of care of the 21st century. It distilled recommendations and identified areas of where government needs to invest to rebuild primary care as the vibrant core of an effective, modern health system.

The Taskforce envisioned a primary care system that is incentivised to improve population health and that all Australians are supported to be healthy and well, through access to equitable, affordable, person-centred primary care services, regardless of where they live and when they need care, with financing that supports sustainable primary care.

The Taskforce made a range of recommendations including in relation to strengthening funding for primary care, ensuring Australians, including those on low incomes, can access the care they need. The report emphasised the implementation of reforms to healthcare in a staged approach and the importance of reducing pressure on emergency departments.

This section outlines the benefits and costs for each of the policy options proposed in this IA, including analysis of key impacts to stakeholders and a preliminary net benefit assessment of each option.

This analysis indicates that, overall, the greatest net benefit is delivered under Option 2.

Multi-criteria Analysis

To inform the decision as to which of the options delivers the greatest net benefit, a multi-criteria analysis was conducted along with completing an estimation of the regulatory cost of each option. This approach supports the comparison of the relative benefits of each option. The chosen option reflects the greatest benefit in terms of the multi criteria analysis score, the increase/decrease in regulatory cost and consideration of the distributional impacts for the preferred option. The structured methodology of multi-criteria analysis was selected as the most appropriate to assess and compare options based on multiple criteria. A multi-criteria analysis provides an efficient and flexible tool and is generally well-suited to public policy contexts.[50] The multi criteria analysis weighs up the extent to which the options work to achieve the Governments objectives:

- **Objective 1** - Support GPs and Practices to provide bulk billed care.
- **Objective 2** - Reinforce primary care as the first point of contact within the health system.
- **Objective 3** - Make it easier for patients to access affordable care where cost is not a barrier to access.

[50] Australian Government. (2021). Guide to multi-criteria analysis. Assessment Framework 2021 Guide to multi-criteria analysis.pdf

In weighing up the objectives, regard has been given to impacts of each option on the following stakeholder cohorts, external to Government, that are likely to be most affected:

- **Patients** – those who seek to access GP services to address their health needs. This is the most affected cohort under the current landscape in regards to facing financial barriers to accessing primary care.
- **GPs** – those providers who play an essential role as the first point of contact a patient generally has with the health system and a crucial point of coordination to ensure access to and effective delivery of quality, comprehensive primary care services. This cohort is affected by the current landscape in relation to ensuring good health outcomes for their patients whilst having regard to the viability of their associated practices.
- **GP Practices** – often the overarching organisation under which a number of GPs provide services to patients. This cohort is affected by the current landscape from a practice viability lens.

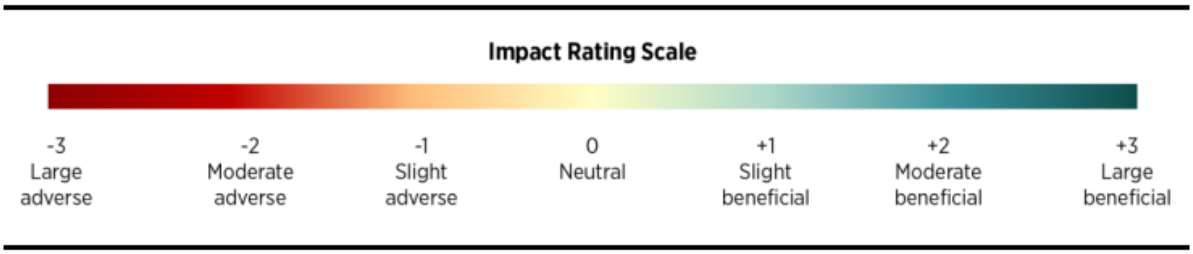
The Department assessed the likely impact of the proposed options on each identified stakeholder group, with regard to views expressed as part of recent review processes and consideration of:

- How the changes proposed would impact the key identified stakeholders.
- Whether the options presented an increase, decrease or no change to regulatory burden.
- An assessment of the impact, using a common scale.

The scale chosen to be used for the assessment is a seven-point scale, indicating the anticipated impact of the preferred option on the achievement of the objectives and impact on particular stakeholder groups relative to the status quo which represents no change to current arrangements. The simple seven-point scale ranges from -3 to +3 (with 0 representing no net change in benefit).

Changes which result in a beneficial impact, or reduce burden, have been rated as positive (green on Figure 7). Changes which increase operating costs or burden have been rated as negative (red on Figure 7). The neutral rating was used to signify minimal impact and that there would be no overall benefit or cost from the option relative to the status quo (yellow on Figure 7).

Figure 7. *Seven-point impact rating scale with -3 to -1 indicating an adverse impact, zero indicating no change from the status quo (neutral), and +1 to +3 indicating a beneficial impact.*



The nominated values in the impact rating scale are intended to support easy interpretation of the ratings rather than representing a precise scale.

Table 2. *Estimate of the benefits and likely achievement of each of the options in the context of the three reform objectives outlined in Question 2 using the seven-point impact rating scale.*

Objective	Option 1	Option 2	Comments
1 - Support GPs and Practices to provide bulk billed care.	+1	+3	Option 1 partially achieves the first objective in supporting access to bulk billed care, with a greater focus on those who are aged 16 and under or who hold a Commonwealth concession card. With an overall long-term decline in the bulk billing rate for GP NRA and a trend of practices shifting towards mixed billing models and away from fully bulk billing models, it is assessed that the status quo achieves an overall slight benefit. Option 2 would significantly increase the proportion of GP NRA bulk billed services and the number of clinics offering fully bulk billed services. This would largely support all Medicare-eligible Australians to access the primary care they need.
2 - Reinforce General Practice as the first point of contact within the health system.	0	+3	With overall GP NRA service numbers declining in recent years, compared to historical year-on-year increases, coupled with a larger portion of the population avoiding GP care due to cost, Option 1 presents a risk of further undermining the role that GPs play in primary and preventative care. Comparatively, Option 2 seeks to restore the level of GP NRA services being sought and rebates claimed, redirecting patients who may be presenting to emergency departments back into the community to receive ongoing primary care from GPs. Option 2 presents a large system efficiency benefit in reinforcing GPs as an initial healthcare contact point.
3 - Make it easier for patients to access affordable care where cost is not a barrier to access.	+1	+3	Under Option 1, only those who are under 16 or have a Commonwealth concession card are eligible for a bulk billing incentive. While service numbers have decreased in recent years, the average out-of-pocket cost has increased and more people are deferring or delaying care due to cost. As inflation continues to apply pressure to business costs, it is likely that this financial pressure will continue to be a barrier for patients seeking to access care. Under Option 2, all patients would be equally supported to access primary care services through universal access to bulk billing incentives and access to fully bulk billed

	services where the patient attends a practice participating in the Program. This provides a large benefit to all patients who are seeking to access care without facing a financial barrier in having to pay an out-of-pocket cost.

The Decision Rule applied for the multi-criterion analysis was to identify the option with the highest overall rating across each criterion. While there is a level of subjectivity to this IA, overall, Option 2 was considered to have the highest rating across each of the three criteria.

Monetized Regulatory Impact

Option 1 – Status Quo

Table 3. *Regulatory impact ($ millions) on key stakeholders for Option 1.*

Average annual regulatory costs				
Change in costs ($ million)	Individuals	Business	Community organisations	Total change in cost
Total, by sector	$0	$0	$0	$0

Option 1 was calculated on the basis that there would be no change to the existing arrangements for bulk billing incentive eligibility and no introduction of additional incentive payments. Children under the age of 16 and those who hold a Commonwealth concession card would remain eligible for a bulk billing incentive in instances where they received a bulk billed GP NRA service.

