AUSTRALIAN SENATE

Select Committee on Medicare

Inquiry into

The access to and affordability of general practice under Medicare

Supplementary Submission of the

Australian Government Department of Health and Ageing

Australian Government

Department of Health and Ageing

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1. INTRODUCTION

In April 2003, the Government announced *A Fairer Medicare,* a $917 million package targeted at general practice services. *A Fairer Medicare* contained measures in relation to the medical workforce, provided targeted incentives for doctors to bulk bill concession card holders, offered protection from high out-of-pocket medical costs, and aimed to improve patient convenience.

From the outset, the Government indicated that *A Fairer Medicare* would proceed only as an integrated package. For several elements of the package, the passage of legislation was required. Since April 2003, *A Fairer Medicare* has been debated widely in the Parliament, among key stakeholders and in the broader community.

Following this period of debate, including publication of the Report of the Senate Select Committee on Medicare on 30 October 2003, the Government reviewed and substantially revised *A Fairer Medicare.* A further $1.5 billion was added. A small number *of A Fairer Medicare* measures were retained unchanged, many components of the original package were enhanced significantly, and a series of new measures were added. The Government's total commitment to the new **MedicarePlus** package is just over $2.4 billion over the four years to 2006/07.

MedicarePlus responds to many of the concerns expressed about *A Fairer Medicare* while preserving the intentions of the original package. **MedicarePlus** contains:

- incentives for GPs to bulk bill Commonwealth Concession Card holders and children under the age of 16;
- measures to improve convenience for patients within the framework of existing legislation;
- a proposed safety net for high out-of-pocket costs for medical services provided outside hospital;
- new and substantial measures to support the medical workforce.

The Senate Select Committee on Medicare reconvened on 25 November 2003 to consider key components of **MedicarePlus**.

This Submission has been prepared to assist the Committee in these further deliberations. It supplements the Department's original Submission to the Committee lodged on 10 July 2003, and evidence presented by Departmental officials at hearings of the 21st July and the 28th August this year.

Section 2 presents the context in which health policy is being developed, and identifies the challenges that our health system faces, now and in the future. Section 3 provides detailed information about the policy response of the Government through **MedicarePlus**. Each measure is described and key questions are posed and answered.

2. THE CURRENT CONTEXT

2.1 Emerging Challenges for the Health System

Australia's health system is one of the best and most responsive in the world. It is built on partnerships between the public and the private sectors, between different spheres of government, the health professions, and patients. In the current year (2003/04), the Australian Government expects to spend almost $37 billion or one-fifth of the Commonwealth Budget on health.

For the past 20 years, Medicare has provided essential protection to all Australians through its three pillars:
- free treatment in public hospitals;
- universal access to a Medicare rebate for visits to a doctor;
- access to subsidised medicines through the Pharmaceutical Benefits Scheme (PBS).

The proposed changes to Medicare through **MedicarePlus** aim to preserve these pillars and to strengthen Medicare.

The Department of Health and Ageing lodged a submission to the Senate Select Committee on Medicare in July 2003, and appeared at several Committee hearings. In its Submission and appearances before the Committee, the Department outlined some of the emerging challenges for the health system and how policy decisions by government are addressing these challenges.

As noted in the *Intergenerational Report 2002*, changing consumer expectations, the rapid growth in technology, a differently constituted medical workforce and an ageing population provide a new context in which Medicare is being delivered.

Life expectancy in Australia is increasing significantly. Latest data from the World Health Organisation puts Australia 5th highest in the world for life expectancy at 80.4 years[1]. The population aged over 65 years is growing at a faster rate than the rest of the population, and the focus of our health problems are shifting from infectious disease to chronic conditions. This is occurring at the same time that people are expecting cures for ailments that previously could not be detected or treated, and relief and management of chronic conditions over long periods of time. Meanwhile, the medical workforce has changed significantly in composition, distribution and expectation.

People’s use of medical services funded through Medicare has increased. In recent years there has been a 55 percent increase per head of population, in the total number of medical services funded by Medicare, from 7.2 services per person per year in 1984/85 to 11.1 services per person per year in 2002/03.

The number of services accessed by each individual has grown, as have the range of services provided. Increased utilisation relates to an overall increase in the number of GP services, pathology and new specialist and diagnostic services linked to population ageing and technological advancement.

[1] World Health Organisation, *World Health Report*

Prominent among the rapidly growing specialist and diagnostic services are items such as Magnetic Resonance Imaging, Positron Emission Topography testing, Ultrasound, Computerised Tomography, Nuclear Medicine and Radiation Oncology.

This changing pattern of service delivery is creating new challenges for access and affordability of Medicare services that were not apparent when Medicare began in 1984.

As noted in the Department of Health and Ageing's Submission of July 2003, the changing pattern of service provision has resulted in a 64 percent increase in real terms in Medicare Benefits Schedule (MBS) expenditure and an almost 96 percent increase in real terms in patient contributions between 1984/85 and 2001/02.

Total MBS expenditure has grown from $2.3 billion in 1984/85 to $7.8 billion in 2001/02, while the average patient contribution for all MBS patient billed services has grown from $3.95 in 1984/85 to $19.70 in 2001/02.

2.2 Affordable General Practice and Related Services

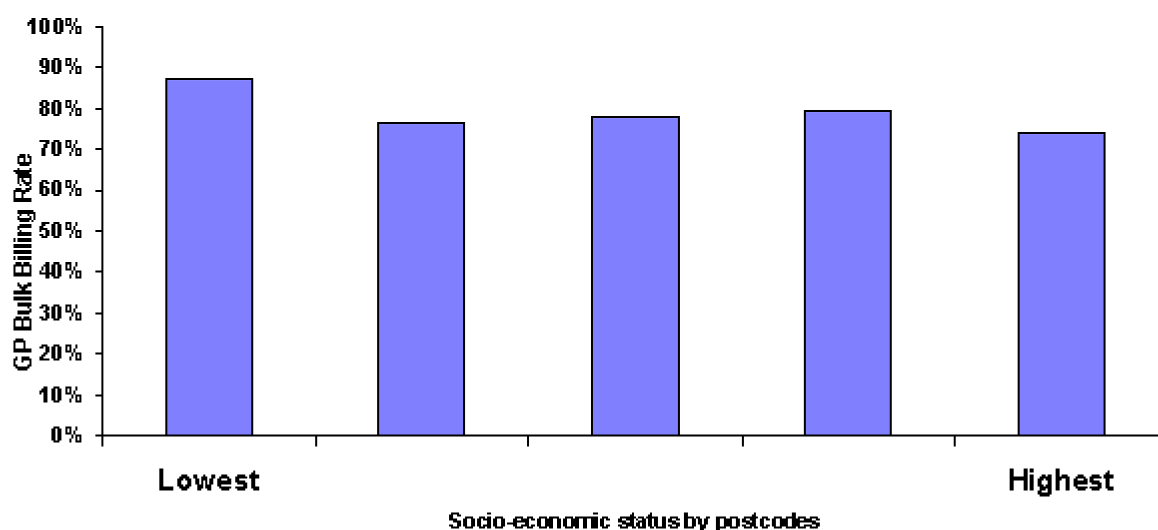
In recent years, despite increases in the real level of the Medicare rebate for GP services and an increase in total income for GPs, the bulk billing rate has declined. Figure 4 at Section 2.3, 'The Medicare Rebate' illustrates this. At the same time, it is important to note that more than 98 percent of full time equivalent GPs bulk bill some of their patients some of the time. This is shown at Section 3.2, Table 2.

Certain key factors affect the affordability and accessibility of medical services.

Predominant among these is the supply of doctors. The impact of competition between GPs in a local area remains a primary influence on the numbers of services that a GP bulk bills. For example, in the June quarter 2003/04, the bulk billing rate was 73.7 percent for GP services in capital city areas, where there are high doctor to patient ratios, compared with 54.1 percent of services bulk billed in rural areas, where there are lower doctor to patient ratios.

As noted by Departmental representatives in evidence given to the Senate Committee in July 2003, this is a stronger determinant of bulk billing than is the income of patients. Figure 1 illustrates that, in 2001/02, the bulk billing rate for services delivered to people on high incomes was almost as great as the rate for services delivered to people on low incomes.

Figure 1: GP Bulk-Billing Rate by Income Quintile, 2001/02



The impact of doctor supply on the affordability of GP services was noted in the Senate Select Committee Report *Medicare – healthcare or welfare?*

> *"Declining doctor numbers have critical implications for current and future access to primary health care, both from outright shortages and the increasing pressure on prices caused by short supply and high demand. These factors are both evident in the falling bulk-billing rates."*[2]

Addressing the size and distribution of the medical workforce remains key to ensuring affordable general practice services.

Secondly, the question of affordability of health services goes beyond bulk billed services delivered by GPs. While patient contributions to GP services have increased over time (rising by 65 percent in real terms since 1984/85), by far the largest increase in cost to patients has been in specialist, diagnostic and treatment services.

Specialist services are much less likely to be bulk billed than are GP services – in the last quarter, around 27 percent of specialist services were bulk billed, compared to a rate of 67 percent for GP services.

