Senate Select Committee on Medicare

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

SUB 138B

28 August 2003

Question: 1

Topic: Bulk Billing

Hansard Page: 76

Senator Stephens asked:

Bulk billing has been declining since 1997 – that comes from your figures. Can you tell me whether or not the number of GP services has been declining since that time as well?

Answer:

The following table shows the number of Medicare non-referred attendances, rendered on a 'fee-for-service' basis, for which claims were processed by the Health Insurance Commission in the financial years ending June 1996-97 to 2002-03, inclusive. Excluded are details of services to public patients in hospital, to Veterans' Affairs patients and some compensation cases.

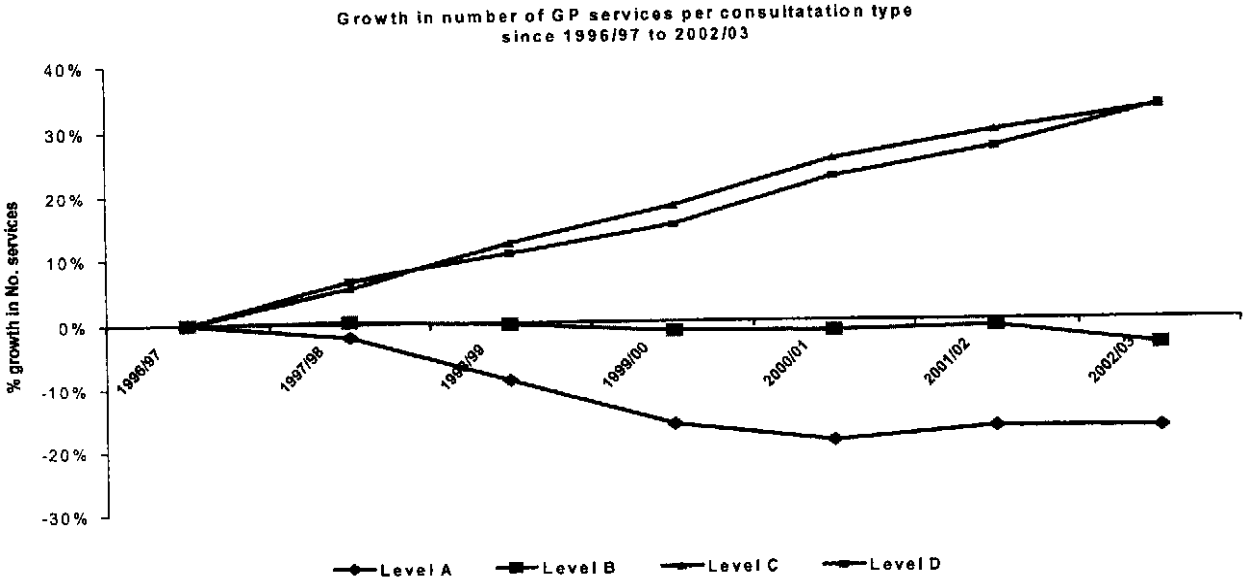
Medicare Non-referred Attendances

1996-97 to 2002-03

Year	Number
1996-97	102,529,070
1997-98	103,132,518
1998-99	102,552,234
1999-00	101,517,066
2000-01	100,645,359
2001-02	99,920,660
2002-03	96,919,246

Although the total number of attendances declined between 1996-97 and 2002-03, the total benefits paid through the MBS have increased each year and equate to an 18.2% or $427 million increase from 1996-97 to 2002-03.

This is due in part to the fact that GPs have increased the proportion of longer consultations that they perform. The number of GP services for Level C and D consultations have increased each year since 1996-97, while over the same period the number of Level A and B consultations has declined. (see chart below).



Between 1996-97 and 2002-03 longer consultations have increased by 34% or 2.8 million attendances, while for the same period shorter consultations have decreased by 3% or 2.1 million services.

Senate Select Committee on Medicare

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

28 August 2003

Questions: 2 & 4

Topic: Concession Card Holders

Hansard Page: 79

Senator Allison asked: What are the trends lines for Drs who have been bulk billing 100% for some years but aren't now? Do we know the percentage that have moved away from bulk billing? Can we have 100% bulk billed over 12 months for the last 3 calendar years.

