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Who's getting caught?

An Analysis of the Australian Medicare Safety Net

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Abstract

The Medicare Safety Net Policy was introduced in March 2004 to provide financial relief for those Australians who face high out-of-pocket costs incurred through out-of-hospital medical services. This study examines variation in Safety Net benefits by federal electorate and by type of medical service. The results indicate widespread variation in Safety Net benefits. There were significantly higher Safety Net benefits in electorates with relatively high median family income and lower health care needs. The study also shows that patients who use private obstetrician and assisted reproductive services are the greatest beneficiaries of the policy. Whilst the Safety Net was introduced to help reduce out-of-pocket medical costs, this analysis shows that it may be missing the intended policy target.

Key words: Medicare, health care policy, out-of-pocket costs, co-payments, catastrophic insurance, Australia.

1. Introduction

Since its introduction in 1984, the Medicare program has been a fundamental component of Australia's public health care funding arrangements. In 2003/04, the Australian Government spent nearly $9 billion on Medicare related services, accounting for 11% of total health care expenditure (Australian Institute of Health and Welfare. 2005; Department of Health and Ageing 2006a). Medicare covers eligible out-of-hospital services such as general practice visits, specialists' consultations, pathology and diagnostic imaging services, as well private inpatient therapeutic services.

The Medicare Safety Net was introduced in March 2004 to supplement existing Medicare subsidies and provide additional public funding for families and individuals who have incurred high out-of-pocket (OOP) costs in any given calendar year. The Medicare Safety Net only covers services received on an out-of-hospital basis – often referred to as outpatient services. The focus of this paper is therefore on Medicare outpatient services.

Under the Medicare program, patients receive a subsidy worth 85% of the Medicare schedule fee for all eligible outpatient services. The schedule fee is set by the government but providers are not bound by it. In fact, providers are free to set their fees and their right to do so is widely regarded as constitutionally guaranteed (Scotton 1998).

Before the introduction of the Safety Net, Medicare was a "rear-end" deductible (as opposed to a "front-end" deductible) insurance program - where a fixed amount of the service fee was publicly subsidised and any fees above this level could only be met by patients directly through OOP costs. Private insurance is prohibited for Medicare eligible out-of-hospital services.

In recent years there have substantial rises in the OOP costs for Medicare outpatient services. Between 1995 and 2004 these costs increased by 7.1% per annum in real terms (Australian Institute of Health and Welfare. 2005). Following this period of rapidly rising expenses, the Australian Government introduced a package of measures, labelled *Medicare Plus*, designed to reduce OOP costs. The Safety Net formed part of the *Medicare Plus* package (Department of Health and Ageing 2004a; Department of Health and Ageing 2004b).

The policy starts providing benefits once an individual's or family's Medicare related OOP expenses exceed a certain threshold. After the threshold is reached, the Safety Net reimburses patients 80% of all subsequent OOP costs for Medicare outpatient services – the remaining 20% is met by patients themselves.

Each person is covered by one of two thresholds. When the policy commenced, the threshold for concession card holders and recipients of Family Tax Benefit Part A[i] was AUD300, and AUD700 for everyone else. The government estimated that around 12 million Australians would be covered under the lower threshold (Department of Health and Ageing 2005a).

All OOP costs incurred through the use of Medicare outpatient services are counted towards the threshold. Once a family is registered, each family member's OOP benefits is counted towards the family's Safety Net threshold. There is no distinction in the threshold level between individuals, couples and families. As a result, registered families are more likely to reach the threshold sooner because their OOP medical costs are combined. For families who have not registered, each member's OOP expenses counts towards their own, rather than collective, threshold. The threshold count starts afresh on 1 January of each year.

The Safety Net represents a major change in public funding arrangements. For the first time, coverage has been expanded beyond the schedule fee and public subsidies are available for health care costs that were previously uninsurable (either publicly or privately).