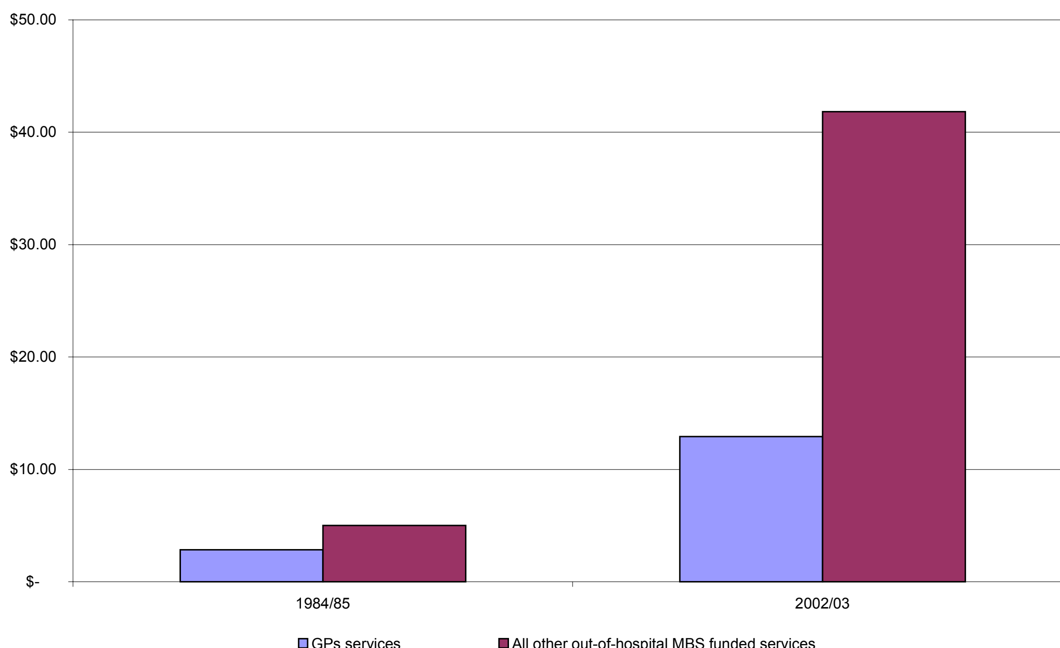
In regard to average patient contributions where a fee is charged, there is also a large difference in the cost of GP and non-GP services. In 2002/03, GP attendances accounted for around 44 percent of all MBS funded services provided outside hospital, but only for around 18 percent of the total cost to patients of these services.

Figure 2 compares average patient contributions for GP and non-GP services delivered through the Medicare Benefits Schedule in 1984/85 and 2002/03.

In 1984/85, patients contributed an average $2.86 for GP services and $5.03 for non-GP services. In 2002/03, patient contributions to GP services increased to $12.90 (65 percent in real terms) while patient contributions to non-GP services increased to $41.82 (310 percent in real terms).

[2] The Senate, Select Committee on Medicare, *Medicare – healthcare or welfare?,* p.xii

Figure 2: Total patient contributions for GP and Non-GP services



Thirdly, for many individuals and families, out-of-pocket costs for the range of health services mount up in the course of a year. To understand affordability for these families, it is again important not to concentrate solely on GP services. In 2001/02, more than 21 percent of Australians accessed 15 or more Medicare Benefits Schedule services in the year.

2.3 The Medicare Rebate

It has been claimed that a simple increase in the Medicare rebate for GP services will increase the level of bulk billing and improve the supply of doctors.

The Senate Select Committee has noted that evidence does not clearly support such a view:

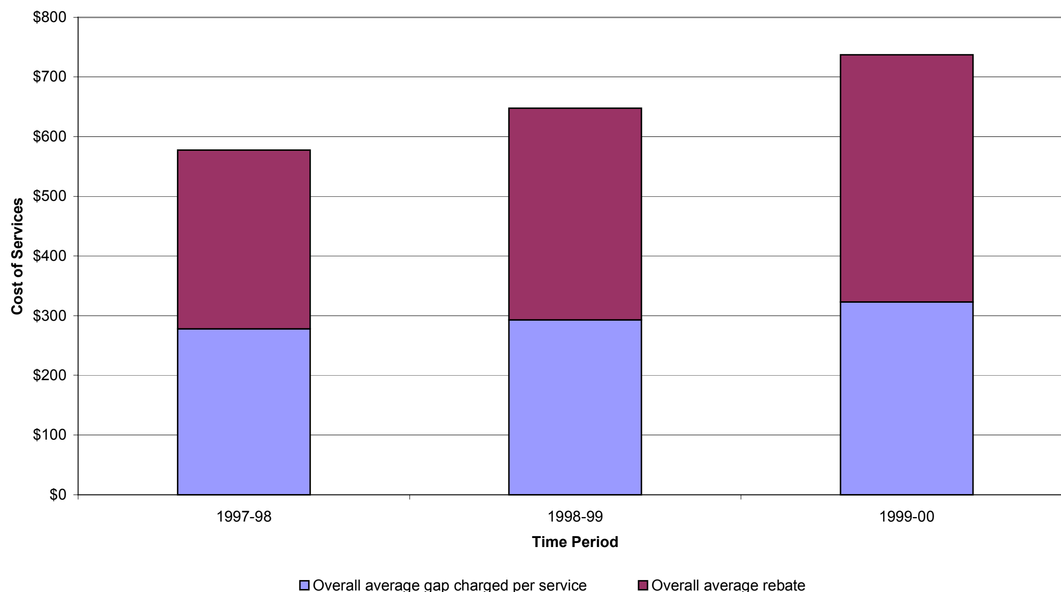
> *"The Committee is not convinced of the need to substantially increase the level of the MBS rebate, and has reservations as to whether doing so would, of itself, improve levels of bulk billing. It is clear that other incentives are also required."*[3]

In this regard, the Department notes its previous evidence to the Senate Select Committee that there does not appear to be a direct link between the level of a Medicare rebate and bulk billing rates for GP or other services.

In fact, there is evidence from specialist services where the reverse has occurred, with significant increases in rebates for a particular set of services accompanied by continued increases in patient charges. Figure 3 illustrates this for certain obstetric items.

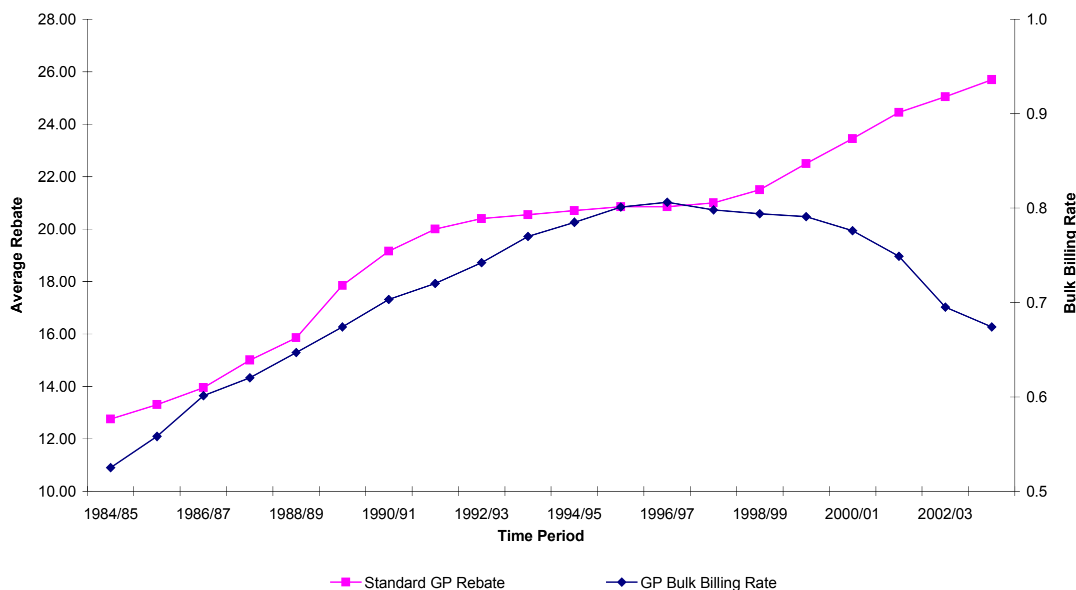
[3] ibid, p.xx

Figure 3: Obstetrics (MBS Items 16519, 16520, 16522): MBS Rebate and Average Gap Charged



The same phenomenon has been seen in recent years for GP services, where despite the fact that the MBS rebate for a standard consultation has grown in real terms (from $20.85 in 1996/97 to $25.70 today), the rate of bulk billing has declined and average patient co-payments increased.

Figure 4: Comparison of Standard GP Rebate (Item 23) with GP Bulk Billing Rates[4]



[4] Figure 3 updates evidence presented to the Senate Roundtable of 21 July 2003, incorporating the Medicare rebate for a Level B consultation at 1 November 2003 and bulk billing rates in the June and September quarters.

It does not appear likely from this evidence that an across the board increase to the MBS rebate would suddenly reverse the trend of recent years. A rebate increase alone would not guarantee affordability for patients or further equity of access for those in greatest need.

2.4 Structure of the Medicare Benefits Schedule

In recent commentary, some doctors' organisations have argued for a restructure of the Medicare Benefits Schedule, arguing firstly for implementation of the Relative Value Study (RVS) of the Medicare Benefits Schedule completed in December 2000, and more recently, advocating for change based on the conclusions of the Report of the Attendance Item Restructure Working Group (AIRWG) tabled in October 2003.

2.4.1 Relative Value Study

The Department's July Submission and a response to a Question on Notice from the Senate Select Committee (lodged in September 2003) explain the Government's interpretation of the Relative Value Study. Essentially, the overseeing committee of the Medical Services Review Board could not reach agreement on a range of issues important to the modelling of payments and as a result, there was no agreed methodology for modelling and no agreed outcome of that Study.