The regulatory impact in terms of monetized net benefit is expected to be zero for Option 1, given no change to current arrangements. However, as noted above, there is a level of MBS complexity that would remain if the status quo was retained. There is a level of regulatory burden on GP practices in the form of administration and decision making between cohorts of patients, those eligible for bulk billing incentives and those that are not. This places an additional level of consideration and process on GPs and their practice when compared with Option 2 that would have a blanket eligibility for all Medicare registered patients and therefore a more streamlined and consistent process for all patients.

Option 2 – Expand eligibility for bulk billing incentives to all Australians and implement the Bulk Billing Practice Incentive Program

Table 4. *Regulatory impact ($ millions) on key stakeholders for Option 2.*

Average annual regulatory costs				
Change in costs ($ million)	Individuals	Business	Community organisations	Total change in cost
Total, by sector	$0	-$12.8	$0	-$12.8

Under this preferred option, bulk billing incentive eligibility would be expanded to all Medicare eligible patients and the *Bulk Billing Practice Incentive Program* would be implemented.

There is anticipated to be a minimal regulatory impact on businesses in the first year of the Program, or in the year that the practice registers for the Program. This accounts for a small amount of administrative effort that would be required by the practice in signing up to the Program, advertising that the clinic is part of the Program, advising GPs and patients on the requirements of the Program, and adhering to any compliance activities as required. However, over time, this initial registration work is mitigated through incentives linked to the Program and bulk billing incentives as well as efficiencies gained through a more streamlined and consistent process for all patients compared to Option 1 (as outlined above).

The Program will leverage existing IT system infrastructure which will help to support practices easily register for the Program. While a new systems module will be developed specific for the Program, having a familiar system in place will support Practices to quickly become familiar with system requirements, support streamlined registration processes, and minimise any burden on practices and GPs wherever possible. Additionally, encouraging registration and providing training information and support will help to build staff familiarity in using the system and further offset any initial costs associated with implementation.

The Program will also incur a cost to businesses due to the assumed requirement for Practitioners and Practice Managers to meet to discuss their potential involvement, or non-involvement, in the *Bulk Billing Practice Incentive Program*.

The regulatory impact in terms of monetized net benefit is expected to be a save of $51.2 million for Option 2 over four years, or an average annual regulatory cost of -$12.8 million.

Distributional Impacts

The following sections outline the distributional impacts for Option 2 as the option that has been identified as delivering the greatest net benefit.

Bulk Billing Impact

Expanding eligibility for bulk billing incentives to all Australians would mean an additional 15 million people would be eligible for an incentive. Further, we estimate 4,800 GP practices would join the *Bulk Billing Practice Incentive Program* by the end of the forward estimates. Taken together, we estimate these measures would increase the GP bulk billing rate by around 10.5% (from 77.3% to 87.8%). This would equate to an additional 57.6 million services being bulk billed with 18 million additional services per year once the program is fully implemented. This would reduce patient out-of-pocket expenditure by $2.7 billion over the forward estimates. This level of uptake would restore the number of fully bulk billing clinics to levels seen before 2019 and would restore to most Australians the genuine opportunity to receive guaranteed bulk billed GP services if and when they need them. Further detail on costing assumptions and analysis methods are included at Appendix B.

Financial Impact

Implementing this option would cost an estimated $7.9 billion over the forward estimates, and around $2.4 billion per year ongoing.

Business Competition Impact

There is potential for this measure to generate greater competition between practices that register for the Program and those that do not, in the context of attracting and retaining patients. This will be particularly the case in areas that have multiple practices or where patients are able to reasonably travel to other practices located nearby. Patients, when faced with a choice, may gravitate towards a practice that offers bulk billed services. This will generate competition between practices, having a positive impact for patients. Practices will be incentivised to encourage patient retention through signing up to the Program and offering bulk billed services. The risk of enhanced competition leading to reduced business viability is unlikely given the ability of practices to opt-in to the Program at any time and the anticipated continued demand for GP services for the foreseeable future.

Gender Impact

As reported by the Australian Institute of Health and Welfare[51], women lose more healthy years of life from living with injury and disease (58%) than from dying prematurely (42%). Women are more likely than men to live with one or multiple chronic conditions (56% compared to 49%), noting that almost half of all women (45%) experience a mental health condition at some point in their life. Women are more likely to face financial obstacles to accessing primary care than men. The Australian Human Rights Commission's commentary on gender equity highlights that women face a gender pay gap and many encounter reduced employment opportunity due to the time they give to family and caring responsibilities. The ABS' *Patient Experiences* survey found that women were more likely to defer or delay care due to cost in almost all age groups, except for those aged 76-to-80 where the trend was reversed. Younger females were more likely to delay or defer care, peaking at 14.4% for females aged 21-to-25.

Access to medical services, including those delivered by GPs, is often influenced by social, economic and environmental factors. Women represent a higher proportion of the population accessing primary care services, receive a higher number of total services, and a higher average number of services when compared with males[52]. Women are more likely to suffer from more complex or chronic conditions and are more likely to delay or defer care due to cost[53]. Additionally, women are more likely to be single parents, be on income support, earn lower incomes or experience a gender payment gap resulting in lower lifetime earnings.

As a result, while the preferred option is designed to increase access to affordable primary care for all Medicare eligible patients regardless of gender, this proposal will likely have a higher indirect positive impact for females.

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[51] Australian Institute of Health and Welfare (2023). *How does the health of females and males compare?*
[52] Analysis of Medicare Benefits Schedule data for GP Non-referred Attendance Services.
[53] Analysis of the Australian Bureau of Statistic's Patient Experience Survey data.

First Nations Impact

This proposal will contribute towards achieving the Closing the Gap Target 1 – 'Everyone enjoys long and healthy lives'. This proposal will support all Medicare-eligible people to access bulk billed medical services. This includes all First Nations peoples who meet the criteria.

Rural and Remote Impact

Bulk billing incentive benefits vary based on the MBS service provided and remoteness of the practice as determined by the Modified Monash Model. Practices in Modified Monash 2 areas receive around 150 per cent of the rebate compared to those in metropolitan areas, increasing to 190 per cent of the metropolitan rebates in very remote (Modified Monash 7) areas. Providing higher bulk billing incentives in more remote areas helps support bulk billing of patients in thin markets, while recognising that a higher level of competition will influence provider behaviour in metropolitan areas. Under Option 2, higher bulk billing incentives will be available for all regional, rural and remote patients.

Commonwealth/State Impact

The Australian Government has responsibility for administering benefits for services listed on the MBS. This includes bulk billing incentives and all GP non-referred attendance services. In addition, the Australian Government has responsibility for the implementation and administration of incentive payment programs designed to support GPs and clinics remain viable in providing services to the Australian public.

The preferred option may have a positive impact on State and Territory Governments. This would largely be the result of a decrease in potentially preventable hospitalisation presentations attributable to patients being able to access primary and preventative care within the community as a result of the implemented option. This reduction in presentations to hospital would see a small reduction in public hospital expenses.

Preventing hospital admissions and supporting long-term care through regular GP visits is far more cost-effective for the healthcare system. By intervening to increase bulk billing rates, the government can reduce avoidable hospital admissions and shift healthcare resources toward prevention rather than expensive, reactive care.

Greatest Net Benefit

Based on the above regulatory impact costings, seven-point multi-criteria analysis, and distributional analysis, Option 2 was found to have the greatest net benefit.