Can we also see the number of GPs that are bulk billing at 90, 80, 70% etc. Is it possible to get a spreadsheet on that?

Answer:

The following table shows the number of general practitioners and the number of full-time equivalent general practitioners, by percentage of services bulk billed range, 2000, 2001 and 2002 (year of processing).

In general terms, practitioners were regarded as general practitioners if more than 50 per cent of Schedule fee income in the December quarter of the year in question, was from non-referred attendances.

The statistics relate to providers of services for which Medicare benefits were paid in the year in question. Excluded are details of services to public patients in hospital, to Veterans' Affairs patients and some compensation cases.

MEDICARE - GENERAL PRACTITIONERS
NUMBER OF PROVIDERS OF AT LEAST ONE SERVICE
AND NUMBER OF PROVIDERS
BY PERCENTAGE OF SERVICES BULK BILLED RANGE
2000, 2001 AND 2002 (YEAR OF PROCESSING)

% of Services Bulk Billed Range	2000 No of Providers	2001 No of Providers	2002 No of Providers
A:100	1,677	1,483	1,514
B:90-<100	8,320	7,596	6,407
C:80-< 90	1,832	1,949	1,818
D:70-< 80	1,909	1,911	1,803
E:60-< 70	1,759	1,866	1,790
F:50-< 60	1,607	1,639	1,783
G:40-< 50	1,165	1,267	1,587
H:30-< 40	957	1,142	1,406
I:20-< 30	844	996	1,318
J:10-< 20	760	943	1,221
K:>0-< 10	938	1,000	1,218
L: 0	2,410	2,396	2,190
Total	24,178	24,188	24,055

* Number of providers includes all providers who have billed Medicare in that period.

Senate Select Committee on Medicare

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

28 August 2003

Question: 3

Topic: Concession Card Holders

Hansard Page: 81

Senator Forshaw asked:

Could you give us some data on the proportion of concession card holders who would be utilising GP visits and services most? I suppose I am interested in whether 80 or 90% of concessions card holders have the same number of visits on average.

Answer:

The following table shows, for non-referred attendances provided by general practitioners to concession card holders in 2002 (year of service) the proportion of patients and services by number of services range.

MEDICARE – CONCESSION CARD HOLDERS
NON-REFERRED (GP) ATTENDANCES RENDERED BY GPS
PROPORTION OF PATIENTS AND SERVICES
BY NUMBER OF SERVICES RANGE
2002 (YEAR OF SERVICE)

Services Range	Patients % Total	Services % Total
1-5	51.1%	18.5%
6-10	25.7%	25.9%
11-15	12.0%	19.9%
16-20	5.5%	12.7%
21-25	2.6%	7.8%
26-30	1.3%	4.8%
31-35	0.7%	2.9%
36-40	0.4%	1.9%
41-45	0.2%	1.3%
46-50	0.2%	1.0%
51-55	0.1%	0.8%
56-60	0.1%	0.5%
>60	0.2%	2.1%
Total	100.0%	100.0%

The above statistics only relate to general practitioner providers of services to concession card holders for which Medicare benefits were paid. Excluded are details of services to public patients in hospital, to Veterans' Affairs patients and some compensation cases.

In general terms, practitioners with at least 50% of Schedule fee income from non-referred attendances in the December quarter 2002, were taken to be general practitioners.

Senate Select Committee on Medicare

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

28 August 2003

Question: 5

Topic: Bulk Billing

Hansard Page: 85

Senator Humphries asked:

Can you provide an estimate of what it would cost to means test the seven million people who are presently on health care cards to determine whether they might be eligible, if you had a different model, to access bulk billing (a rough estimate)?

Answer:

A proposal to means test current concession card holders would fall within the responsibilities of the Department of Family and Community Services.

Senate Select Committee on Medicare

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

28 August 2003

Question: 6

Topic: Increase in Rebate

Hansard Page: 89

Senator McLucas asked:

Does the increase in the rebate appear in the Commonwealth set of expenditures or in the health fund expenditures?