The Department's modelling of the Relative Value Study showed that while general practitioner attendances were under-funded to a small degree, Government budget decisions since the Study was undertaken have more than offset this under-funding.

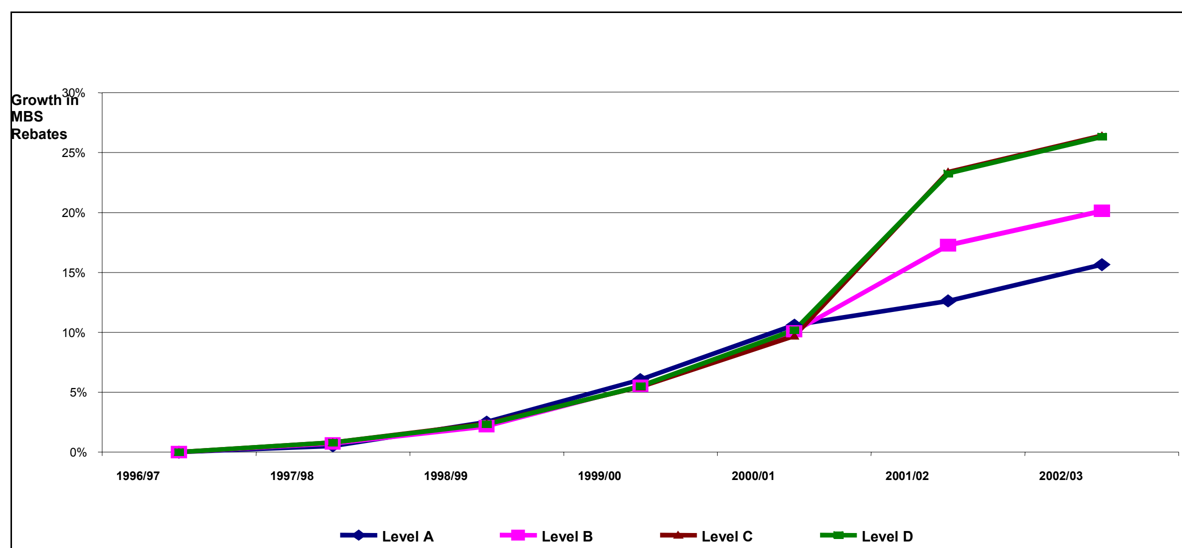
2.4.2 Attendance Item Restructure Working Group

The Department has been working with the profession through the Attendance Item Restructure Working Group to assess the time structure and relativities between items of the current MBS.

The AIRWG was established in February 2002 to examine an alternative MBS attendance item structure and to consider evidence on the relationship between longer consultation times and improved health outcomes.

The rebates for longer consultations have seen significant increases since 1996/97 – in fact, rebates for these services have increased by more than 26 percent. Figure 5 shows the relative increase by consultation type in recent years.

Figure 5: Growth in MBS Rebates per Consultation type since 1996/97 to 2002/03



The AIRWG finalised a technical report in July 2003. It makes a number of recommendations including the adoption of a seven-tier GP attendance item structure to replace the current four-tier attendance item structure. The modelling work was undertaken on a without prejudice basis, with no assumption that additional Government funding would (or would not) be made available to implement its findings.

At its meeting in September 2003, the Working Group agreed that more work was needed to understand the impact that any restructure of the attendance items would have, particularly on access for patients. This work will proceed in the New Year.

2.5 The Need for Change and Guiding Principles

As noted in Section 2.1, the greatest challenges to maintaining an accessible and affordable health system are emerging as the population changes, consumer expectation increases, and technologically advances.

The environment in which health care is now delivered and the challenges it needs to face are quite different from that of 1983/84 when Medicare began.

There are three areas of immediate concern:

- Continued access to affordable general practice services, particularly for those in greatest need. The most important drivers in this regard are the size and distribution of the medical workforce.
- Ensuring that neither patients nor doctors are inconvenienced by administrative arrangements that underpin Medicare. New technologies provide opportunities to streamline these arrangements within existing legislation.

- Protecting families and individuals from the impact of cumulative costs. This is an issue that is largely outside general practice. Rather it goes to the impact of costs that accumulate across different types of services (particularly diagnostic and specialist services), which in general are borne by people that face a major health event or are managing chronic conditions.

  As the number, complexity and likely cost of out-of-hospital services increases, as the population increasingly experiences chronic and complex conditions associated with ageing, and as consumer expectations about the availability and breadth of service grow, so the imperative to address cumulative out-of-pocket costs grows.

At the same time, the underlying principles of Medicare, as framed at its inception, together with the guiding principles set out in the Department's July Submission, remain key features of Medicare policy development. In summary these principles are:

- A universal Medicare, where all Australians:
  - Can access affordable health care, no matter where they live or how much they earn;
  - Are eligible for a universal rebate for the services they receive;
  - Are able to benefit from free care in public hospitals;
  - Are able to receive subsidised medicines through the PBS;

- Equitable access to doctors, where an adequate supply of appropriately trained doctors provide high quality, accessible and affordable access for all;

- Fairness, such that people in similar financial circumstances can be treated equitably regardless of where they live;

- Sustainability, where policy decisions are assessed on the basis of cost and their capacity to deliver desired outcomes;

- Simplicity for patients and health professionals, without unnecessary red tape; and

- Adherence to current fee setting parameters as, within the Australian context, the Government does not have the power to set GP fees or force GP's to bulk bill all or some of their patients.

These guiding principles were important features of *A Fairer Medicare*, and remain relevant for **MedicarePlus**.

3. FEATURES OF MEDICAREPLUS

3.1 Context

MedicarePlus provides $2.4 billion between now and 2006/07, with an additional $1 billion each year thereafter.

Attachment A details the estimated cost of each **MedicarePlus** measure, from 2003/04 to 2006/07. **MedicarePlus** adds $1.5 billion to the $917 million committed in *A Fairer Medicare.* Budget estimates for those aspects of *A Fairer Medicare* that are not to proceed, have been reallocated to **MedicarePlus** measures.

In summary**, MedicarePlus:**

- Replaces the bulk billing incentives proposed in *A Fairer Medicare* with a $5 payment for every bulk billed service provided to a concession card holder or child under 16;
- Expands incentives for doctors to sign up to HIC Online, a means of improving convenience for doctors and patients;
- Introduces a new national safety net to protect all Australians from major costs for medical services provided outside hospital;
- Builds on the workforce measures of *A Fairer Medicare* and expands them.

The key features of **MedicarePlus** emerged from extensive consultations with doctors, patients and the wider community. It responds to some of the concerns raised in the course of these consultations, including many of the recommendations of the Report of the Senate Select Committee on Medicare.

This Section provides detailed information on each **MedicarePlus** measure and responds to some of the key questions that have emerged since the package was announced on 18 November 2003.

3.2 Additional $5 payment for certain bulk billed services

From 1 February 2004 an additional payment of $5 will be made to GPs for every bulk billed service provided to a child under 16 years of age or to a person covered by a Commonwealth Concession Card. The cost of this initiative is $956.7 million over the four years to 2006/07.

This targeted bulk billing payment is intended to make it easier for GPs to bulk bill patients in financial need and children. As is the case now, a GP remains free to bulk bill anyone they choose.

Around 60 percent of all services that GPs provide are for children under 16 and concession card holders. Around 50 million GP services each year are provided to concession card holders and their dependents, with a further 10 million services provided to children not covered by concession cards.

GPs will be able to claim an additional MBS item each time they bulk bill one of these patients. Estimates of the cost of this item assume that GPs will continue to bulk bill these patients where they are already doing so, or where they are charging a gap of up to $5. About 79 percent of these services are now either bulk billed or charged up to $5 over the Medicare rebate.

The new item – set at $5 – will be claimed in addition to the normal item that would apply to the service delivered. The item will be paid to the doctor through the claims processing system administered by the Health Insurance Commission (HIC) as part of normal transactions with that practice.

In 2002, more than 80 percent of all providers of GP services bulk billed some concessional patients. The distribution of bulk billing ranges across all GP providers is at Table 1.

Table 1: Bulk billing range of concessional patients for all GPs, 2002

% Proportion of Provider Numbers	% Bulk Billing Range
14.1%	100%
33.7%	90-<100%
11.5%	80-<90%
7.8%	70-<80%
5.6%	60-<70%
4.4%	50-<60%
3.6%	40-<50%
3.6%	30-<40%
3.7%	20-<30%
3.8%	10-<20%
3.8%	>0-<10%
4.4%	0%

Table 1 uses a headcount of providers and therefore includes GPs who may only deliver a handful of services each year. If a full time workload equivalent GP figure is used, then more than 98 percent of GPs bulk billed some of their concessional patients in 2002. Table 2 illustrates.

Table 2: Bulk billing range of concessional patients by full time workload equivalent GPs, 2002

% Proportion of Full Time GPs	% Bulk Billing Range
25.3%	100%
35.0%	90-<100%
10.2%	80-<90%
6.4%	70-<80%
3.9%	60-<70%
3.2%	50-<60%
2.7%	40-<50%
3.0%	30-<40%
3.1%	20-<30%
3.1%	10-<20%
2.8%	>0-<10%
1.3%	0%

Any doctor who bulk bills any concession card holder or child will benefit from this measure to some degree. A typical GP providing 7,000 services a year and with a typical patient and bulk billing profile will gain $15,500 from this measure.