Importantly, Option 2 will deliver a significant investment into primary care to reduce patient out-of-pocket costs, support the viability of bulk billing for GPs and GP practices, and reinforce Medicare's guiding principle of universal access to quality primary care regardless of a patient's financial circumstances.

Option 2 will save patients $2.7 billion in out-of-pocket costs over the forward estimates. Removing cost as a barrier to accessing care is an important element of strengthening the financial protection offered by a universal healthcare system. Financial protection through universal healthcare access can strengthen health status, reduce poverty, and lessen health and socio-economic inequalities.

The remainder of the net benefit under Option 2 will flow to GPs and GP Practices in the form of additional revenue from expanded bulk billing incentive eligibility as well as additional incentive payments through the Program.

This investment will support viability of bulk billing for GPs and clinics through increased revenue for:

- GPs who are already bulk billing patients not currently eligible for bulk billing incentives,
- GPs who transition to bulk billing patients not currently eligible for bulk billing incentives,
- GP Practices (and their associated GPs) who participate in the Program and commit to bulk billing all their patients for all GP NRA services delivered.

This investment will support viability of remaining fully bulk billing GP clinics and support more GP practices to shift towards adopting a fully bulk billed model. Offering bulk billed care often helps to strengthen patient-provider relationships and enable practices to deliver comprehensive care that achieves the best possible health outcomes for their patients, particularly in instances where patients may avoid care due to cost.

Access to bulk billed services is an essential mechanism in enabling inclusive, equitable and cost-effective primary care services. Supporting practice viability and reducing patient out-of-pocket costs will support patients to access the primary care they need. Option 2 will work to safeguard Medicare's founding principle of universality, ensure good patient health outcomes and cost-effective delivery of health services.

Q5. Who was consulted and how was feedback incorporated?

Purpose of Consultation

Consultation is vital in the development of health policy. It ensures that initiatives are informed by the experiences, needs, and perspectives of diverse stakeholders which includes healthcare providers, patients, peak bodies, and community groups. The Department understands the importance of engaging in meaningful consultation to help identify potential impacts, gaps, and challenges to support the development of more effective, equitable and sustainable solutions. Supporting transparency, accountability and public trust is paramount in ensuring this ongoing collaborative approach. Additionally, the Department sees real value in integrating expert knowledge, lived experiences, and cultural considerations which enhances the relevance and applicability of health policies in addressing real-world issues and improving health outcomes for all communities.

Who should be consulted?

A range of stakeholders should be consulted to support design, implementation and evaluation of the preferred options. This includes:

- Cross-departmental consultation and with impacted policy agencies, including Services Australia.
- Consultation with central agencies, including the Department of Finance, the Department of Prime Minister and Cabinet, the Treasury Department.
- Consultation with peak body representatives including the Royal Australian College of General Practitioners and the Australian Medical Association.
- Consultation with consumer representatives such as the Consumers Health Forum.
- Consultation with Aboriginal Controlled Community Health Organisations.

When will/were stakeholders consulted and how?

In informing the development of the options being considered in this IA, the Department has drawn on the broad range of consultation undertaken in relation to primary care and MBS specific reform over the last five years. In the spirit of ongoing collaboration and the creation of an extensive information base, the Department, along with the support of a range of independent committees, has undertaken a series of reviews and consultation processes in relation to primary care and MBS reform specifically.

The Department considered the incorporation of stakeholder views from the base of recent existing literature to be the most appropriate based on the sensitive nature of the changes, timeframes, and resourcing weighed against the overall net benefit to GPs, GP practices and patients. Further, the options provide for an opportunity for future consultation with stakeholders in the design, implementation and evaluation of the preferred option as detailed further below.

The following sections outline the existing literature, the consultation processes underpinning each, key findings as well as highlighting future consultation opportunities.

2020 - MBS Taskforce Review Final Report

In June 2015, the Australian Government established the Medicare Benefits Schedule (MBS) Review Taskforce to consider how the more than 5,700 items on the MBS could be aligned with contemporary clinical evidence and practice and improve health outcomes for patients. More than 700 clinicians, consumers and health system experts participated in clinical committees and working groups, providing expert advice in the consideration of MBS items and the development of the MBS Review Taskforce Final Report. Primary care was an important element of the review, with a range of allied health, nurse and general practitioner clinicians providing expertise in the consideration of issues and development of recommendations.

The review invested significant time and resources to consult with consumers in an effort to ensure the system remains responsive to and supportive of their healthcare needs. As a result, ongoing collaboration with consumers was built in from the very beginning including by consulting on the development of the review methodology, including consumer impact statements, ensuring additional consideration was given to the views of First Nations people in a culturally safe and appropriate manner, hosting consultation forums and webinars, including representation in clinical committees, establishing consumer panels, and consulting on draft recommendations. This approach ensured that the voice of consumers remained at the centre of considerations and provided sound foundation of views that could be drawn upon.

The review highlighted a number of key issues of concern to stakeholders including out-of-pocket costs, pricing transparency, fee-for-service models, voluntary patient enrolment, and barriers to care. The Taskforce reported that patients frequently choose to receive private care, with limited understanding of the potential costs that may be realised. Consumers often find the fees and treatment plans of medical practitioners confusing and complex and can cause considerable stress. While many practitioners take steps to disclose the relevant costs, the increasing magnitude of out-of-pocket costs having a greater impact on households. In addition to out-of-pocket costs, social disadvantage, geography, and cultural factors can all contribute towards consumers having difficulty in accessing care. The Taskforce highlighted remoteness as a particular example in the Australian context where consumers may be faced with high out-of-pocket costs to access private services or long waiting lists in public hospital systems.

The Taskforce also considered the MBS fee-for-service model. The majority of healthcare providers are small businesses that, in order to be financially sustainable, align their practices according to the incentives of the funding model. While the Taskforce held the view that fee-for-service models support sustainable business models, a number of limitations were highlighted. These included that fee-for-service funding can lead to service delivery fragmentation, perverse incentives to favour high-throughput care, and not achieving the best possible health outcomes for the patient. In circumstances where complex integrated care over longer periods of time is required, the Taskforce noted that fee-for-service can also cause confusion for patients who need multiple attendances potentially with multiple practitioners. Ultimately, the Taskforce considered that alternative funding models should be considered as options to complement MBS fee-for-service funding as a way to support patients to achieve the best health outcomes possible.

2022 – Australia's Primary Health Care 10 Year Plan 2022-2032

As part of the Primary Care 10 Year Plan development, extensive consultation was undertaken by the Department and the appointed Steering Group and included[54]:

- A Consultation Group drawing in more than 100 organisations from across the health system, held in November 2019. These groups were also consulted on the draft Steering Group recommendations in June/July 2021 and on the Consultation Draft of the plan.
- More than 20 roundtables and targeted consultations with consumer, population and provider groups and on various issues for primary health care, including: consumers, rural and remote health, Aboriginal and Torres Strait Islander health, health and the first 2,000 days of life, the health of older Australians, dementia care, preventive health, general practice, nursing and midwifery, allied health, practice managers, mental health, after hours care, the health of people with disability, the health of culturally and linguistically diverse (CALD) communities, LGBTIQ+ health, Primary Health Networks (PHNs), private health insurance and future focused health care.
- Intensive targeted consultations were also held on the health of people with intellectual disability, resulting in the finalisation of the National Roadmap for Improving the Health of People with Intellectual Disability in association with this plan. Each of these roundtables and targeted consultations heard from people with lived experience and involved relevant stakeholder groups, researchers and other experts.
- The Steering Group conducted a consultation on its draft recommendations in June/July 2021, with an associated webinar and submissions process. Over 200 responses were received from interested organisations and individuals.
- The Department conducted a public consultation on a draft of the plan during October/November 2021, with 187 responses received from a range of organisations and individuals for consideration in finalising the plan.