The objective of the Medicare Safety Net policy is to provide "disaster insurance" for people with a complex condition and for those with other high health care needs (Department of Health and Ageing 2004b). Given these objectives, we anticipate that people with poor health will benefit most from the Safety Net because of our expectations that these people are high users of health care and therefore face high out-of-pocket costs. Furthermore, given that people on lower incomes qualify more easily for Safety Net benefits and that people on low income generally suffer poor health (Draper, Oldenburg, Turrell 2004; Turrell, Stanley, de Looper et al. 2006), we would expect that people on low incomes will benefit more from the Safety Net.

This paper analyses the geographical and professional distribution of Safety Net payments, using data from the 2004 and 2005 calendar years. The data used in this study covers the period that witnessed the introduction and implementation of the policy and finishes just prior to recent government changes which came into effect on 1 January 2006. The study has two objectives. Firstly, it identifies the significant area-level drivers of high OOP costs and Safety Net benefits. Secondly, it estimates the distribution of Safety Net Expenditure by professional services category. Sections 2.1 and 2.2 set out the methods for meeting these two objectives respectively. The results of the area-level analysis are reported in Section 3.1 and the distribution of Safety Net benefits by professional category is reported in Section 3.2. Section 4 discusses the implications of this study.

2. Methods

2.1 What drives area-level OOP costs and Safety Net benefits?

In the absence of individual level data on Safety Net benefits, we use area-based data to identify the factors driving Medicare service related OOP costs and Safety Net benefits. Safety Net benefits data in Australia's 150 federal electorates were made publicly available for the 2005 calendar year (Department of Health and Ageing 2006b).

Three regression models were used to estimate the effect of area-based characteristics on Safety Net benefits. The models each have a different dependent variable but the area-

based characteristic (independent) variables are identical. Model 1 estimates the area-based drivers of the number of people who qualify for Safety Net benefits. This model can be regarded as a proxy for the number of people who face high OOP costs; Model 2 estimates the level of support that the Safety Net provides to an electorate per capita. Model 3 estimates the level of support the Safety Net provides to an electorate per individual who has qualified for benefits. Model 3 therefore estimates the intensity, or level of concentration, of Safety Net benefits within the electorate.

$$(1) \quad P_i = \alpha_1 H_1 + \alpha_2 D_i + \alpha_3 I_i + \alpha_4 X_i + \alpha_5 G_i + u_i$$

$$(2) \quad E_i = \beta_1 H_1 + \beta_2 D_i + \beta_3 I_i + \beta_4 X_i + \beta_5 G_i + v_i$$

$$(3) \quad Q_i = \partial_1 H_i + \partial_2 D_i + \partial_3 I_i + \partial_4 X_i + \partial_5 G_i + e_i$$

Where, for each federal electorate i, P_i = number of people who qualified for Safety Net benefits; E_i = average Safety Net benefit per capita; Q_i = average Safety Net benefit per qualifier; H_i = health need measured by the premature mortality rate and self-assessed health status; D_i = demographic variables; I_i = median weekly family income; X_i represents supply of and access to medical services; G_i = geographic variables and u_i, v_i and e_i are the error terms for Models 1, 2 and 3 respectively.

Table 1 provides more detail on the variables used in the models as well as data sources.

INSERT TABLE 1

Our hypotheses regarding the model's results were that (1) better health is associated with lower health care use, lower out-of-pocket costs and therefore lower Safety Net benefits, (2) electorates with a higher proportion of older citizens receive greater benefits, (3) income is negatively correlated because low income households qualify more quickly through the lower Medicare Safety Net threshold (4) greater access to health care is a proxy for greater competition amongst health care providers and therefore should be associated with lower OOP costs and (5) that rural electorates have higher Safety Net benefits. This is because people living in rural areas face higher OOP costs for their medical services compared to inner metropolitan residents (Department of Health and Ageing 2005b) and should therefore be greater beneficiaries of the Safety Net.

2.2 Safety Net benefit distribution by professional services category

This part of the study estimates the distribution of Safety Net payments by broad category of service. Safety Net benefits are incorporated in data routinely reported by Medicare Australia, the federal agency that administers the policy. These publicly available data provide a means of estimating Safety Net benefits by each Medicare item number.