This bulk billing payment replaces the previously announced General Practice Access Scheme.

<u>Frequently Asked Questions</u>

Why link a payment to a bulk billed service, why not raise the MBS rebate by $5 for every service?

A simple increase in the Medicare rebate would not necessarily result in higher levels of bulk billing or improved affordability for patients and would be expensive (around $500 million a year). The rebates for GP services have increased significantly over the last few years at the same time as bulk billing rates have been falling.

The Report of the Senate Select Committee on Medicare supports this view:

> "The Committee is not convinced of the need to substantially increase the level of the MBS rebate, and has reservations as to whether doing so would, of itself, improve levels of bulk billing" (Executive summary, p.xx).

Linking a payment to a bulk billed service provided to patients in greatest need is an effective means of targeting this investment to maintaining affordable services for those patients where the impact will be greatest.

What concession cards will be covered by the $5 payment, how many people hold these and what are the income limits?

For the purpose of MedicarePlus, Commonwealth Concession Card holders include people covered by Pensioner Concession Cards, Health Care Cards and Commonwealth Seniors Health Cards.

At October 2003, 5 million Commonwealth Concession Cards covered 7 million people, comprising:

- Pensioner Concession Card (3.1 million cards covering 4.2 million people);
- Health Care Card (1.6 million cards covering 2.5 million people);
- Commonwealth Seniors Card (280,000 individuals).

The income limits and eligibility criteria for these cards as at September 2003 are listed at Table 3.

Table 3: Commonwealth Concession Cards, income limits and eligibility

Card	Income Limit*	Eligibility	Examples
Health Care Card (including Low Income Health Care Card)	$17,472 pa $29,068 pa $30,836 pa + $1768 pa	Singles Couples (combined income) Singles or couples with one child for each additional child	People with low incomes, on Newstart, Youth Allowance, Parenting Payment (partnered)
Health Care Card through FTB(A)	$31,755 pa	Families who receive full rate Family Tax Benefit Part A	
Pensioner Concession Card	$32,929 pa $33,569 pa $55,029 pa $65,130 pa + $640 pa	singles singles with one child couples (combined income) illness separated couple (combined income) for each additional child	Age pensioners, disability support pensioners
Commonwealth Seniors Health Card	$50,000 pa $80,000 pa $100,000 pa	singles couples (combined income) couples (combined income, if separated by illness, care or gaol)	Self-funded retirees

* Income limit data: While equivalent annual incomes are given on this table, income tests for pensions and allowances are fortnightly, and for low income earners are measured over eight weeks. There are also assets tests for some concession cards. In certain circumstances, concession cards can also be retained for short periods when incomes exceed these limits, to enable recipients to return to work.

Why is the Government only offering a $5 increase for bulk billed services to concession card holders and children? It offered more than that in some locations where a practice signed up to the General Practice Access Scheme.

The availability of a new MBS item of $5 for bulk billed services provided to concession card holders and children cannot be compared to incentives proposed in the General Practice Access Scheme of *A Fairer Medicare*.

The $5 item will be available with no conditions attached in respect of any bulk billed service provided to a concession card holder or child. It will be administratively simple for doctors and make it easier for doctors to bulk bill these patients. The total level of additional funding to the system is also higher than was the case in *A Fairer Medicare* - an estimated $956.7 million for the $5 item compared to $347.4 million for the GP Access Scheme.

There will be no need for GPs to sign up or to guarantee that any proportion of patients will be bulk billed. It can be claimed in respect of any bulk billed service that is provided to a concessional patient or child. It will increase income for the vast majority of practices.

Why isn't a $5 payment being provided for every bulk billed service?

The new $5 MBS item targets an additional payment to people in greatest need – those with Commonwealth Concession Cards and families with children - and makes it easier for doctors to bulk bill these patients. As has been the case since the start of Medicare, doctors are able to bulk bill any patient.

What happens to the price of services that do not attract the $5 new MBS item?

There is nothing in this package that will cause doctors' fees to rise for any patient. Virtually all practices will see their income increased through the various elements of this package including:

- the $5 MBS item for bulk billed services to concession card holders and children;
- the practice nurse grant and MBS item for certain practice nurse services;
- the incentives to provide services to residents of aged care homes;
- financial assistance with ongoing education and training;
- payments to rural doctors.

Furthermore, the $1 billion that this package invests in increasing the supply of doctors and nurses is likely to improve the affordability of services through downward market pressure on fees.

Will all bulk billed services provided by all GPs be eligible for the additional $5 payment for where these are delivered to a person covered by a Commonwealth Concession Card or to a child under 16?

Yes. Every bulk billed service provided by a GP that is delivered outside hospital and covered by the MBS will be eligible for the $5 payment where that service is delivered to a concessional patient or child. The $5 will apply regardless of the type of service that is provided, including for pathology and diagnostic imaging services provided by a GP to an eligible patient where that service is bulk billed.

Services delivered by a practice nurse under the 2 new MBS items for immunisation and wound management services delivered by a practice nurse will also be able to attract the $5 payment.

In a similar vein, all GPs, whether they are vocationally registered or non-vocationally registered, will be eligible to claim.

3.3 Patient convenience through new technologies

Improving convenience for patients was an important feature of *A Fairer Medicare*. Many patients pay up-front for a GP service at some time during the year. In 2002, around half of all GP patients (or 8.1 million people) were, at some stage, charged a gap by their GP. Under current arrangements at the vast majority of practices, these patients are left out-of-pocket for a period and face the inconvenience of needing to claim their Medicare rebate back from a Medicare office.

For those patients who are not bulk billed, **MedicarePlus** will provide the option of greater convenience by allowing Medicare claims to be lodged electronically at their GP's surgery. The Medicare rebate will then be paid directly into the patient's bank account within a few days, avoiding the need for them to visit a Medicare office. The mechanism for achieving this is HIC Online, the new electronic way of doing business with the Health Insurance Commission.

To encourage electronic claiming through HIC Online, GP's and specialists will be able to access grants to assist with associated costs. Doctors will require a computer and a connection to the Internet. Market research indicates that over 90 percent of doctors have both these already.

It is expected that around 18,000 GP and specialist practices will apply for the one-off payments of $750 for metropolitan practices and $1,000 for rural practices, at a total cost of $16 million.

A further $9.2 million is being provided to assist GPs in Rural, Remote, Metropolitan Areas Classification (RRMA) 4 – 7 to access broadband technology, where it is not already available. Broadband solutions will be tailored through a whole of government approach that addresses needs of local communities. It will provide them with the infrastructure to support a range of services, both clinical and practice management that will help to improve health care delivery.

MedicarePlus also adds $4.6 million over four years to the existing *Primary Care Providers Working Together* initiative to form the Australian Primary Care Collaboratives Program, bringing its total budget to $21 million over four years. It is expected that around 20 percent of practices (about 1,000 practices) will participate in the Collaboratives Program, which aims to improve quality of care for patients focused on chronic disease, and to improve practice scheduling and business practices.

Frequently Asked Questions

Do patients who are not bulk billed still have to pay the full fee up-front or can they just pay the gap between the rebate and the doctor's fee?

The Government had intended to encourage patients who were billed by their doctor to pay only the difference between the Medicare rebate and the doctors' fee at certain practices that were participating in the GP Access Scheme and had therefore guaranteed to bulk bill all concessional patients. This would have meant that patients who were charged a fee did not have to pay the full cost, but only the gap that the doctor charged, with no need to claim back from Medicare. In **MedicarePlus**, the Government decided not to proceed with this measure.

Under the arrangements proposed through HIC Online, the patient still pays the fee in full – if one is charged – but avoids the need to lodge a claim at a later time. Through HIC Online technology, patients can lodge their Medicare claim at the doctor's surgery and have it paid directly into their bank account. This is consistent with current legislation. It will be implemented as quickly as the new technology can be installed. Both GP and specialist practices will be provided financial support to sign up to HIC Online.

Under current arrangements, patients do not have to pay the full fee up front in all cases. Bulk billing and pay doctor cheque arrangements remain and are managed efficiently through HIC Online. However, if patients do pay in full, HIC Online makes the transaction easier for them.

How is patient privacy protected when claims are lodged through HIC Online?

All claims lodged through HIC Online must be made using the public key infrastructure encryption system. This provides a very high level of security, both within the doctor's surgery (where the claim can only be sent by identified people) and in the transmission process.

Some doctors have said that the cost of connecting to HIC Online will be much more than the Government incentive of $750 and $1,000 per practice. Why isn't the Government subsidising the whole cost?

The cost of connecting to HIC Online will vary, from almost nothing for those with up to date computer systems, Internet connections and practice management software, to higher costs for practices that are not yet computerised.

The payments of $750 and $1,000 per practice are intended as incentives to sign up to HIC Online, not to cover the full cost of the product. The validity of this approach was noted by the Senate Select Committee on Medicare:

> *"…the incentives are not designed to meet the whole of the cost, but rather to make a contribution. This is appropriate given that, notwithstanding its wider significance to best practice health care, information technology is a business cost that must be met by all businesses and one that offers a general practice significant financial dividends through increased efficiencies."* [5]

[5] Ibid, p.114

Since 1999, the Government has invested more than $430 million through the Practice Incentives Program to assist GPs with computerisation of their practices.

When will GPs be able to apply for the $750 and $1,000 assistance for connecting to HIC Online?