The consultations highlighted many challenges and opportunities facing Australia's health system and for primary health care and primary care services within it. Some select themes, in relation to access to appropriate care and funding models, that emerged throughout the consultation processes included:

- People living in rural and remote areas have more limited access to health care services and poorer health outcomes than people living in metropolitan areas.
- Socioeconomic factors remain important determinants of health, with people in socioeconomically disadvantaged circumstances experiencing poorer access and health outcomes.
- With more investment in prevention and primary health care services, the health system could see fewer hospital attendances and admissions.
- Funding models for primary care services, particularly the MBS fee-for-service structure, tend to reward volume of services provided over value and quality of care. Moving over time to more blended payments – a mix of fee for service and block payments made per patient and/or

[54] Australian Government. (2022). Australia's Primary Health Care 10 Year Plan 2022–2032 | Australian Government Department of Health and Aged Care

for quality and outcomes, with fee for service a lower proportion of the mix – would balance the incentives in the system.
- Greater investments in primary health care would result in savings in hospitals and other parts of the health, aged care and disability care systems. Such investments need to be guided by analysis of the best available data and evidence.
- Greater incentives and reduced barriers are needed to attract more medical students into general practice over other specialities.

2023 - Strengthening Medicare Taskforce

Building on the Primary Care 10 Year Plan, the Minister for Health and Aged Care established the Strengthening Medicare Taskforce in 2022. The members of the Taskforce were health leaders from across Australia's health care system including GP, consumer and health systems and economics experts. Six meetings were held in the latter half of 2022 to consider a range of issues with a focus on:

- improving patient access to general practice, including after hours
- improving patient access to multidisciplinary team care, including nursing and allied health professionals
- making primary care more affordable for patients
- improving prevention and management of ongoing and chronic conditions
- reducing pressure on hospitals.

In the development of the report, the Taskforce conducted a number of deep dives, including on approaches to strengthen relationships between the patient and their care team, and to provide more integrated, person-centred care. The report recommends significant changes to how primary care is funded and delivered to enable high quality, integrated and person-centred care for all Australians and outlines their vision of a primary care system where:

1. all Australians are supported to be healthy and well, through access to equitable, affordable, person-centred primary care services, regardless of where they live and when they need care, with financing that supports sustainable primary care, and a system that is simple and easy to navigate for people and their health care providers.
2. coordinated multidisciplinary teams of health care professionals work to their full scope of practice to provide quality person-centred continuity of care, including prevention and early intervention; and primary care is incentivised to improve population health, work with other parts of the health and care systems, under appropriate clinical governance, to reduce fragmentation and duplication and deliver better health outcomes.
3. data and digital technology are better used to inform value-based care, safely share critical patient information to support better diagnosis and healthcare management, empower people to participate in their own health care, and drive insights for planning, resourcing, and continuous quality improvement.
4. the primary care sector is well supported to embrace organisational and cultural change, and to support innovation; consumers are empowered to have a voice in the design of services to ensure they meet people's needs, particularly for disadvantaged groups; and all levels of government work together to ensure the benefits of reform are optimised.

Under part one of the Taskforce's vision, which is most correlated to the current Government considerations, the report outlined that, since the pandemic, more people are presenting to

emergency departments or delaying care. Access challenges are concentrated amongst people living in rural and remote communities, First Nations Australians, people from culturally and linguistically diverse backgrounds, people with disability and people on low incomes. The Taskforce highlighted the importance of health literacy and awareness in empowering consumers to access care that meets their needs. The Taskforce acknowledge that a combination of blended funding and fee-for-service as well as better targeting of general practice incentive payment programs would help support GPs to remain at the heart of primary care provision and achieve better health outcomes. Among other things, the Taskforce recommended strengthening funding to support more affordable care, ensuring Australians on low incomes can access primary care at no or low cost.

2024 - Practice Incentives Review

In response to the Primary Health Care 10 Year Plan 2022-23 and Strengthening Medicare Taskforce recommendations, the Australian Government announced a Review of General Practice Incentives. An Expert Advisory Panel was established to identify whether the Practice Incentive Program and Workforce Incentive Program are effective and fit for purpose. The panel comprised a broad range of experts from primary care, First Nations, health economics, and health system perspectives.

Stakeholders were consulted through direct consultation, focus groups, a public survey and written submissions. 16 Primary Health Networks (PHNs), 2 Aboriginal Community Controlled Health Organisations (ACCHOs) and 21 Primary Care peak bodies were consulted directly and through focus groups. A public consultation, seeking survey responses and written submissions, was open from 17 November 2023 to 22 December 2023 with190 completed surveys and 35 written submissions received.

The review recommended the programs be retained in the short term and refined to increase their effectiveness in promoting continuity of care. A strong theme that emerged was the Panel's vision for a primary care system that is funded using a blend of fee-for service payments and other funding made directly to practices. To achieve this, among other areas of focus, the Panel recommended a simplified general practice payment architecture, the establishment of an oversight pricing body, and a phased approach to transitioning to such a payment model[55].

Key findings of the overall PIP and WIP included:

- Lack of coherent strategy and alignment between the individual incentives and other government policy.
- Lack of clear linkage between incentives and patient health outcomes.
- Incentives aren't evolving in response to current healthcare challenges, for example, workforce shortages, operational costs and the increasing size of general practices.
- Complex administrative requirements reduce incentive uptake, which disproportionately affects smaller and/or rural and remote practices.
- Many practices rely on incentive payments for practice sustainability, rather than using them to support behavioural change.

[55] Expert Advisory Panel. (2024). Review of General Practice Incentives - Expert Advisory Panel Report to the Australian Government

Addressing Stakeholder Views

In shaping the options proposed in this IA, the Department has had regard to the views of stakeholders as outlined above. The proposed policy options have a focus on further investment of funding into primary care, with particular regard to overcoming out-of-pocket costs to ensure patients, including the most vulnerable and disadvantaged, can access GP care. Access barriers have been a recurring theme throughout the above consultation processes as one of the main concerns to consumers, particularly in a context where there is increasing focus on ways to strengthen the role of GPs in being the initial point of contact with the health system and as a fundamental part of supporting Medicare's guiding principle of universal access to health care.

The proposed option has regard to funding arrangements, both on a fee-for-service basis through bulk billing incentives under the MBS and further program-based incentives and blended funding approaches through the *Bulk Billing Practice Incentive Program*.

In relation to bulk billing incentive, as canvassed in Question 2, benefits vary based on the MBS service provided and remoteness of the practice as determined by the Modified Monash Model. Practices in Modified Monash 2 areas receive around 150 per cent of the rebate compared to those in metropolitan areas, increasing to 190 per cent of the metropolitan rebates in very remote (Modified Monash 7) areas. As part of the preferred option, in expanding bulk billing incentive eligibility, the Government will retain the remoteness scaling as a way to help support bulk billing of patients in thin markets. This approach responds to the repeated consumer feedback above in relation to the access challenges faced in rural areas. While not a complete solution in isolation, it is an important element in providing the additional support to GPs and patients located in these areas.