Answer:

Total health expenditure by broad source of funds, as a per cent of GDP, 1984-85 and 1990–91 to 2000–01

	Public				Private				
Year	C'Wealth	State and Local	Total	% of total spend	Health Funds	Individual	Other	Non-Gov't	% of total spend
1984-85	3.4	1.9	5.3	71.6	0.6	1.0	0.4	2.1	28.4
1990–91	3.3	2.0	5.3	67.7	0.9	1.3	0.4	2.6	32.3
1991–92	3.5	2.0	5.5	67.3	0.9	1.4	0.4	2.7	32.7
1992–93	3.6	1.9	5.5	66.9	0.9	1.4	0.4	2.7	33.1
1993–94	3.7	1.8	5.5	66.4	0.9	1.4	0.5	2.8	33.6
1994–95	3.7	1.8	5.5	66.3	0.9	1.4	0.5	2.8	33.7
1995–96	3.8	1.8	5.6	67.1	0.9	1.4	0.5	2.8	32.9
1996–97	3.7	1.9	5.6	66.6	0.9	1.5	0.5	2.9	33.4
1997–98	3.8	2.0	5.8	67.9	0.8	1.5	0.5	2.8	32.1
1998–99	4.0	2.0	6.0	68.8	0.7	1.5	0.5	2.7	31.2
1999–00	4.2	2.0	6.2	70.3	0.6	1.5	0.5	2.6	29.7
2000–01	4.3	2.0	6.3	70.0	0.6	1.6	0.5	2.7	30.0

The table demonstrates that with the introduction of the 30% Rebate in 1998-99, the Commonwealth health expenditure share of GDP increased from 3.8 to 4.0% while the health fund share of expenditure decreased.

Senate Select Committee on Medicare

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

28 August 2003

Question: 7

Topic: Practice Nurses

Hansard Page: 96

Senator Lees asked:

Could we have a global view of what increasing the level of support for practice nurses would cost across the entire medical workforce in Australia. In NZ and a lot of European countries you are able to access one practice nurse for every two Drs. Would you do some costings on that for us? What would be the cost if you were to fund Drs at that level, so for every Dr there was effectively 50% of a Practice Nurse? 50% of a full time practice nurse on a standard salary of say $40,000.

Answer:

Based on an annual salary of $40,000 per nurse, the estimated annual cost of funding one practice nurse for every two full time workload equivalent GPs across Australia is $334.7 million.

Senate Select Committee on Medicare

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

28 August 2003

Question: 8

Topic: Practice Nurses

Hansard Page: 97

Senator Lees asked:

Could you do the same thing (as 7) for one Allied Health Professional for every four Drs and average it?

Answer:

Based on an annual salary of $40,000 per allied health worker, the estimated annual cost of funding one allied health worker for every four full time workload equivalent GPs across Australia is $167.4 million.

Senate Select Committee on Medicare

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

28 August 2003

Question: 9

Topic: Allied Health Workers

Hansard Page: 97

Senator Lees asked:

Can you also provide other figures that you might have looking at what the cost would be of some of the options for supporting Drs to make their time as GPs more valued and enable them tow work with other allied health professionals and nurses, any work you have done, but perhaps these two examples specifically?

Answer:

A number of current initiatives such as the Enhanced Primary Care (EPC) Medicare items and the practice nurse initiatives provide support for GPs to work with allied health professionals and nurses.

The EPC items for multidisciplinary care planning and case conferencing provide increased Medicare rebates for GPs working as a member of a multidisciplinary team to provide better coordinated care for people with chronic conditions and complex care needs. Allied health professionals and nurses can be members of EPC multidisciplinary teams. The Medicare rebate for preparing an EPC care plan is $167.95. Rebates for GP involvement in multidisciplinary case conferencing range from $46.65 to $130.65 (depending on duration of case conference and whether the GP is organising or participating in the case conference).

EPC health assessments include provision for nurses or other assistants to work under the supervision of the GP in collecting information about the patient for the health assessment. The Medicare rebate for a health assessment ranges from $130.65 (if undertaken in the surgery) to $184.75 (if undertaken wholly or partly in the patient's home).

The Practice Incentives Program provides incentives to rural and regional practices and other areas of workforce shortage to employ nurses in general practice. Practice nurses provide support to GPs in managing a patient's care. There is scope under the Medicare Benefits Schedule for nurses and other health professionals to assist in care delivery whist acting under the supervision of a GP. Practice nurses can take part in assisting with the provision of care for chronic disease management, specifically diabetes, asthma and cervical screening.