Medicare item numbers were selected on the basis that they were predominantly provided in an outpatient setting and where there were indications of changes between the 2003 and 2004 calendar years in the average benefit received. In all, 28 items were selected and grouped within the following categories: GP attendances, specialists' attendances, consultant physicians' attendances, psychiatry consultations, assisted reproductive services, radiotherapy, pre-natal obstetric consultations and obstetric ultrasounds. Table 4 describes the selected MBS items.

For any given type of service, the Safety Net benefit is equivalent to the government benefit received minus the Medicare subsidy for that service (usually 85% of the schedule fee). The government benefits for each of the 28 Medicare items were obtained from the Medicare Australia website. The schedule fee was obtained from the November 2003 Medicare Benefits Schedule (MBS) and weighted to take into account the proportion of services provided on an inpatient and outpatient basis. A further adjustment was made to take into account two rises in schedule fees, which occurred in November 2004 and November 2005. The difference between the adjusted schedule fee and the benefits received provides an estimate of Safety Net benefits for that item.

3. Results

3.1 Drivers of area-based safety net benefits

Table 2 summarises the mean values and 95% confidence interval for safety net benefits, health care needs, income, age profile and health care access for all 150 electorates. It also presents corresponding values for the 15 electorates with the lowest and highest Safety Net benefits per capita (i.e. the highest and lowest 10% of electorates). There are significant differences in the number of people qualifying for Safety Net benefits, mean Safety Net benefit, income, number of full-time-equivalent GPs per 1,000 population, proportion of the population aged 85+ and premature mortality rates between the overall average and the top and bottom 10% of Safety Net benefit electorates. No significant differences in the mean self-assessed health status scores and the proportion of GP services that were bulk-billed (i.e. GP services with zero OOP costs to the patient) or other age profiles were found.

INSERT TABLE 2

Table 3 shows the results for the three estimated models. In each model the omitted variables are inner metropolitan electorates for region and Queensland for Sate/Territory.

INSERT TABLE 3

Model 1 (Table 3) shows that for both measures of health (premature mortality rate and self-assessed health status), better health is associated with more people qualifying for Safety Net benefits ($P<0.05$). Higher proportions of people aged 45-64 and 75-84 in an electorate is positively correlated with the number of people qualifying for Safety Net benefits ($p<0.10$ and $p=0.001$ respectively). On the other hand, the proportion of 85+ year olds in the population is not significant. Further, a one dollar increase in median

weekly household income is associated with an additional 12 people qualifying for the Safety Net in the electorate ($p<0.001$). Also, the proportion of GP services that are bulk-billed in the electorate is negatively correlated with the number of people qualifying for Safety Net benefits ($p<0.001$). The electorate's region variables have a mixed effect in Model 1; rurality does not appear to be significant but the electorate's state or territory does. Significantly fewer people living in electorates in NSW, the Northern Territory, Western Australia, South Australia, Tasmania and Victoria ($p<0.005$) qualified compared to their Queensland counterparts.

Model 2 (in Table 3) models the per capita Safety Net benefits in each federal electorate. While self-assessed health status is no longer significant in Model 2, better health, as measured by lower premature mortality rates in an area, is associated with more Safety Net spending. The results also show that the proportion of 25-44 and 75-84 year olds in the electorate is associated with higher per capita Safety Net benefits, whereas the proportion of 15 to 24 year olds was negatively associated with Safety Net benefits ($p<0.001$). There was an non-significant association between the proportion of 65-74 and 85+ age groups and Safety Net benefits per capita. Average weekly family income in an electorate was positively correlated with high Safety Net benefits ($p<0.001$), indicating that wealthier electorates are greater beneficiaries of Safety Net benefits. The rate of GP bulk-billing in the area was negatively correlated with per capita Safety Net benefits but not significant ($p<0.103$). The state/territory variable showed significantly lower payments in electorates in Western Australia, ACT, South Australia, and Victoria compared to Queensland ($p<0.05$).