In shaping the proposed Program, Government has considered the most simple and effective way to provide payments without adding complexity or drastically increased regulatory burden to practices. The linking of the Program to MyMedicare is an important element in addressing stakeholder feedback about the long-term health strategy of coherence and connectedness among initiatives, building the foundations to move towards blended funding approaches and ensuring patients remain at the centre of care.

In shaping the preferred option, the Government has also had regard to the feedback of stakeholders on the importance of transparency of information and building patient awareness as a crucial step in accessing affordable care. GP practices will be required to advertise their participation in bulk billing initiatives at their practice, on their website as well as on the National Health Service Directory website. This is an important aspect of promoting visibility to patients of where they can go to access bulk billed services.

Dissenting Views

While stakeholders have highlighted limitations of a fee-for-service model, there have also acknowledged that complete replacement is not necessarily a feasible option in the current context and the more pressing issue is the investment to support access to primary care and the ongoing viability of general practice.

While the MBS Review Taskforce held the view that fee-for-service models support sustainable business models, a number of limitations were highlighted. These included that fee-for-service funding can lead to service delivery fragmentation, perverse incentives to favour high-throughput care, and

not achieving the best possible health outcomes for the patient. In circumstances where complex integrated care over longer periods of time is required, the Taskforce noted that fee-for-service can also cause confusion for patients who need multiple attendances potentially with multiple practitioners. Ultimately, the Taskforce considered that alternative funding models should be considered as options to complement MBS fee-for-service funding as a way to support patients to achieve the best health outcomes possible.

In addition, the Taskforce also considered financial incentives in the fee-for-service model and the distortions such incentives can create. One rationale for the use of loadings is to promote the uptake of items, or service delivery in areas with access issues. Stakeholders noted that this may over-reward clinicians that specialise in particular modes of delivery. The Taskforce endorsed the principle that MBS fee loadings should not be used for purposes such as: incentivising the uptake of new MBS services promoting service delivery in locations which may have access issues (such rural and remote areas) and compensating for additional capital or other costs associated with delivering a service.

In considering these views, the Department adopted a two-pronged approach to investment. The preferred option will support GPs and practices to remain viable when bulk billing all patients through two mechanisms, bulk billing incentive eligibility for all patients and additional incentive payments under the Program. This combined investment is a foundation step towards blended funding which is proposed to be further developed under Phase 2 of the Program. Importantly, the preferred option does not seek to differentiate patient cohorts through discriminating loadings but rather make incentives available to all patients regardless of where they live and their financial means. The proposed option will support GP practices in terms of the financial viability of delivering a primary care service and patient needs (by removing cost barriers to accessing primary care), in line MBS principles that MBS benefits are patient benefits.

Evaluation of Consultation Approach

While the Department has not consulted specifically on the totality of the options outlined in this IA due to the sensitive nature of the proposals and their consideration through confidential Government Budget processes, the Department has drawn on a broad range of recent reviews that have had consideration of primary care issues and had extensive consultation as part of the review process. While the Department's usual approach would be to use existing literature to inform development of policy and targeted consultation on the proposed options, the approach taken by the Department in this instance was considered reasonable given sensitivities, resourcing and time pressures.

The reviews outlined above have been finalised within the last five years, meaning that the views of stakeholders are contemporary, and the recommendations made based on extensive consultation and extensive data. Further the preferred policy option is not a drastic change to the current primary care policy landscape. Bulk billing incentives and incentive programs for GPs are not new concepts meaning that the existing literature and stakeholder views concerning these types of arrangements are relevant and appropriate to consider.

Overall, the approach adopted for this policy development has been assessed as reasonable particularly given the extensive nature of existing reviews, the existence of current incentives and the opportunities for consultation that will be available during implementation.

Further Consultation Opportunities

The Department proposes to undertake additional consultation with a range of stakeholders to inform the refinement of the proposed approach to implementation. This is an integral step in implementing any healthcare reform agenda to ensure that solutions remain flexible to emerging needs and are informed by on-the-ground experiences from a diverse range of affected patient and practitioner cohorts.

This includes consultation with Aboriginal Community and Controlled Health Organisations (ACCHOs), primary care providers, GPs, medical representative groups such as the Royal Australian College of General Practitioners (RACGP), the Australian Medical Association (AMA), other primary care health professionals and their representative organisations, relevant areas of the Australian Government and state and territory governments. Significant consultation will be undertaken with Services Australia, particularly in relation to the design of IT systems that can support implementation of each of the Programs outlined. This systems consultation would be ongoing in the lead up to implementation commencing. Other digital and data reforms would involve ongoing consultation with the Digital Transformation Agency, Australian Digital Health Agency and HealthDirect.

In addition, implementation of changes to the MBS also has an extensive consultation and engagement process. This generally includes consultation with peak bodies and information sessions with individual practitioners. In line with usual practice, the Department proposes to prepare factsheets to ensure proposed changes are understood and disseminated to providers and practice managers well in advance of amendments commencing.

Phase 2 of the *Bulk Billing Practice Incentive Program* will be subject to an internal review. This will provide additional opportunities for consultation and to collect feedback from stakeholders and end users on the success of the Program and any areas of improvement. Maintaining a collaborative approach is vital to ensure a smooth transition and a fit-for-purpose program that supports patients to access primary care as well as supporting the viability of practices.

Q6. What is the best option from those considered and how will it be implemented?

What is the best option?

Of the options presented, Option 2 is the most effective in delivering on the Government's objectives as outlined in Question 2 and presents the greatest net benefit.

Option 2 is recommended because it provides the greatest increase in patient access to bulk billed GP attendance services and offers the greatest alignment in returning Medicare to its original intent of providing universal access to free primary care through near universal GP bulk billing coverage. Option 2 also presents net regulatory efficiencies of $51.2 million over the forward estimates, as administrative staff at GP clinics would save time by not needing to confirm that patients were eligible for bulk billing incentives before lodging a claim.

Without the additional investment in primary care proposed under Option 2, there will likely be a continued increase in cost pressures faced by patients in trying to access the care they need and an increased likelihood that patients will defer or avoid care altogether. Without intervention, overall health outcomes are likely to deteriorate with more patients presenting to public hospital emergency departments for health issues that could have been managed if access to primary and preventative care had been possible.

Implementation

Implementation of Option 2 will require legislative amendments and investment to support changes to payment systems managed by Services Australia to administer the changes to bulk billing incentive eligibility and to support implementation and payment of incentives under the Program.

The expansion of eligibility for bulk billing incentive items would be implemented through amendment of the *Health Insurance (General Medical Services Table) Regulations 2021*. The expenditure element of the Program would be initially supported through amendment to the *Financial Framework (Supplementary Powers) Regulations 1997*.

Implementation of the Program will require Services Australia to make systems changes, leverage existing systems and platform infrastructure for implementation where possible including the newly delivered organisational payment capability. This is an extensive process that requires the detailing of business rules underpinning the registration, payment and compliance activities for administration of the Program. This will be developed between the Department and Services Australia.

Communication and awareness of the proposed policy intervention will be a crucial component of implementation. This will build awareness and understanding of the initiatives both for members of the public and GPs and their associated clinics.

Development of a tailored communications strategy will be undertaken and will require formative research to determine attitudes and behaviours of patient cohorts (including rural and remote and First Nations research), concept development and testing based on audience, identification and securing of appropriate media channels, public relations activities including liaison with key

organisations and stakeholders, and collaboration with specialist agencies to cater to diverse patient cohorts.

Consultation processes for MBS item changes generally involve engagement with peak bodies, hosting information sessions and distribution of factsheets ahead of these being published on the MBS Online website. Additionally, the Department will consider appropriate channels to promote awareness of the changes to the public. This may include social media, advertisements, and announcements. Communication activities would occur prior to implementation on 1 November 2025 and after to maintain awareness once changes are live.