The Government's recently announced *A Fairer Medicare* package, includes provision for up to an additional 800 practices in urban areas of workforce shortage to gain access to practice nursing subsidies. This will improve access by patients to a range of health services and ease pressure on GPs in these practices.

Senate Select Committee on Medicare

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

28 August 2003

Question: 10

Topic: Relative Value Study

Hansard Page: 98

Senator McLucas asked:

Different assumptions were made on the same technical data and came up with a different figure of the RVS of $50. Can you give us a briefing that explains what the differences were between the RVS assumptions and the Departmental assumptions?

Answer:

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 RVS outcome.

The Department undertook its own modelling based on the technical reports produced as part of the study, as did the AMA.

The Department and the AMA's modelling differed in terms of the assumptions made in relation to four key issues:

- GP workload (expressed as the number of services performed by GPs per year);
- Practice costs;
- Target income for GPs; and
- The work value of a standard consultation (expressed as the relativity of activities as a function of time and intensity of effort).

These four key issues are discussed below:

Annual doctor workloads

We understand the AMA modelling which was not formally published assumed GPs perform three services per hour, for 40 hours per week over 49 weeks of the year for a total of 5,880 services per GP per year. The Department based its modelling on 7,207 services per year, a figure derived from Medicare data on actual workloads with reference to work profiles of various categories of doctors developed in the *Practice Costs Study* conducted by PricewaterhouseCoopers.

The Department believes that it is essential for the service profiles of model practitioners to reflect the workloads of reasonably efficient doctors working full time on MBS rebated

services. Our modelling is based on 7,207 services (based on an analysis of MBS data, which showed that this was the average of the 8th decile of all GPs in terms of annual throughput). This is the denominator by which the annual practice costs and remuneration are divided, and has a significant impact on the bottom line (the larger the number of services, the smaller the amount required to cover income and expenses). This difference could explain most of the difference between the AMA modelling and Departmental modelling.

The AMA also argued that face-to-face time represented 75% of total time on average for consultations. Therefore, the AMA estimates assume that, a 15 minute face-to-face consultation involves a total of 20 minutes of doctor time (ie. 75/25% split of direct and indirect time). The Department's position is that available evidence points to an 85/15% split of direct and indirect time. However, the Department's method of estimation of GP workloads based on Medicare data of actual workloads makes the attendance item indirect time irrelevant to the modelling.

GP practice costs (practice size)

The Practice Costs Study component of the RVS produced practice costs for a range of GP practices from one doctor practices to four doctor practices. The AMA adopted the practice costs for a two doctor practice ($118,743 per GP) while the Department used the practice costs for a three doctor practice ($113,526 per GP).

Departmental analysis of the available data indicates that the weight of available evidence supports a three doctor practice as the more representative of practice costs. In particular the *General Practices Profile Study: Campbell Research and Consulting, 1997*, stated that 68% of GPs were in practices with three or more doctors. Health Insurance Commission (HIC) data from the Practice Incentive Payments Scheme (PIP) shows that almost 60% of GP practices enrolled in PIP comprise three or more full time equivalent GPs, with the average being 3.3.

The analysis shows that there has been a steady rise in the size of GP practices and the Australian Institute of Health and Welfare (*Medical Labour Force 1998*) showed that 49.9% of GPs were practicing in group practices of four doctors or more and 64.2% were practicing in group practices of three or more.

A later survey conducted by the AMA (*AMA GP Workforce Survey 2001*) found that there were significantly lower costs for practices than previously identified. This reported that for a two doctor practice costs were $80,000 per GP and for a three doctor practice they were $75,000 per GP.

Target income for GPs

The AMA modelling adopted a target annual income for GPs of $130,000 per annum. Departmental modelling adopted a target income of $120,000 per annum with $8000 per annum derived from non-fee-for-service items under the PIP.

The *Remuneration Rates Study* data on paylines for comparable professions indicated that the appropriate level of GP remuneration was $118,583pa. The AMA believed that there were grounds for some upward adjustment for factors affecting medical practice which were not quantified and therefore adopted a GP remuneration reference rate of $130,000pa.