Model 3 (Table 3) estimates the impact of electorate characteristics on average Safety Net benefit per person qualifying. This provides a proxy of the intensity of use of Safety Net benefits in an electorate. The results show that better health (measured in terms of premature mortality) is significantly associated with lower Safety Benefits ($p<0.10$). A higher proportion of 0-4 year olds and 15-24 year olds in an electorate are linked to lower Safety Net benefit concentration whereas a higher proportion of 25-44 year olds is correlated with a higher level of concentration ($p<0.10$). None of the other age groups were statistically significant. Higher median income and GP bulk-billing rates were both linked to higher levels of Safety Net benefit concentration ($P<0.01$). Outer metropolitan and provincial electorates had lower levels of Safety Net benefit per qualifier compared to inner metropolitan ones ($P<0.10$). Model 3 shows higher Safety Net benefits in NSW (compared to Queensland) but significant lower levels in Western Australia, Tasmania and Victoria ($p<0.1$).

There are some important points worth highlighting when examining the results of all three models together. Firstly, the proportion of 25-44 year olds living in an electorate is not significant in predicting the number of people who qualify for Safety Net benefits in any given electorate (Model 1; $p=0.979$), but this group is significant in predicting per capita Safety Net benefits (Model 2; $p=0.058$) and highly significant in predicting benefits per qualifier (Model 3; $p=0.000$). This suggests that where 25-44 year olds qualify, they attract high Safety Net benefits. Conversely, higher proportions of 75-84 year olds are associated with more people qualifying for the Safety Net as well as Safety Net benefits per capita (Models 1 and 2) but are not significant in predicting Safety Net

benefits per qualifier (Model 3). This indicates that, this age group do qualify for the Safety Net but receive relatively few benefits.

GP 'bulk-billing' rates have significant but opposite effect on Models 1 and 3 ($p<0.001$) and is not significant in Model 2 ($p=0.103$). This result could be explained by the fact that fewer people qualify for Safety Net benefits in electorates with high GP bulk-billing rates (Model 1) but is not significant in predicting Safety Net benefits (Model 2). This means that GP bulk-billing rates has a negative and significant impact on the denominator in Model 3 (number of Safety Net qualifiers) but a non significant impact on the numerator (Safety Net benefits). Thus, higher GP bulk-billing means fewer qualifiers which means a lower denominator in Model 3 and therefore a higher benefit per qualifier.

3.2 Safety Net benefit distribution by broad service category

We estimate the distribution of Safety Net benefits by selected Medicare items, grouped together in broad professional groups. The 28 MBS items selected for this analysis accounted for 71% of all Safety Net expenditure. The remaining 29% is attributed to all other items in the MBS. Table 4 shows the number of services and an estimate of the average Safety Net benefit per service as well as overall Safety Net expenditure using the selected items. In total, the Safety Net policy cost taxpayers $446 million over the 2004 and 2005 calendar years (2005; Abbott, T. 2006). Table 4 shows that the average Safety Net benefit for a GP item of service is quite small ($0.26) although it still accounts for an estimated 10.3% of total Safety Net expenditure due to the high volume of GP services. Obstetric items account for 24.5% of total Safety Net expenditure, with an average $42.47 subsidy per service. Assisted reproductive services account for only 0.5% of all Medicare services but account for 13.7% of Safety Net Benefits in 2004 and 2005 respectively. The average Safety Net contribution per assisted reproductive service was $250. Radiotherapy services for the treatment and management of cancer attracted an average $18.65 per service, and accounted for 0.3% of all services and 0.6% of Safety Net benefits.

Table 4 also shows that for the 28 Medicare items selected for this part of the analysis, the overall number of services used did not differ dramatically between the 2004 and 2005 calendar years. The exception is assisted reproductive services, which increased by 14%. On the other hand, the average Safety Net benefit per service did rise substantially between 2004 and 2005 for almost all items (except those associated with general practice consultations). This rise may have been driven by more people qualifying for Safety Net benefits in 2005 compared to 2004, higher fees charged by providers, or both.

INSERT TABLE 4

Figure 1 shows the average government benefit per service and identifies the amount of benefit contributed by Medicare rebates and the Safety Net program for 2004 and 2005 combined. The Medicare rebate component is also an indication of the average government benefit prior to the introduction of the Safety Net Policy. The figure illustrates the large increase in public funding to assisted reproductive and obstetrics

services following the introduction of the Safety Net policy. Also of note is the relatively small Safety Net contribution to cancer-related radiotherapy services - an average Safety Net benefit of $19 per service compared to an average Medicare subsidy of $271.