Table 5. *Implementation Plan including stage description and timing.*

Stage	Description	Timing
Stage 1 – legislation amendment and IT build	Legislative amendments passed. Business rules drafted and confirmed by the Department of Health and provided to Services Australia to confirm IT build specifications.	Q2/3 2025
Stage 2 - communicate	Consultation with key stakeholders undertaken to inform policy, legislative and system development. Communication campaign – including formative research, material development, concept testing, factsheets etc.	Q2 2025
Stage 3 - commence	Practice registration for the Program open and Phase 1 of the Program commenced. Bulk billing incentive eligibility expanded and in force.	Program commenced from 1 November 2025 noting registration to open prior and be ongoing. Implementation of bulk billing incentive item changes to be completed and in force on 1 November 2025.

Implementation Risks

While Option 2 has been determined as the most suitable from those considered, it is not without challenges and risks to achieving successful implementation.

Changes to MBS items require legislative drafting and approval processes. There is a small risk in implementing these changes by the proposed date. To reduce the risk of this occurring, the Department will closely and regularly engage with key stakeholders to ensure they are aware of the action required and time constraints. In the unlikely scenario that changes could not be implemented by the proposed timeframe, a new commencement day may need to be agreed which would be communicated to the relevant stakeholders and the public well in advance.

In relation to implementation of the Program, there is a risk that the required IT solution is not in an operational state by the commencement date (1 November 2025). This risk is being mitigated by close and ongoing consultation between the Department and Services Australia regarding system requirements and design.

Considering the recent decline in GP service volumes and emerging workforce shortages, there is a risk the benefits from improved access to bulk billing services are offset by continued decline in the overall number of GP NRA services. There is also a risk that an ageing population with higher prevalence of complex health needs means more GP services go towards older and wealthier patients, with services for working-age and poorer patients continuing to decline. This risk will be mitigated by Government policies to expand the GP workforce to meet the needs of the population.

Given the proposed approach to consultation as part of implementation, stakeholders will be closely involved throughout the development process. As such, there will be collective efforts in working towards successful implementation and awareness of risks that can be mitigated by appropriate parties should the need arise. There is a risk that the requirement to provide Services Australia with urgent policy parameters detracts from our ability to respond to stakeholder feedback. This risk has been partially mitigated through building some flexibility into the payment system.

Interim and Final Decision Points

The interim decision point for the preferred option will be when the Government considers the proposal. The Final Decision Point will be either when the policy is announced publicly or when legislative amendments are introduced – whichever comes first. A First Pass assessment was undertaken in February 2025 with a Second Pass assessment expected to be completed prior to the Final Decision Point.

Q7. How will the chosen option be evaluated against success metrics?

Evaluation of the preferred option

In accordance with the decision rule and considerations outlined in this IA, the chosen option (Option 2) to expand bulk billing incentive eligibility to all Australians and implement the *Bulk Billing Practice Incentive Program* delivers the greatest net benefit. This option clearly corresponds to all three Government reform intervention objectives by:

- Supporting GPs to provide bulk billed care while sustaining the ongoing viability of GP practices.
- Reinforcing General Practice as first point of contact with the health system.
- Making it easier for patients to access affordable care.

Option 2 has been assessed as delivering the greatest net benefit to stakeholders (particularly patients, GPs and practices) including a combined increase of 10.5% to the overall bulk billing rate for GP services (from 77.3% to 87.8%), an additional 57.6 million services being bulk billed (up to 18.3 million per year at full implementation) leading to a $2.7 billion reduction in patient out-of-pocket costs over the forward estimates. This option will also support an additional 2,850 practices to transition from mixed billing to fully bulk billing – for a total of 4,800 clinics signing up to the Program.

Option 1 (status quo) does not deliver the same net benefit. It is anticipated that the overall bulk billing rate will remain largely static. However, this is not a guarantee that, meaning there is a risk that it could decline further, particularly for non-eligible patients, without intervention.

How will the chosen option be evaluated?

Purpose

Evaluation is a critical part in determining whether policies and programs are efficiently achieving their objectives and is an important tool to improve policy design and implementation.

The Department will internally evaluate the two components of the preferred option (Option 2) to assess implementation and determine whether the preferred option achieved its objectives, measure impact on key stakeholders, and provide an evidence base to support any further policy development and decisions. This will support consideration of refinements to the *Bulk Billing Practice Incentive Program* prior to any progression to Phase 2 as well as to guide future policy direction and implementation.

The evaluation report will be considered internally within the Department as well as by Government, as required.

Methodology

The evaluation will be conducted in accordance with the Department of Health and Aged Care's Evaluation Strategy 2023-2026 as well as the Australian Centre for Evaluation's Commonwealth Evaluation Policy. This will support a principles-based evaluation approach that is fit-for-purpose, useful, robust, ethical, culturally appropriate, credible, transparent, timely and embedded where

appropriate. In addition, the evaluation will be undertaken with consideration of the Department's 4As of evaluation:

- Accountability: observing the core set of obligations of the *Public Governance Performance and Accountability Act* that apply to all Commonwealth entities.
- Allocation: informing consideration of policy and program investment decision for great returns.
- Analysis: providing reliable and robust information and evidence to support evidence-based policy development, program design and implementation.
- Advocacy: evidence-based articulation and communication of the value of the Department's work and provide greater confidence for stakeholders and build trust in government.

In selecting the methodology, consideration will be given to evaluation questions, objectives, audience, any practical, ethical and cultural issues, cost and timeframes. The evaluation will consist of both process and outcome evaluations to ensure that the policy is not only implemented effectively but also achieves its intended objectives. Both existing metrics and data sources will be drawn on primarily to support assessment of implementation against each objective. Additional metrics and data sources may also be identified throughout the evaluation process and incorporated as appropriate.

Process evaluation will monitor the extent to which requirements, including as outlined in legislation and guidelines, are being met by participating GP clinics and other parties. Process evaluation will help to assess the appropriateness and effectiveness of the implemented initiatives. It will be used to identify if there are any factors that might impact achievement of the intended outcomes as well as whether there are any refinements that may be appropriate to consider. This will help to support ongoing compliance with legislative requirements.

Outcome evaluation will seek to undertake analysis and generate evidence to measure and assess the extent to which the preferred option is achieving the stated objectives and overall bulk billing outcomes. It is proposed that this will occur two years after the implementation date to ensure that sufficient data and information is available to undertake a comprehensive and well-informed evaluation.

Evaluation Plan

Stage 1: Planning and budgeting

The evaluation will be designed to assess the impact and outcome of expanding bulk billing incentive eligibility to all Australians and implementation of the *Bulk Billing Practice Incentive Program*.

A detailed evaluation plan will be developed that will:

1. Be informed through investigation of the Department's operating context, purposes, key activities and current performance framework. It will also consider the key stakeholders that will be affected and/or consulted throughout the evaluation, including to inform a culturally and ethically appropriate approach to the evaluation.
2. Outline evaluation questions and defines the evaluation objectives which, at a minimum, will include:
    - To assess the extent that success metrics have been achieved for each of the following intervention objectives:
        - Support GPs and Practices to provide bulk billed care.