General practices that are already connected to HIC Online are eligible to claim the incentive payment now. All other general practices will be eligible for the incentive as soon as they make their first HIC Online claim.

Are the grants only for GPs or can any practice that uses HIC Online receive the incentive payment?

The incentive payment is available to any practice claiming Medicare benefits, including general practice, specialists, optometrists and accredited dentists.

3.4 The proposed MedicarePlus Safety Net

As highlighted in Section 2, 'The Current Context', demographic change and advancing technology are driving higher out-of-pocket medical costs. Families and individuals can experience mounting health care costs as a result of chronic illness, a single major health care episode or a series of family illnesses or incidents.

More costly and complex services are now being provided safely outside hospital. Costs that add up for an individual or family are not generally those related to general practice. Rather they relate to services such as specialist consultations, x-rays, psychiatry, electro-cardiographs, CT scans, MRI, radiation oncology, blood tests and the like.

The proposed **MedicarePlus** safety net aims to protect all Australians from high out-of-pocket medical costs for services covered by the Medicare Benefits Schedule incurred outside hospital. At a cost of $266.3 million over this and the next three years, an average 200,000 individuals or families are expected to qualify for benefits under the safety net each year.

For concession card holders and families receiving Family Tax Benefit (A) (FTB (A)), the Government will cover 80 percent of the out-of-pocket costs for medical services provided outside hospital above $500 per individual or family per year. This new entitlement will cover 12 million Australians, including around four out of five Australian families.

For all other individuals and families, the Government will cover 80 percent of out-of-pocket medical costs provided out of hospital above $1,000 per individual or family per year. This will cover a further 8 million people.

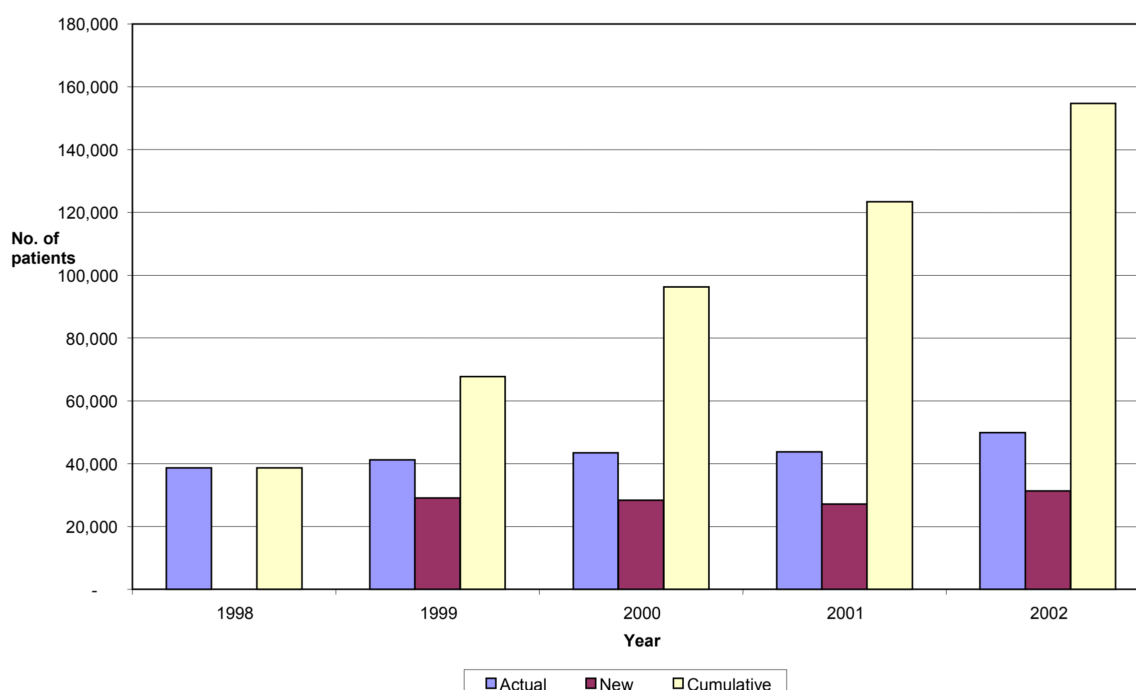
Families for safety net purposes are already defined in the *Health Insurance Act 1973*. Under the Act, children may belong to more than one family where shared custody arrangements apply. Gap payments in these situations are credited to the family whose Medicare card number was used to process the claim.

Where a family or an individual has reached the safety net and lodges a claim for a rebate, the Medicare rebate and additional safety net amount will be calculated automatically and benefits paid to the patient, ie they will receive the Medicare rebate plus 80 percent of the out-of-pocket cost of the service. For example, if a doctor charges $50 and the Medicare rebate for that service is $30, then the rebate received by the patient will increase from $30 to $46 once the relevant safety net threshold is reached.

Concern has been expressed that the proposed new safety net does not deliver benefits to a large number of individuals or families each year. It should be noted in this regard that it will not be the same people who benefit each year. While an individual or family has around a 5 percent chance of needing the safety net in a particular year, their chance of needing it in the course of their lifetime is much higher.

To illustrate, Figure 6 shows the usage pattern of the current MBS safety net over the past 5 years. While an average 43,404 people benefited from the current MBS safety net in each year, a total of 154,680 different people benefited at some time during that 5 year period.

Figure 6: Actual, new and cumulative usage of the current MBS Safety Net



Frequently Asked Questions

What is the difference between the existing MBS safety net and the proposed ***MedicarePlus*** *safety net?*

A Medicare Benefits Schedule safety net has operated since the inception of Medicare. This MBS safety net covers the difference between the Medicare rebate and the Medicare schedule fee for out-of-hospital services, both in terms of the gaps that count toward reaching the MBS safety net threshold ($319.70), and the amount that is covered once the threshold is reached.

Legislation sets the Medicare rebate at 85 percent of the Medicare schedule fee. Under the existing MBS safety net, once an individual or family has incurred costs between the rebate and the schedule fee that add up to $319.70, any further payments to that individual or family are paid at 100 percent of the schedule fee. It is important to note in this context that many doctors charge amounts greater than the Medicare schedule fee. These amounts are not covered by the existing safety net: they do not count toward reaching the threshold and are not reimbursed in whole or part once the safety net threshold is reached.

The proposed new **MedicarePlus** safety net covers all Australians who face high medical costs each year and applies to all out-of-pocket costs, including those in excess of the Medicare schedule fee. Out-of-pocket costs are defined as the difference between the relevant medical expenses that are incurred and any Medicare rebate received in respect of those services. A wide range of services are covered under the proposed new safety net including GP and specialist consultations, blood tests, psychiatry, X-rays, CT scans, tissue biopsy, radiotherapy and pap smears, in fact any service provided outside hospital where you can claim a Medicare rebate.

Subject to the passage of necessary legislation the Government will meet 80 percent of out-of-pocket expenses, for services provided outside hospital that are covered by Medicare once an annual threshold is reached.

- For families eligible for Family Tax Benefit (A) and concession card holders:- Medicare will meet 80 percent of total out-of-pocket costs for medical services provided outside hospital (including amounts above the schedule fee), once an annual threshold of $500 per individual or family is reached.

- For all other individuals and families*:* - Medicare will meet 80 percent of the total out-of-pocket costs for medical services provided outside hospital (including amounts above the schedule fee), once an annual threshold of $1,000 per individual or family is reached.

Will patients benefit more from the new safety net than the existing MBS safety net?

The proposed **MedicarePlus** safety nets covers out-of-pocket costs up to the full fee charged by the doctor, whereas the existing safety net only covers costs up to the MBS schedule fee. The families presented in the safety net examples in the **MedicarePlus** information kit would receive no benefit from the existing MBS safety net as they would not reach the MBS safety net threshold, whereas they would receive additional benefits of $382 and $186 respectively from the proposed **MedicarePlus** safety net.

In general, if an individual or family would benefit from the existing MBS safety net, they would receive greater benefit from the proposed new safety net. For example, a concessional patient who needed to attend weekly psychotherapy sessions for 35 weeks and was charged $175 per session, would receive a total of $436.00 from the existing safety net, compared to a total of $1,096.75 with the new safety net in place – an extra $660.75. If this person was not covered by a concession card, they would still receive a greater benefit with the introduction of the proposed new safety net, compared to the current MBS safety net: a total of $719.68 or an additional $283.68

What prevents doctors from increasing their fees once a patient reaches the safety net threshold?

Doctors will generally not be aware when a patient or family reaches the safety net threshold. Costs that contribute to the threshold will come from a diverse range of services and often from several family members. If a doctor does become aware that a patient has reached the threshold, they will also be taking into account that the patient is continuing to pay 20 percent of the fee beyond the level of the rebate.

The Senate Select Committee on Medicare considered any potential inflationary consequences of the safety nets proposed for *A Fairer Medicare* and concluded:

> *"On the evidence presented, the Committee does not consider inflationary pressures to be a significant concern arising out of the proposed safety nets."*[6]

Why does the safety net only cover 80 percent of out-of-pocket costs once the threshold is reached?

The proposed **MedicarePlus** safety net reimburses 80 percent of out-of-pocket costs for medical services provided outside hospital once the annual threshold of $500 or $1,000 per individual or family is reached (depending on eligibility criteria).

This means that the Government covers a very significant portion of out-of-pocket costs, across a wide range of services and for costs over and above the schedule fee. Retaining a small contribution reduces the likelihood of over-servicing by the doctor or unnecessary use by the patient, and avoids a potential 'moral hazard' for doctor charging.