INSERT FIGURE 1

4. Discussion and conclusions

This study's design has been constrained by data availability. The Australian Government has only released Safety Net data by federal electorates and hence the analysis in this study is based on the characteristics of the local area, rather than individual level data. As with all spatial studies there is a risk of committing ecological fallacy – where conclusions about individuals are falsely made on the basis of aggregate data. Therefore, the results of this analysis can only be interpreted at the group level, not the individual level. However, local area data is likely to be the only information released by the Australian Government for this type of analysis, given its policy to not release individual level Medicare data without consent.

A further caveat is that the analysis is based on data from the first two years following implementation of the policy and the full impact of the Safety Net has not yet filtered through the health care system in full. The results may, for example, be influenced by variation between electorates in the number of families registering for Safety Net benefits. Alternatively, current patterns of utilisation of specialists' services may change once the impact of Safety Net policy on OOP costs is fully appreciated. Analysis over the longer term, once some of these potential implementation issues have been settled, would therefore provide a more complete and robust picture.

This analysis has shown that Safety Net benefits varied considerably by electorate. The uneven distribution in benefits across the country gave rise to questions about which groups were benefiting most from the Safety Net policy.

The fact that obstetrics and assisted reproductive treatments accounted for 26% and 13% of Safety Net benefits respectively (Table 4) may explain the results found in our local area analysis which showed that higher proportions of people aged 25-44 in an electorate are significantly associated with high levels of Safety Net benefits per qualifier (Model 3, Table 3).

The Safety Net has clearly increased public funding for privately provided obstetric services as well as assisted reproductive services. It can be argued that such services do not constitute the type of 'disaster insurance' for which the policy was intended. It is perhaps not surprising that these areas have benefited most from the Safety Net, given the high OOP costs associated with these services. This in turn is a reflection of the low Medicare subsidy compared to the fee charged for these types of services. With the Safety Net in place, providers are under less competitive pressure to keep fees down and the Government has essentially provided an open-ended commitment to fund fee increases.

The results also show that the Safety Net only contributes, on average, $19 per radiotherapy service. This result may reflect low levels of co-payments for such services (Radiation Oncology Inquiry 2002). Yet, Butler and Howarth (1999) estimate that the OOP costs incurred by women with breast cancer can be high if they were treated privately. For those women, the three major sources of OOP costs were inpatient services, chemotherapy and support services such as physiotherapy, social worker and devices (Butler and Howarth 1999). None of these services are covered by the Safety Net which suggests that for people with complex needs such as cancer, OOP costs may still be significant.

Our area-based analysis shows that areas with better – not poorer - health (proxied by the premature death rate and average self-assessed health status within an electorate) are associated with more people qualifying for the Safety Net and receiving higher benefits. This result is contrary to our prior expectation that poor health status would be associated with higher service use, higher out-of-pocket expenses and therefore higher Safety Net expenditures. This result suggests that the policy may not be directed effectively at those areas with the highest levels of health care need.

Despite strong evidence that poor health is associated with low income (Draper, Oldenburg,Turrell 2004; Turrell, Stanley, de Looper,Oldenburg 2006), the Safety Net appears to be most beneficial to electorates with high median income, suggesting that the Safety Net may be assisting those groups in society who can more easily afford health care.

The results found in this analysis could be explained in three different ways. Firstly, poorer electorates may use more Medicare services that have low OOP costs such as bulk-billing GPs. Secondly, people in poorer electorates may utilise more health care services that are outside the realm of the Medicare program such as emergency departments and public hospitals. Thirdly, low income electorates may utilise fewer services and thereby face lower OOP costs.

Previous research has found evidence consistent with each of these explanations. The Australian Institute for Health and Welfare found evidence that persons from disadvantaged socioeconomic circumstances were less likely to have visited a medical specialist but consultation rates for GPs were often significantly higher among socioeconomically disadvantaged groups (Turrell, Stanley, de Looper, Oldenburg 2006). This finding is consistent with our first explanation because GP services have lower co-payments than specialists' services.