    - Reinforce General Practice as first point of contact with the health system
    - Make it easier for patients to access affordable care where cost is not a barrier to access.
  - To identify any emerging needs, gaps or priorities.
  - To identify opportunities for improvement.
  - To provide accountability and transparency.
3. Determine the scope and approach including the resourcing and effort required and the optimal evaluation design, including both process and outcome evaluation methodology.
4. Identify the evidence and data that will be fit for purpose, sufficient and appropriate to use in a manner that is ethical, culturally appropriate, efficient and adheres to privacy principles as required.

The Senior Responsible Officer overseeing the team responsible for implementation of the preferred option will be the responsible decision maker and consider the appropriate conduct of an evaluation as well as appropriate timing. This decision is proposed to occur within two years of implementing the preferred option - prior to the end of the 2027 calendar year.

The Department will have dedicated resourcing to undertake the evaluation and will draw on technical expertise from teams within the Department that are responsible for MBS data analytics, MBS policy and incentive program design and implementation. The evaluation team will be supported by the Department's evaluation hub which is responsible for the Department's evaluation strategy, providing evaluation expertise, tools and methodologies to support best-practice evaluations.

Within the Department, teams responsible for the implementation or ongoing management of policies and programs will be responsible for providing the resourcing to undertake the evaluation including for specific data resources. The Department has MBS data analytics expertise and program incentive expertise that will be drawn on to inform the technical aspects of the evaluation. The Department's evaluation hub provides support to teams in the form of evaluation expertise, tools and methodologies. In some circumstances, the Department may seek additional support where independent analysis may be appropriate.

Stage 2: Measuring and assessing

The success of the chosen option will be measured against metrics that align with the desired objectives of the reforms. Question 2 outlines the initial metrics that will be used to measure the reform objectives. At a minimum, the following metrics will guide the evaluation:

Objective 1 - Support GPs and Practices to provide bulk billed care

I. Success Metric – 87.8% of GP NRA services are bulk billed by 2028-29.
II. Success Metric – 3,600 GP clinics sign-up to the Bulk Billing Practice Incentive Program in the first 2 years (noting 4,800 are expected to sign up at full implementation).

Objective 2 - Reinforce primary care as the first point of contact within the health system.

I. Success Metric – Over 90% of the eligible population receives an MBS service from a GP.

Objective 3 - Make it easier for patients to access affordable care where cost is not a barrier to access.

I. Success Metric - 87.8% of GP NRA services are bulk billed by 2028-29.
II. Success Metric - 50% decrease in total out-of-pocket costs for GP NRA services.

Data analysts within the program implementation team will consider the type of data required to assess each of the evaluation objectives and metrics, how the data will be organised and stored, and the best way to visualise the data. The technical nature, level of subject expertise, and extent of data analysis will require dedicated resources from within the Department. Analysis of data will occur within appropriately secure data environments, including in the Department's Enterprise Data Warehouse. Release of data will follow the Department's formal processes of data custodian approval. This will ensure that the collection, storage and use of data remains robust, ethical, culturally safe and properly governed as appropriate. Analysis will seek to understand the appropriateness, efficiency and effectiveness of the implemented option and will be undertaken in a way that is:

- Rigorous and unbiased
- Repeatable, objective and done in context with a view to having impact
- Understood, with uncertainty managed
- Robustly addressing the key evaluation questions and objectives.

The evaluation is not likely to involve human research as part of its data collection and analysis activities. The evaluation will largely draw on administrative data sets, particularly MBS administrative data collected by Services Australia in the process of administering MBS claims. This data is provided on a routine basis, is de-identified, does not contain personal documents or information, and adheres to strict confidentiality provisions. Linked datasets and official statistics, including as published by the Australian Bureau of Statistics will also be drawn upon as part of the evaluation.

All holders of confidential Medicare data are bound by the secrecy provisions in the *Health Insurance Act 1973*. Publication of statistics by the Commonwealth is permitted under the Act, however, the Act specifies that statistics shall not be published in a manner that enables the identification of an individual patient or an individual practitioner. These provisions will be strictly adhered to during the evaluation, including for any consultation or publication purposes.

Data that will be considered as part of the evaluation will include but not be limited to:

- Number of GP NRA services claimed.
- Number of GP NRA services bulk-billed.
- Number of bulk billing incentives claimed.
- Out-of-pocket costs associated with GP NRA services.
- Number of practices and Practitioners participating in the Program each quarter.
- GP NRA bulk billing rate of practices participating in the Program.
- Percentage of patients delaying or deferring care, including due to cost.

Data is often analysed in aggregate and sliced by patient age, patient location, practice type (e.g. practices participating or not in the Program) and service type to provide trend insights and identify gaps.

Success of the implemented option may be measured in a number of ways but will include the monitoring of the realised bulk billing rate compared post implementation to currently predicted trends. The Department monitors the claiming of bulk billing items and bulk billing rates on an ongoing basis and will continue post implementation. The Department will continue to undertake analysis on the proportion of practices that bulk bill all GP NRA services they deliver. A comparison against trends in proportion of fully bulk billing practices will be undertaken as a key measure of Program success.

The Department will work with Services Australia to monitor the implementation of the Program and compliance with requirements.

While not anticipated, the Department will seek independent ethics approval by an independent Human Research Ethics Committee if additional human-centered data collection analysis activities are undertaken, such as through surveys, interviews or focus groups, and in the instance where those activities would present a risk of harm to participants.

As part of this stage, a tailored stakeholder and communications strategy will be developed to support development and consultation on the evaluation plan and data analysis findings. The Senior Responsible Officer will be responsible for agreeing which stakeholders will be included in the consultation process, the extent of information that will be shared, and the format in which consultation will take place.

It is anticipated that the Department will formally engage in a consultation process with peak bodies, including the Royal Australian College of General Practitioners and the Australian Medical Association. This is likely to include the distribution of consultation papers to test initial findings and gather views and commentary from the sector on the success and challenges experienced through implementation. This will be particularly important in informing further policy development in relation to Phase 2 of the Program. Additionally, consumer groups such as the Consumer Health Forum may be engaged to ensure there is equal sector and patient representation and input. Engagement with key stakeholders will help to ensure the analysis is fit for purpose, test assumptions, alert them to the evaluation process, and provide an opportunity for comment including to identify any issues with the evaluation process and presented data insights.

Stage 3: Reporting and accountability

The program implementation team will be responsible for preparing the evaluation report. The report will include the findings from the evaluation in answer to the evaluation questions and objectives, identify any implementation challenges or limitations, and provide data visualisations that inform decision makers and support them to understand whether the program is on track. The evaluation may include recommendations to improve the implemented mechanisms as well as suggested considerations for future policy design and implementation, including for Phase 2 of the Program.

The timing of report finalisation will largely be driven by the need to inform funding and resourcing decisions for the next phase of the Program. There may be a need for interim evaluation findings to be considered by the Senior Responsible Office to inform such decisions.

As outlined in the Department's evaluation strategy, Executive Committee is responsible for the overall governance, management, policy leadership and strategic direction of the Department. It has responsibility for oversight of the Department's evaluation activities, including whether an evaluation report will be published. As such, the Executive Committee will be the ultimate decision maker in determining whether to publish the evaluation report and the appropriate timing of any publication. Should the report be published, the Department will ensure it meets publication accessibility requirements.

The Program manager and the MBS policy area responsible for bulk billing incentives will have joint responsibility for consideration of any evaluation findings and recommendations and subsequent

implementation as required. This will include responsibility for any internal reporting and progression of further policy initiatives through budget cycles as required.