Many specialists charge additional fees that are separate from their consultation fee – will these count towards the safety net?

The new safety net applies to services covered by the Medicare Benefits Schedule that are provided outside hospital. Any charges made for other purposes are not covered by the *Health Insurance ACT 1973* and will not be recorded by the Health Insurance Commission. If a doctor charges a fee that is not attached to a Medicare Benefits Schedule item, the cost of that service will not count towards the safety net.

Why do individuals have to reach the same threshold as families?

This follows the same model as the existing MBS and PBS safety nets and targets those in greatest need. It recognises that families generally face higher costs across the range of services they access.

What happens if a family stops being eligible for FTB (A) part way through the year? How will this affect safety net eligibility?

Any family in receipt of FTB (A) at any time in a calendar year will be eligible for the $500 safety net threshold for that calendar year.

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[6] ibid, p.92

There will be no part payments of the safety net - families and individuals will either be eligible for the safety net at the annual $500 threshold or they will be eligible at the annual $1,000 threshold - they cannot be both. It is impractical to manage the safety net any other way.

Why are Health Insurance Commission costs a significant component of the cost of the new safety net?

The **MedicarePlus** safety net will provide payments to around 200,000 families and individuals in a full year, and is expected to cover around 4 million services. The costs of registering all the eligible and potentially eligible families, of checking receipts where necessary, of making payments, and of handling the large volumes of queries expected is substantial. This is in part because of the work the Health Insurance Commission will do to make the system less onerous for patients.

The overall Departmental cost of managing the safety net by 2006/07 is around $15 million or 75 cents per person in Australia. The **MedicarePlus** safety net will have HIC administrative costs of around $3.60 per service covered. The current Medicare safety net costs around $6.30 per service covered and the administrative costs for Private Health Insurance ancillary payments, are around $5.30 per service.

Some groups have suggested combining the MBS and PBS safety nets? Why hasn't this been done?

This option was considered but is not practical as the two systems are administered quite differently. Pharmacists administer the PBS safety net at the local level through information held in every pharmacy while the existing MBS and the proposed **MedicarePlus** safety nets are administered by the HIC.

In the case of the PBS safety net, the HIC does not know total costs paid by patients as they do not collect all this information and in particular do not collect information on payments below the threshold. It is therefore not possible to calculate the total out-of-pocket costs across the two sectors.

3.5 Medical Workforce

An effective health care system relies on a skilled workforce of GPs, specialists and nurses who can be accessed when needed. As described in Section 2.2 'Affordable General Practice and Related Services', an adequate supply of doctors is a critical factor in maintaining the affordability of services.

In many parts of Australia, the supply of doctors and nurses is not sufficient to meet local demand. Government policy in recent years has focussed on increasing the number of doctors and nurses in those areas where there is workforce shortage. Since 1996, about $2 billion has been spent on targeted rural health and aged care to promote and support access to doctors, specialists and nurses in rural and remote areas.

Positive results are emerging. In the past seven years, GP activity in rural and remote areas has increased by more than 15 per cent – the equivalent of 550 GPs, and in some of the more remote parts of Australia by 18 per cent.

MedicarePlus applies a further $1,083.9 million in this and the next three years to achieve an immediate and sustained growth in the number of health professionals working in the community, in the places that need them the most. The measures announced in **MedicarePlus** are targeted to those areas that experience the greatest difficulty in attracting and retaining doctors. This includes regional, rural and remote Australia and many of the outer metropolitan areas of the capital cities.

By 2007, these workforce measures should result in 1,500 more full time equivalent doctors and 1,600 more practice nurses.

Table 4 shows the expected impact of **MedicarePlus** workforce measures in each year on the supply of full time equivalent doctors and nurses.

Table 4: MedicarePlus Workforce Supply Matrix

	Cumulative Impact on Supply (FTEs)			
	2003-04	**2004-05**	**2005-06**	**2006-07**
More nurses and allied health workers in general practice	137	229	320	457
MBS Item for nursing support in GP practices	106	892	1083	1147
GP supply impact	91	127	154	163
Better access to medical care for residents of aged care homes				
More GP training places, and support for practice and GP supervisors*	150	300	450	450
Bringing more graduate doctors to outer metropolitan and rural areas* [equivalent of 280 places for doctors with no post-graduate qualifications who require supervised experience]		70	70	70
Drawing on qualified health professionals from overseas	50	275	500	725
Supporting Rural and Remote GPs, especially procedural GPs	50	(-150)	(-225)	(-300)
Specialists re-entering the workforce		15	33	53
GPs re-entering the workforce		11	22	33
234 new medical school places a year				
Higher rebates for patients of non-vocationally registered GPs	(-20)	(-40)	(-60)	(-80)
Total				

Cumulative Impact on Supply	Package			
	2003-04	**2004-05**	**2005-06**	**2006-07**
Additional FTE nurses	243	1,121	1,403	1,604
Additional FTE doctors	200	671	1,075	1,331
Additional FTE doctor services (as a result of practice nurses)	91	127	154	163

Notes: FTE = Full-time equivalent

* These doctors will spend some of their time training

Figures in parentheses indicate estimate of likely trends in doctor FTEs if the measure in question was not to be implemented. These figures are indicative only and are not reflected in annual FTE totals.

Each **MedicarePlus** workforce measure is described in detail below, together with frequently asked questions.

3.5.1 Support for Practice Nurses

Practice nurses provide vital support to general practices, assisting in the effective delivery of health care for patients. Nurses who work in general practice are generally involved in a wide range of service delivery and support arrangements including nursing services, coordination of patient services, managing the clinical environment, health promotion and education, and managing health through immunisations, recall and chronic disease management.

MedicarePlus provides direct support for practice nurses in general practice through more than $140 million over the four years to 2006/07 on grant payments ($64.2 million) and new Medicare items ($76.03 million).

Grants to practices in urban areas of workforce shortage will support 457 additional full time equivalent practice nurses and/or allied health workers and are expected to benefit around 800 practices, or almost 40 percent of practices in RRMAs 1 and 2. This builds on the practice nurse program for rural and remote areas announced in the 2001/02 Budget at a cost of $104 million.

In addition, two new MBS items commencing on 1 February 2004 (subject to regulation) will allow specified services to be provided by a practice nurse, without a GP being present.

The availability of these items provides additional income to practices and means better access for patients. Doctors can focus on other services that need their attention, knowing that their patients are receiving the care they require delivered by a professional colleague.

This measure will support more than 1,600 practice nurses by 2007 and is expected to apply to about 6 million services, or 6 percent of all GP services delivered. It will free up the equivalent of around 160 GPs for other activity that requires their clinical expertise.

Frequently Asked Questions

Will it cost the same to see a nurse as to see a doctor?

The Government does not prescribe doctors' fees. It will be a matter for individual practices as to how they structure their business and what they charge for individual services.

Why is the support for practice nurses still linked to areas of workforce shortage? Wouldn't all practices benefit from this initiative?

Grants to support the employment of practice nurses are linked to areas of workforce shortage, as are many of the measures to increase the supply of GPs, because practices in these areas are under most pressure to provide more services. However, every practice that employs a practice nurse will be able to access the new MBS items.

Why is the Government supporting practice nurses through new MBS items but not allied health professionals, such as psychologists?

The Medicare Benefits Schedule supports the provision of medical services. The services that practice nurses will provide are medical services that GPs would otherwise be providing.

Support for other allied health professionals is available through specific parts of the MBS, such as care planning and case conferencing. Practices in areas of workforce shortage will also be supported to employ allied health professionals under the practice nurse grant arrangements.

Will the practice nurse items qualify for the new $5 payment for certain bulk billed services?

Yes, the practice nurse items will qualify for the additional $5 payment where the service is provided to a concession card holder or child under 16 and is bulk billed.

Will employing practice nurses in general practice draw staff from public hospitals?

The workforce measures of **MedicarePlus** are intended to add to the current supply of doctors and nurses, not to re-distribute the existing pool.

The Australian Institute of Health and Welfare's Nursing Labour Force 2002 report shows that the number of people registering and working as nurses has lifted significantly in the past two years. The extra support for nursing in general practice will encourage people who are not currently nursing to return to the profession, in their local community, with more choice of hours that are compatible with family life. The practice nurse allocation includes an amount for refresher and retraining courses to assist nurses return to nursing after a period away.

How will general practices access funding for practice nurses?

From March 2004, grants averaging $8,000 per full time doctor will be offered through the Practice Incentives Program to help GPs in urban areas of workforce shortage, including regional cities, to employ practice nurses.

Urban areas of workforce shortage will be determined in January 2004 based on doctor to patient ratios and the socio-economic characteristics of the area. In February 2004, practices located in these areas will be invited to participate in the Scheme. These practices can use their grant to support a nurse they already employ in their practice or to create a new position.

3.5.2 Better Access to Medical Care for Residents of Aged Care Homes

MedicarePlus will support doctors to care for residents of aged care homes by investing $47.9 million in a new MBS item and grants to GPs and the Divisions of General Practice.

Under the new MBS item, doctors will be able to undertake comprehensive medical assessments of new and existing residents of aged care homes. These will attract a Medicare rebate of about $140 (subject to consultation with key stakeholders). In 2006/07, it is expected that about 90,000 residents will receive an assessment. A comprehensive medical assessment provides important information for care planning and medication management of a resident.