An international study found that the use of hospital services was greater amongst the poor even after adjusting for health care needs in Australia (van Doorslaer and Masseria 2004). This finding suggests that poorer individuals may be substituting public hospital care for Medicare outpatient care – consistent with the second explanation above.

Furthermore, a recent Commonwealth Fund survey shows that, in the year to April 2004, 17% of Australians reported they "had a medical problem but did not visit a doctor because of the medical care cost of the doctor's visit" (compared with 4% of people in

the UK); an increase from 11% answering a similar question in 2001 (Blendon, Schoen, DesRoches et al. 2002; Schoen, Osborn, Huynh et al. 2004). This finding supports the notion that OOP costs are a major barrier to accessing care for some people – consistent with explanation three above.

Ultimately, policies such as the Safety Net aim to ensure greater access to health services for those people who need them most. We can define need in terms of individuals who can least afford health care, those who could benefit most from health care, or both. Results from this paper provide preliminary evidence that the Safety Net is missing the mark, under either definition. Until we have a far greater understanding of which groups in society face high OOP costs, it will be difficult to target such policies effectively.

Table 1 Variables and Data Sources Used in the Regression Analysis.

	Variable	Source:
Dependent variable	Model 1: Number of people who reached Safety Net threshold by federal electorate in 2005 Model 2: Safety Net benefits per capita by federal electorate in 2005 Model 3: Safety Net benefits per qualifying person by federal electorate in 2005	(Department of Health and Ageing 2006b)
Health needs	Death rate per 100,000 population aged < 75	(Public Health Information Development Unit 2005)
	Average self-assessed health status on a 0 to 100 scale (0 is equal to the worst health state)[1]	(Cummins 2005)
Socio-economic	Median weekly household income	(Kopras 2004)
Demographic	Percentage of the population aged: - 0 to 4 - 5 to 24 - 25 to 44 - 65 to 74 - 74 to 84 - 85+	(Kopras 2004)
Health care access	Number of FTE GP	(Department of Health and Ageing 2005c)
	Percentage of GP services bulk-billed	(Department of Health and Ageing 2006b)
Geographic	State or territory: - NSW, NT, WA, ACT, SA, Tas, Vic, Qld (omitted) Rurality - Inner metropolitan (omitted) - Outer metropolitan - Provincial - Rural	(Australian Electoral Commission 2005)

[1] This index comprises seven domains of wellbeing, including one question on how respondents rate their health. The data used in this analysis is the combined survey results from 13 Unity Wellbeing survey rounds taken over a four year period (2001-2004), with a total sample of 22,829 Australian adults (Cummins et al, 2005).

Table 2: Mean Values for all Electorates, and the Lowest and Highest 10% Ranked by Per Capita Safety Net Benefits

	15 lowest Safety Net Benefits Electorates			**All electorates**			**15 highest Safety Net benefits electorates**		
	Average	95% Conf. Interval		Average	95% Conf. Interval		Average	95% Conf. Interval	
No. persons qualifying for Safety Net benefits	6,852	5,038	8,667	13,765	12,701	14,828	22,731	19,486	25,976
Average per capita Safety Net benefit	$3.97	$3.21	$4.72	$14.63	12.75	$16.52	$38.44	$32.23	$44.64
Average Safety Net benefit per qualifier	$83.32	$65.98	$100.66	$129.26	$118.56	$139.97	$223.15	$184.72	$261.58
Pre-mature mortality rate per 100,000 population	1071	995	1147	869	837	901	703	651	756
Health status score	75	74	76	75	75	75	76	75	77
Average income	$777	$718	$835	$972	$927	$1,016	$1,501	$1,409	$1,592
Percentage of GP consultations 'bulk-billed'	74%	69%	78%	73%	71%	75%	72%	66%	77%
Full-time equivalent GPs per 1,000 population	0.6	0.5	0.7	0.8	0.8	0.8	1.0	0.8	1.1
Percentage of electorate aged:									
0-4	7%	7%	8%	7%	6%	7%	6%	5%	6%
5-14	16%	15%	13%	14%	14%	15%	12%	10%	13%
15-24	13%	12%	13%	14%	13%	14%	14%	13%	14%
25-44	29%	27%	31%	30%	29%	30%	33%	30%	35%
45-64	23%	22%	24%	23%	23%	23%	23%	22%	24%
65-74	7%	6%	8%	7%	7%	7%	7%	6%	7%
75-84	4%	3%	5%	4%	4%	5%	5%	4%	6%
85+	1%	1%	1%	1%	1%	2%	2%	2%	2%