The Department considers that there is no obvious justification for any approach other than the most straightforward, ie a simple average of annual GP remuneration indicated by the five

comparable professions (accountants, lawyers, engineers, chemists and geologists). The Department rounded that figure to $120,000pa.

For the purposes of modelling the Department adopted a GP remuneration reference rate of $112,000 to take account of an average of $8,000pa a GP would receive in PIP payments at the time of the analysis.

Work value of standard GP consultation

While this was a significant issue of debate between the AMA and the Department, it does not effect the GP estimate. This is because the GP value for remuneration was calculated directly not on an item by item basis. The number of units attributed to a GP service, a specialist service or a procedure was then calculated by a different system and the values for remuneration of the non GP groups worked out from the GP dollars and the relative numbers of units for the service. The debate about the number of units for the GP service therefore does not affect the GP remuneration estimates, which are taken directly, but does impact upon non GP services provided.

Senate Select Committee on Medicare

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

28 August 2003

Question: 11

Topic: Allocation of Medical School Places

Hansard Page: 98

Senator McLucas asked:

Can you provide us with a table that explains what the current 2003 intake is, including a subset of that intake, which is the rural bonded scholarships that currently exist and then as they are going to be allocated for 2004, separating out the total per university from regular intake, rural bonded and bonded. Before and after in terms of the two categories at the moment evolving into three categories from January, with the 234 separately identified?

Answer:

See attached table.

Change in Allocation of Medical School Places - 2002 to 2004

	2002 intake*			2004 allocation				
University / State	DEST unbonded places	rural bonded scholarship places	TOTAL INTAKE**	DEST unbonded HECS places	rural bonded scholarship places	bonded medical places (BMP) scheme	total bonded allocation	TOTAL ALLOCATION
New South Wales (UNSW)	150	4	154	146	10	26	36	182
Sydney	181	15	196	158	11	27	38	196
Newcastle	64	9	73	64	5	11	16	80
ANU	0	0	0	64	5	11	16	80
NSW/ACT TOTAL	*395*	*28*	*423*	*432*	*31*	*75*	*106*	*538*
Melbourne	174	9	183	157	11	26	37	194
Monash	138	9	147	128	9	22	31	159
VIC TOTAL	*312*	*18*	*330*	*285*	*20*	*48*	*68*	*353*
James Cook	79	9	88	74	5	12	17	91
UQ	216	14	230	220	17	38	55	275
Gold Coast***	0	0	0					
QUEENSLAND TOTAL	*295*	*23*	*318*	*294*	*22*	*50*	*72*	*366*
UWA	136	9	145	148	11	26	37	185
Notre Dame***	0	0	0					
WA TOTAL	*136*	*9*	*145*	*148*	*11*	*26*	*37*	*185*
Adelaide	90	4	94	80	6	13	19	99
Flinders	57	9	66	64	5	11	16	80
SA TOTAL	*147*	*13*	*160*	*144*	*11*	*24*	*35*	*179*
Tasmania	54	9	63	67	5	11	16	83
TASMANIA TOTAL	*54*	*9*	*63*	*67*	*5*	*11*	*16*	*83*
AUSTRALIA TOTAL	***1339***	***100***	***1439***	***1370***	***100***	***234***	***334***	***1704***

Source: 2002 - Department of Education, Science and Training (DEST) (ENROL 2001-2002)
2004 - Allocation of Medical School places.

Notes:
* intake figures for 2002 are the latest actual data available from DEST
** total excludes full-fee paying temporary resident students (non-HECS)
*** places earmarked for these universities have been allocated to other universities within the state until their new medical schools are approved for intake - 2005 or later.

Senate Select Committee on Medicare

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

28 August 2003

Question: 12

Topic: Relative Value Study

Hansard Page: 98

Question:

Explain the RVS modelling that supports the contention you make in the 2nd last paragraph at the bottom of page 22.

Answer:

The paragraph referred to above says:

> "By comparison, modelling by the Department of Health and Ageing, based on the same technical reports but using different assumptions, showed that while general practitioner attendances were under-funded to a small degree, Government budget decisions since the RVS was undertaken has more than offset this under-funding."