Improving access to GPs by residents of aged care homes is another aim of this measure. Up to $8,000 will be provided each year to a number of GPs who participate in partnership arrangements with aged care providers. Divisions of General Practice will establish panels of GPs in regions across Australia whose purpose will be to identify and implement action to improve the health of aged care residents.

While still able to access the comprehensive medical assessment item, GPs on these panels will also undertake additional activity, including perhaps being rostered for after hours work and working on health improvement strategies with aged care providers. As a result of these measures, care for residents of aged care homes will be more comprehensive and better planned and it is expected to be easier for residents and homes to access a GP, either on a regular basis if that is what they require, or in an emergency.

Frequently Asked Questions

How will local GP Panels operate?

Participating Divisions of General Practice will be eligible for funding for a part time project officer to coordinate local GP panels. A consultation process involving the aged care industry and GP organisations will commence early in 2004. This will enable potential participants in the Scheme to participate in discussions on how panels will operate at the local level.

Will recipients of Community Aged Care Packages or Home and Community Care be Eligible for Comprehensive Medical Assessments?

This measure is targeted at residents of aged care homes. Older Australians living in their own homes, including those in receipt of a Community Aged Care Package or Home and Community Care service, are eligible for treatment by a GP under existing Enhanced Primary Care Medicare items, including annual voluntary health assessments for older Australians.

3.5.3 More GP Training Places and Support for GP Practices and Supervisors

Starting in 2004, **MedicarePlus** will fund an additional 150 places each year through the Australian General Practice Vocational Training Program. The additional places will bring the total number of available training places to 600 per year, and will assist in the provision of an adequate general practice workforce, particularly in outer metropolitan and rural areas.

In addition to the 150 places (at a cost of $189 million over the four years), this measure supports practices and supervisors to participate in training arrangements, by:

- increased funding to practices that wish to become accredited training practices;
- providing higher payments for GP supervisors within the Australian General Practice Training Program;
- creating 100 new supervisor positions;
- funding Regional Training Providers to work with universities in developing recognised academic positions for qualified GP supervisors.

Frequently Asked Questions

How will these places be filled each year?

The process for filling GP training places each year is to add the new 150 places to the current 450 places filled through processes of General Practice Education and Training. Each year, there is a vigorous selection process for people to enter the Australian General Practice Training Program and they are required to pass the exam that leads to Fellowship of the Royal Australian College of General Practitioners before becoming fully qualified GPs.

How will doctors and practices access additional support for training and supervision?

Funding support for practices wishing to become accredited training practices will be administered through General Practice Education and Training and the 22 Regional Training Providers. This is also the case for the funding for supervisors.

3.5.4 Bringing More Graduate Doctors to Outer Metropolitan, Regional, Rural and Remote Areas

MedicarePlus provides $70.3 million to fund 280 short term placements for graduate doctors to work in general practices in outer metropolitan, rural and remote areas each year. This funding covers the cost of supervisors and practice infrastructure needed to support junior doctors. Funds will also be provided to State and Territory governments to meet the cost of releasing doctors for general practice placement.

The initiative provides experience in general practice for junior doctors and may assist them to select general practice as a long-term career option. In the meantime, by working in areas of workforce shortage these doctors will be providing services to patients and thereby improving access to GP services in areas where there is a shortage of GPs. The 280 placements will provide around 70 full time doctors per year to outer metropolitan and rural areas.

Frequently Asked Questions

Will placing pre-vocational doctors in general practice for some of their training draw staff away from public hospitals?

The number of pre-vocational doctors who will be receiving training in general practice at any one time will be small compared to the numbers employed in public hospitals. Hospitals will be able to draw on pools of locum doctors to fill temporary vacancies, and will receive funding from the government through this measure to defray extra costs.

Isn't there already a program that places junior doctors in general practice? How does this initiative differ?

There is an existing program, the Rural and Remote Area Placement program, that places junior doctors in general practice. This has been operating for a few years, but is on quite a small scale, with only around 70 placements each year. The new initiative significantly expands this program adding 280 placements each year.

3.5.5 Drawing on Qualified Health Professionals from Overseas

MedicarePlus provides $432.5 million to significantly increase the number of appropriately qualified overseas trained doctors working in Australia. By 2007, an additional 725 overseas trained doctors will work in Australia as a result of this measure. Medicare provider number restrictions contained in the *Health Insurance Act 1973* will allow the Government to direct these doctors to areas of workforce shortage, where their services are needed most.

A number of components comprise the initiative.

International Recruitment Strategies

An international recruitment process managed by the Government will enhance and better coordinate current State/Territory and private sector recruitment arrangements. There is currently a range of international recruitment activities across Australia for overseas trained doctors. The international recruitment strategy will provide a national, overarching process that will augment and enhance current recruitment activities undertaken by State/Territory and private sector organisations.

It is envisaged that direct marketing activities will be undertaken in selected countries, to be supported by web-based arrangements. The website will provide access to comprehensive, reliable and up to date information for overseas trained doctors and employers, with associated links to a range of key stakeholders. Through these links, employers will have the opportunity to promote localities and specific medical vacancies.

Overseas trained doctors who have expressed an interest in working in Australia through these recruitment arrangements will undertake an assessment process that is acceptable to medical registration boards and employers. The recruitment strategy will not target developing countries.

Reduced Red Tape in Approval Processes

Under this initiative, the Government will support the streamlining of requisite approval processes for overseas trained doctors (including overseas trained specialists) entering the Australian medical workforce. Reduced ‘red tape’ in approval processes will minimise the time taken for appropriately qualified overseas trained doctors to enter the medical workforce and therefore increase the attractiveness of Australia as a destination for skilled doctors.

The Government will work with:
- The Australian Medical Council, bridging course providers and other key stakeholders to modify examination processes for the multiple choice questionnaire and the clinical examination. This initiative will encompass the Australian Medical Council multiple choice questionnaire being made available on line;
- State and Territory health authorities to better align Australian Government and State/Territory definitions of areas of workforce shortage in which overseas trained doctors can work;
- The Australian Medical Council and the medical colleges to streamline specialist recognition processes for overseas trained specialists. This initiative will support the development of new approaches to the assessment of temporary and permanent resident overseas trained specialists.

Assistance for Employers and Overseas Trained Doctors in Arranging Placements

This initiative will support the establishment of a national information and referral service for overseas trained doctors. This service arrangement will assist overseas trained doctors (and employers) to efficiently work their way through the various approval processes leading to entry to Australia, registration/recognition and employment and improve the level of information available regarding these processes. The Government will work with key stakeholders to establish structures to support a national information and referral service.

The activities undertaken by these structures is likely to include:
- support services for the provision of information and referral to other agencies;
- web-based information for the purposes of dissemination of information and, links to relevant organisations;
- other information packages regarding immigration, registration, employment, specialist and GP recognition processes, training issues, and access to Medicare rebates.

Improved Training Arrangements and Additional Support Programs

New training opportunities and support for the undertaking of some training programs will be made available to overseas trained doctors. The Government will work with training providers, the Australian Medical Council and key stakeholders to identify:

- overseas trained doctors who are currently not participating in the medical workforce but with further training, could do so;
- overseas trained doctors in the medical workforce who require further training to obtain full medical registration.

Eligible overseas trained doctors from the above mentioned groups will be provided with financial support for training leading to their obtaining conditional or full medical registration in Australia.

The Government will work with specialist medical colleges, State and Territory health authorities and key stakeholders to support increased training opportunities for certain overseas trained specialists leading to recognition by the relevant Australian medical college. Additionally the Government will work with training providers and key stakeholders to develop a nationally consistent training program addressing the cultural awareness and orientation needs of overseas trained doctors.

Opportunities for Doctors to Stay Longer or Obtain Permanent Residency

Under new extended visa arrangements temporary resident doctors (visa class 422) will have additional time under their visa to undertake Australian Medical Council examinations and further training. This will enhance permanent migration opportunities.

Qualified and experienced overseas-trained doctors, whether in Australia or overseas, will be able to apply to migrate without a sponsoring Australian employer under the General Skilled Migration program. This will mean greater numbers of permanent resident overseas trained doctors working in Australia. Restrictions on Medicare provider numbers will mean that these practitioners will be required to work in an area of workforce shortage for up to 10 years if accessing Medicare rebates.

Frequently Asked Questions

Why is there a reliance on overseas-trained doctors?

The significant investment in increasing the number of Australian trained doctors takes time to deliver new doctors on the ground, whereas increasing the supply of appropriately qualified overseas trained doctors enables additional medical services to be provided quickly.

MedicarePlus supports both short to medium term increases in the medical workforce through the use of overseas trained doctors and a number of other targeted measures, and a longer term increase through the creation of 234 additional medical school places each year. This will see more Australian trained doctors entering the workforce in 2011 and beyond.

How will we be sure that these overseas trained doctors are appropriately qualified to practise in Australia?

Overseas trained doctors must meet appropriate Australian quality standards before they are able to practise medicine in this country. These quality standards are governed by State and Territory medical registration board requirements. The standards relate both to clinical skills and non-clinical skills such as English language and communication abilities. The Government's package of initiatives for overseas trained doctors includes improved training arrangements and support programs.

Rather than concentrating on bringing more overseas doctors into Australia, wouldn't it be more efficient to provide the training necessary to enable those overseas trained doctors already in Australia to qualify as GPs?

There are a number of overseas trained doctors in Australia who have not met medical registration requirements and therefore have not entered the workforce. A number of these have been unsuccessful at passing the Australian Medical Council examinations for medical registration.