The evaluation will be drawn upon by the relevant MBS policy teams to satisfy any requirements of a post-implementation review for changes to bulk billing incentives. It is generally standard practice to undertake a post implementation review of any significant changes made to MBS items, to assess the effectiveness of the changes and identify whether any further policy changes may be appropriate. The report may be used to inform any parallel policy considerations underway, such as the Medicare Benefits Schedule Review Advisory Committee's review into MBS time tiered items for primary care.

Table 6. *Evaluation planning including responsibilities and timing.*

Task	Responsible	Timing
Evaluation plan created and reviewed.	Program team with input from related policy and data teams as well as the Department's evaluation hub.	Q2/3 2025
Decision to begin evaluation.	Senior Responsible Officer.	Q2/4 2026
Data gathering and analysis.	Program team data analysts with input from related policy and data teams.	Ongoing
Communication and consultation with stakeholders.	Program team.	Q4 2026
Interim findings considered to inform resourcing and design considerations for Phase 2 of the Program.	Senior Responsible Officer	Q2 2027
Evaluation report finalised.	Program team with input from related policy and data teams.	Q4 2027
Final report endorsement and decision to publish.	Senior Responsible Officer and Executive Committee	At the discretion of the Executive Committee, no later than one year post finalisation.

Appendix A – Regulatory Impact Costing Estimates

This section endeavours to quantify the impacts of the proposed option on Australians overall, above the baseline scenario represented by the status quo. The net impact will be estimated by summing up the impact on Australian consumers/patients, businesses industry, and community organisations. This supports the costings presented in Question 4 of the IA.

Patient/Consumer and Community Organisation Impact

There is no regulatory burden estimated for individual consumers/patients or community organisations. However, it should also be noted that patients will benefit from the preferred option as they will have greater support to access bulk billed services and consequently receive better continuity of care and ultimately better health outcomes.

Business Impact

The analysis of the business regulatory burden includes costs for GPs and their associated practices (including standard general practices and other practice models such as ACCHOs) to register for the Program and undertake associated administrative tasks.

The estimated costs include:

- The salary and time costs of practice staff (including administrative staff and GPs) to become accustomed with the Program requirements and new BBI eligibility rules, and to decide whether they will participate in the Program or not – estimated to be a one-hour staff meeting.
- The salary and time costs of the practice administrative staff to register for the Program in the Services Australia's IT system, update the practice website with details of the Program and provide information to patients on the bulk billing approach at the practice. This is estimated to be a full day's work for one administration staff member.

Business Impact Offsets

It is estimated that the cost impact to businesses will be more than offset by the efficiencies gained from streamlined billing processes at practices once bulk billing incentive eligibility is expanded. This saving is based on administrative staff at practices no longer needing to check – with patients or through systems – whether patients are eligible for a bulk billing incentive item before making a claim.

Estimated Net Impact

The overall estimated net impact for the preferred option is a save of $51.2 million over four years or an average annual regulatory impact of -$12.8 million.

Clinics Program - Practice Staff Program Decision and Familiarisation

	2025-2026	2026-2027	2027-2028	2028-2029	Total
Total number of practices expected to register for Program	1,603	3,206	4,573	4,814	
Number of new practices registering each year	1,603	1,603	1,367	241	
Average number of administrative staff per practice	2	2	2	2	
Average number of GPs per practice	5	5	5	5	
Time to meet with all practice staff (hrs)	1	1	1	1	
Administrative staffing cost per hour	$85.17	$87.75	$90.40	$93.15	
GP staffing cost per hour	$250	$257.50	$265.25	$273.25	
Sub-total	**$2,276,805**	**$2,345,189**	**$2,060,137**	**$374,165**	**$7,056,296**

Clinics Program - Meeting Initial Program Requirements

	2025-2026	2026-2027	2027-2028	2028-2029	Total
Total number of practices expected to register for Program	1,603	3,206	4,573	4,814	
Number of new practices registering each year	1,603	1,603	1,367	241	
Time to register, update clinic website and health direct website, distribute patient information (hrs)	7.5	7.5	7.5	7.5	
Administrative staffing cost per hour	$85.17	$87.75	$90.40	$93.15	
Sub-total	**$1,023,956**	**$1,054,974**	**$926,826**	**$168,369**	**$3,174,125**
Total costs	**$3,300,761**	**$3,400,163**	**$2,986,963**	**$542,533**	**$10,230,421**

Expansion of Eligibility for Bulk Billing Incentives - Administrative Efficiencies

	2025-2026	2026-2027	2027-2028	2028-2029	Total
Total number of GP practices	6,633	6,633	6,633	6,633	
Time saved per week in process efficiencies and patient claim processing (hrs)	0.5	0.5	0.5	0.5	
Administrative staffing cost per hour	$85.17	$87.75	$90.40	$93.15	
Total savings	**-$14,688,248**	**-$15,133,190**	**-$15,590,203**	**-$16,064,463**	**-$61,476,103**
Total impact (savings)	**-$11,387,487**	**-$12,603,240**	**-$12,603,240**	**-$15,521,930**	**-$51,245,682**

The following assumptions have been applied to the costings:

- Based on an estimate that an average clinic employs two administrative staff and five general practitioners.
- Administrative staff hourly rate is based on the Office of Impact Analysis' Regulatory Burden Measurement Framework's scaled default hourly cost which accounts for non-wage labour on-costs such as payroll tax and superannuation as well as overhead costs such as rent, telephone, electricity and information technology equipment expenses. An average 3% increase has been applied year on year.
- Hourly cost for GPs has been selected based on an average hourly rate on a search using seek.com.au. It is important to note that this is an indicative cost for a GP to attend an hour practice meeting for the purposes of discussing the Program rather than accurately reflecting the hourly practicing rate for a GP. An average 3% increase has been applied year on year.
- It is unlikely that all practices will commence participation in the first year and not all practices within Australia will participate in the Program. As such, we have assumed a phased uptake with a total of 4,814 practices registered for the Program by the fourth year.
- Only costs and saves directly related to delivery of MBS services have been considered.
- Totals have been rounded to the nearest dollar.

Appendix B – Costing Assumptions

The modelling for the preferred option (Option 2) was separated into two models that interact with each other to calculate the overall cost and impacts – such as impact on the bulk billing rate, impact on patient out-of-pockets, additional bulk billed services, and number of patients bulk billed.

Expanding eligibility for Bulk Billing Incentives to All Australians

The bulk billing incentive model takes in MBS data containing the number of GP NRA services, bulk billing services and the bulk billing rate aggregated by single year of age and concession card status. The model assumes that when the bulk billing incentive eligibility change is implemented, the bulk billing rate for adult non-concessional patients by single year will increase by 10 percentage-points – this reflects the difference in bulk billing rates for people aged 5-15 who are eligible for a bulk billing incentive because of their age and those who are eligible due to holding a concession card. This increase factor is applied to services to the current non-eligible population to estimate the new number of bulk billed services, benefits paid, bulk billing rate, and patient out-of-pocket savings.

Bulk Billing Practice Incentive Program

The Bulk Billing Practice Incentive Program model takes in MBS data containing information on GP NRA services and income, split into benefits paid and out-of-pocket costs at a GP practice level. The model assumes that a GP clinic will enroll in the program if the incentive payment the clinic would receive (equal to 12.5% of the clinics MBS benefits) is equal to or greater than the sum of out-of-pocket costs the practice would have to forego. If a clinic is already bulk billing, they will very likely join the program without any change in behavior. The model takes into account the impacts of the bulk billing incentives model by modifying the bulk billing rate and payments at the practice level.

The final costings assume that MBS rebates are indexed using WCI-5 and service volume growth in line with recent trends.

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All information in this publication is correct as at February 2025