Table 3: Small Area Analysis - Explaining High Out-of-Pocket Costs and Safety Net Benefits

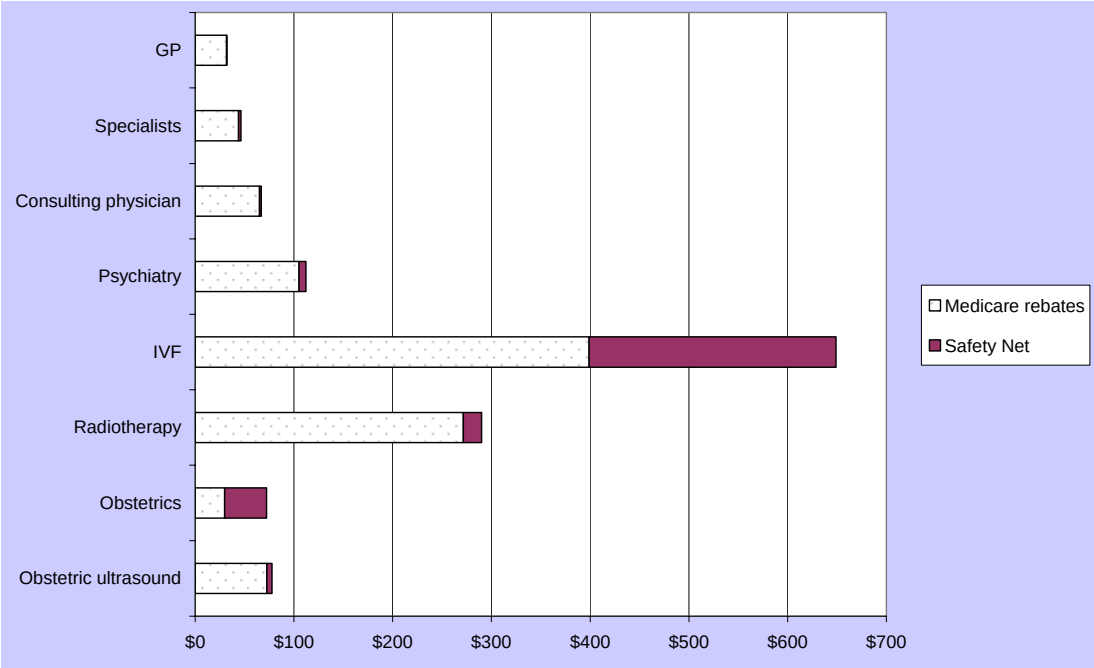
	Model 1	**P>t**	**Model 2**	**P>t**	**Model 3**	**P>t**
Death rate (‘000)	-743	0.002	-1.60	0.000	-4.42	0.081
Self-assessed health	188	0.032	0.18	0.189	-0.62	0.505
Age 0-4 %	62589	0.147	-23.77	0.730	-1665.00	0.000
Age 5-14 %	1922	0.935	-46.67	0.219	-71.60	0.780
Age 15-24 %	-20354	0.180	-127.14	0.000	-306.46	0.062
Age 25-44 %	315	0.979	37.04	0.058	824.42	0.000
Age 45-64	28590	0.081	-9.33	0.720	-197.85	0.262
Age 65-74 %	3513	0.922	50.83	0.377	553.55	0.156
Age 75-84 %	164303	0.000	182.27	0.006	-158.94	0.718
Age 85+ %	-78901	0.147	-30.70	0.723	254.96	0.663
Median weekly family income	12	0.000	0.03	0.000	0.05	0.006
GP bulk-billing rate %	-21739	0.000	-6.17	0.103	130.35	0.000
GPs per 1000 pop	-1849	0.132	-0.89	0.650	13.00	0.325
NSW	-1343	0.034	-0.46	0.646	17.74	0.010
NT	-8562	0.000	-1.64	0.601	2.81	0.894
WA	-5288	0.000	-6.68	0.000	-29.48	0.000
ACT	2805	0.122	-5.81	0.046	-10.17	0.602
SA	-8669	0.000	-9.00	0.000	-2.70	0.752
TAS	-5125	0.000	-1.89	0.280	-20.78	0.080
VIC	-3094	0.000	-5.21	0.000	-12.26	0.061
QLD (omitted)						
Outer metropolitan	845	0.229	0.26	0.818	-12.80	0.092
Provincial	154	0.857	0.70	0.609	-16.08	0.084
Rural	-1175	0.238	0.13	0.935	-10.32	0.337
Inner metropolitan (omitted)						
Adjusted R^2	0.8793		0.9023		0.869	