MedicarePlus supports the training needs of a greater number of overseas trained doctors including those who, with assistance, may be able to pass the Australian Medical Council examinations, leading to full registration with a State or Territory medical registration board.

3.5.6 Supporting Rural and Remote GPs

MedicarePlus provides $101.2 million to support GPs who practise in rural and remote Australia, particularly those who undertake procedural work. There are three aspects to the initiative. Procedural GPs will be provided with financial support to attend up-skilling courses, both for meeting the cost of the course and for employing a locum. In most cases, doctors in rural areas would be required to leave their practice to attend training in capital cities.

GPs in rural and remote areas with 10 percent or more of their work identified as procedural will be entitled to a loading in recognition of the additional costs involved. Payments will be aligned with the level of a GP's procedural workload, so for example, a GP who spends a quarter of their time on procedural work will receive a 25 percent loading. This loading is capped at 30 percent. To qualify for the loading, a GP or practice must be a participant in the Practice Incentive Program.

Thirdly, the current Rural Retention Payments Scheme will be extended for another four years and funding increased in recognition of the commitment of GPs who provide services to rural and remote communities for extended periods of time.

How will GPs access these payments?

The Department is holding discussions with relevant stakeholder groups as to the best way in which to manage these payments. A further meeting will be held in January 2004 to finalise proposed arrangements.

Will the work that GPs do in hospitals count towards the PIP loading?

The Department is aware that many rural GP proceduralists perform a significant amount of their work within the hospital system. Work is underway with representative organisations to ensure that a fair system is implemented that recognises this work.

3.5.7 Helping GPs and Specialists to Re-enter the Workforce

MedicarePlus will provide GPs and specialists who are no longer practising medicine with refresher training courses and other support to help their return to the medical workforce. It is expected that more than 80 GPs and specialists will benefit.

This $26.8 million initiative will support:

- General Practice Education and Training regional training providers to offer refresher courses for GPs;
- refresher training and mentor support for specialists;
- training placements in private practice for specialists;
- financial incentives for specialist practices, mentors and colleges to participate;

A key cost of this measure is the flow on to the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme of the activity of more GPs and specialists when they are back in the workforce.

Will these re-entry arrangements cover all specialties and how will they work?

Yes. This measure will be introduced across all specialties in cooperation with the relevant specialist medical colleges and other appropriate providers. Placements will mainly be in private practice, with specialists billing Medicare during their placements and on re-entry to the workforce. Financial incentives will encourage specialist practices and mentors to participate and Colleges to provide suitable training and support.

3.5.8 More Medical School Places for Doctors

MedicarePlus retains the additional 234 medical school places each year commencing in 2004 that were announced in *A Fairer Medicare,* with one important change. In line with the recommendation of the Senate Select Committee on Medicare, up to 3 years of post graduate vocational training undertaken in rural areas can now be counted towards the six year bonding period that applies to these places.

This provides an incentive for medical students taking up the new bonded places to serve significant periods of their postgraduate training services in rural areas where there is a need for more doctors.

Frequently Asked Questions

Why has the bonding requirement for medical school places been retained?

The medical school places in **MedicarePlus** are bonded to ensure that they lead to increases in medical services in areas of where they are needed most. In recent years access to doctors in rural areas has improved. However shortages remain in rural areas and in some other locations, such as regional centres and the outer metropolitan areas of the major capital cities.

The Senate Select Committee on Medicare has supported the proposal for 234 new bonded medical school places, and recommended amending the proposal to enable students to begin working off the bond period during postgraduate vocational training as Registrars. This has been adopted in **MedicarePlus**.

3.5.9 Higher Rebates for Patients of Non-Vocationally Registered GPs

Vocational registration was introduced in 1989 to encourage doctors to complete appropriate postgraduate training and continuing professional development. Patients of doctors who are vocationally registered are eligible for level A1 Medicare rebates. The A1 rebate for a Level B consultation is currently $25.70. The Medicare rebate for the same service delivered by a non-vocationally registered GP is $17.85.

The introduction of vocational registration was accompanied by a 'grandfathering' period, which enabled GPs to join the register on the basis of experience alone. This period closed in December 1996. There are still about 3,000 doctors who were practising before 1996 who are not on the Vocational Register.

MedicarePlus invests $22.4 million to allow patients of non-vocationally registered medical practitioners who were practising prior to 1996 to claim the A1 rebate provided the doctor works in an area of workforce shortage for five years. Once these GPs have practised in an area of workforce shortage for at least five years, their patients will continue to be eligible for the A1 rebate, regardless of where the GP is practising.

Frequently Asked Questions

Why are non-vocationally registered GPs being given access to a higher rebate when they are less qualified than vocationally registered GPs?

Non-vocationally registered GPs are not necessarily less qualified than vocationally registered GPs. Some have chosen not to vocationally register, others missed the opportunity. This measure provides some additional encouragement to non-vocationally registered doctors to relocate to areas of workforce shortage for at least five years so they can access A1 rebates from that point on. An important part of this measure will be working with professional organisation to ensuring that these GPs access appropriate Continuing Medical Education.

Some of these doctors are already working in an area of workforce shortage and are eligible for the A1 rebate through a current program. Will this time count toward their five years?

Yes. Pre-1996 non-vocationally registered GPs who are already working in an area of workforce shortage under a current program will have this time counted towards the five years.

3.6 Impact of MedicarePlus on General Practice Income

Through **MedicarePlus** the vast majority of practices will receive some financial benefit from the significant levels of additional funding that are being made available. Individual measures that will result in financial gain to many GPs include:

- the new $5 item which can be claimed by a doctor when they bulk bill a concession card holder or child under 16;
- the new MBS items for immunisation and wound management services provided by practice nurses;
- the new comprehensive medical assessment item for GPs who provide services to residents of aged care homes;
- a range of grants to support the employment of practice nurses, retention of doctors in rural areas, and doctor education and training.

For a typical GP, this could mean additional income of between $35,000 to $47,000 each year depending on where they practice and the degree to which they subscribe to individual measures.

Table 5 lists the source of this expected additional income and the amount a typical GP could benefit if they take advantage of the various initiatives for which they would be eligible under **MedicarePlus**.

Table 5: Additional Income under MedicarePlus per full time equivalent GP by Rural, Remote, Metropolitan Area classification[7]

Measure	**Per Full Time Equivalent GP in:**		
	RRMA 1	**RRMA 2**	**RRMAs 3-7**
More affordable health services – for children and Commonwealth Concession Card holders	$17,780	$15,785	$13,370
Patient convenience through new technologies	$250	$250	$333
Support for practice nurses through a new Medicare item and grant payments	$11,570	$11,570	$11,570
Better access to medical care for residents of aged care homes	$2,765	$2,765	$2,765
More GP training places, and support for practices and GP supervisors	$2,667	$2,667	$2,667
Bringing more graduate doctors to outer metropolitan, regional, rural and remote areas.	$0	$10,000	$10,000
Supporting rural and remote GPs, especially procedural GPs	$0	$0	$6,800
TOTAL	**$35,051**	**$43,056**	**$47,525**

[7] Costs assume that the GP will subscribe to all measures for which they may be eligible under **MedicarePlus.**

ATTACHMENT A: COSTING SUMMARY

MEASURES	A FAIRER MEDICARE 4 year cost of retained measure* ($m)	NEW MEASURES - 4 year cost ($m)		
		Direct Cost	Flow on cost to MBS/PBS	TOTAL
Affordability Measures				
More affordable health services: for children under 16 and Commonwealth Concession Card holders		956.7		956.7
Patient Convenience				
Grants to GPs and specialists to encourage uptake of electronic claiming through HIC Online	9.0	7.0		16.0
Funding to improve broadband internet access for practices	9.2			9.2
Funding to assist GPs to assess current business practices	4.6			4.6
MedicarePlus Safety Net		266.3		266.3
Total cost of affordability measures	22.8	1230.0	0.0	1252.7
Workforce measures				
More nurses and allied health workers in general practice	64.2			64.2
MBS Item for nursing support in GP practices		38.9	37.1	76.0
Better access to medical care for residents of aged care homes		47.9		47.9
More GP training places, and support for practice and GP supervisors	189.5	11.1		200.6
Bringing more graduate doctors to outer metropolitan and rural areas		53.4	16.9	70.3
Drawing on qualified health professionals from overseas		43.7	388.8	432.5
Supporting Rural and Remote GPs, especially procedural GPs		101.2		101.2
Specialists re-entering the workforce		2.1	2.1	4.2
GPs re-entering the workforce		0.6	22.0	22.6
234 new medical school places a year	42.1			42.1
Higher rebates for patients of non-vocationally registered GPs		22.4		22.4
Total cost of workforce measures	295.8	321.2	466.9	1083.9
Measure unchanged from A Fairer Medicare				
Information for public and medical professionals	21.1			21.1
Arrangements for Veterans through Local Medical Officers	61.7			61.7
Total cost of unchanged measures	82.8	0.0	0.0	82.8
A Fairer Medicare measures				
~~*AFM Affordability Program for Geneneral Practice (GPAS) and Signage*~~	~~-347.4~~			
~~*AFM MBS Safety Net for Out-of-Pocket expenses*~~	~~-67.1~~			
~~*AFM Private Health Insurance Product*~~	~~-89.6~~			
~~*AFM Reducing up front costs for GP visits*~~	~~-11.1~~			
TOTAL REVISED COST original + new measures	**401.4**	**1551.2**	**466.9**	**2419.5**
* includes flow on costs to MBS/PBS				