The different assumptions held by the AMA and the Department are explained in response to question 10 provided by the Department.

With regard to Government budget decisions in the years since the RVS, in 2001-02 the Government provided $750 million over four years in additional funding for general practice, which more than covers the under funding identified by the Department's modelling.

As well as income earned directly from the services they provide to patients, GPs can receive payments (averaging around $20,000 per participating GP per year) through the Practice Incentives Program (PIP) and General Practice Immunisation Incentives Scheme (GPII).

In addition to this, the recently announced "A Fairer Medicare" package seeks to directly increase funding to General Practice by almost $500 million.

Senate Select Committee on Medicare

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

28 August 2003

Question: 13

Topic: HECS

Hansard Page: 103

Senator Allison asked:

HECS is payable to any student and if they go to work in rural and remote areas for five years after graduation, they are entitled to have their HECS returned prorata. This is not available to medical rural bonded scholars because they get a $20,000 per annum scholarship. How many students have taken that up so far?

Answer:

Eligible medical graduates who complete their medical degree in 2000 or later, and who provide services in Rural, Remote and Metropolitan Area (RRMA) 3-7 locations will have one fifth of their HECS debt reimbursed for each year of service in a RRMA 3-7 location.

As at 11 September 2003, 80 applicants have applied for the HECS Reimbursement Scheme. 63 participants have received payments under the Scheme.

Senate Select Committee on Medicare

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

28 August 2003

Question: 14

Topic: HECS

Hansard Page: 103

Senator McLucas asked:

Can you provide an analysis of More Doctors, Better Services effectiveness of the program, where people can get their HECS back over time. Do they stay in the bush?

Answer:

First payments for the HECS Reimbursement Scheme were made in late 2002, therefore it is too early to determine whether participants will remain in Rural, Remote Metropolitan Area (RRMA) 3-7 locations.

Senate Select Committee on Medicare

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

28 August 2003

Question: 15

Topic: Comments on submission to Committee by A/Professor Hawthorne

Hansard Page: 104

Senator Lees asked:

Could I ask just one general question: we have a submission that details a lot of information about doctors who are completely unregistered and unqualified, potentially who are out there working – particularly overseas trained temporary resident doctors. Could you have a look at the submission and the sections of Hansard from yesterday that are on the record – which will be available soon; some of it is in camera and it is considerably concerning. Could you look at that and give us some comments on it?

Answer/Comments:

The registration of medical practitioners is a matter for the States and Territories.

All medical practitioners, including temporary resident doctors, need to be registered in each State or Territory in which they practice.

There are two broad categories of medical registration namely full registration, and registration with conditions such as a requirement to work under supervision.

The passing of the Australian Medical Council examinations is not a requirement for conditional registration. An overseas trained doctor who is either a temporary or permanent resident may obtain conditional registration without passing these examinations. However, this is only possible where the registration body (the Medical Registration Board in the State or Territory concerned) is satisfied that the medical practitioner is competent to work in the position for which registration is sought. These positions are usually located in areas of workforce shortage as determined by the States and Territories.

Senate Select Committee on Medicare

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

28 August 2003

Question: 16

Topic: Models of After Hours Primary General Practice

Hansard Page: 83

Senator Lees asked:

Could the Department provide me with an overview of the after hours models being funded? Including what they are, what is working and what is not?

Answer:

To date, 85 projects have been funded nationally through the After Hours Primary Medical Care Development Grants Program. This includes 54 seeding grants, 10 information management/information technology grants, 2 infrastructure grants and 19 service development grants.

- *Seeding Grants* provide funding for the performance of needs analysis and/or business plan development;
- *Infrastructure/ information technology Grants* provide funding for limited infrastructure and IT projects where this would lead to the improvements or implementation of AHPMC services; and
- *Service Development Grants* provide funding for after hours service implementation.

Further to the 19 service development grants an additional 4 projects are being funded through the After Hours Primary Medical Care Program to trial models of after hours care. A description of each of the models being trialed is at Attachment A.

The majority of the trials have recently commenced. An evaluation of these trials will be undertaken.

Senate Select Committee on Medicare

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HEALTH AND AGEING PORTFOLIO

28 August 2003

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