Table 4: Estimating the Distribution of Safety Net Benefits by Broad Category of Service and Selected Medicare Item Numbers[2] - Start 2004 to End 2005

	Number of services ('000)	Percentage of services	Percentage of total Safety Net benefits	Average Safety Net benefit per service $	Total Safety Net Benefit ($'000)
			2004		
GP	88,772	40.66	14.2	0.27	23,579
Specialists	9,469	4.34	11.0	1.93	18,310
Consulting physician	7,503	3.44	5.7	1.27	9,544
Psychiatry	1,594	0.73	5.3	5.51	8,775
IVF	111	0.05	12.7	191.36	21,154
Radiotherapy	69	0.03	0.6	13.85	954
Obstetrics	1,274	0.58	21.4	27.82	35,445
Obstetric ultrasound	906	0.41	1.8	3.33	3,019
Other	108,652	49.76	27.2	0.42	45,219
2004 Total	218,349	100.00	100.0	0.76	166,000
			2005		
GP	87,015	38.37	7.6	0.25	21,371
Specialists	9,525	4.20	9.3	2.73	26,032
Consulting physician	7,684	3.39	5.2	1.91	14,673
Psychiatry	1,554	0.69	4.6	8.30	12,904
IVF	126	0.06	13.5	301.77	37,911
Radiotherapy	70	0.03	0.6	23.35	1,643
Obstetrics	1,256	0.55	25.7	57.34	71,997
Obstetric ultrasound	969	0.43	2.4	7.07	6,852
Other	118,602	52.29	30.9	0.73	86,618
2005 Total	226,799	100.00	100.0	1.23	280,000
			TOTAL		
GP	175,787	39.49	10.1	0.26	44,949
Specialists	18,994	4.27	9.9	2.33	44,342
Consulting physician	15,186	3.41	5.4	1.59	24,217
Psychiatry	3,148	0.71	4.9	6.89	21,679
IVF	236	0.05	13.2	250.09	59,065
Radiotherapy	139	0.03	0.6	18.65	2,597
Obstetrics	2,530	0.57	24.1	42.47	107,442
Obstetric ultrasound	1,874	0.42	2.2	5.27	9,871
Other	227,254	51.05	29.6	0.58	131,837
Total	**445,148**	**100.00**	**100.0**	**1.00**	**446,000**

[2] MBS item numbers: GP attendances: 23, 36, 44, 53; Specialists attendances: 104,105; Consulting physicians: 110,116; Psychiatry: 302,304,306,308; assisted reproductive services: 13200, 13203, 13209, 13221; Radiotherapy: 15524, 15506, 15000, 15500, 15518, 15503; Obstetrics: 16500, 16590; Obstetric ultrasound: 55700, 55703, 55704, 55706; Total: all Medicare services except optometry, operations and anaesthetics; Other; total minus listed items.

Figure 1: Average government benefit per service by broad professional group and by Medicare rebate and Medicare Safety Net – start 2004 to end 2005



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[i] . To be eligible for Family Tax Benefit Part A, the family must have at least one dependent child and earn less than the income limit. The limit is set according to the number and age of the child(ren).