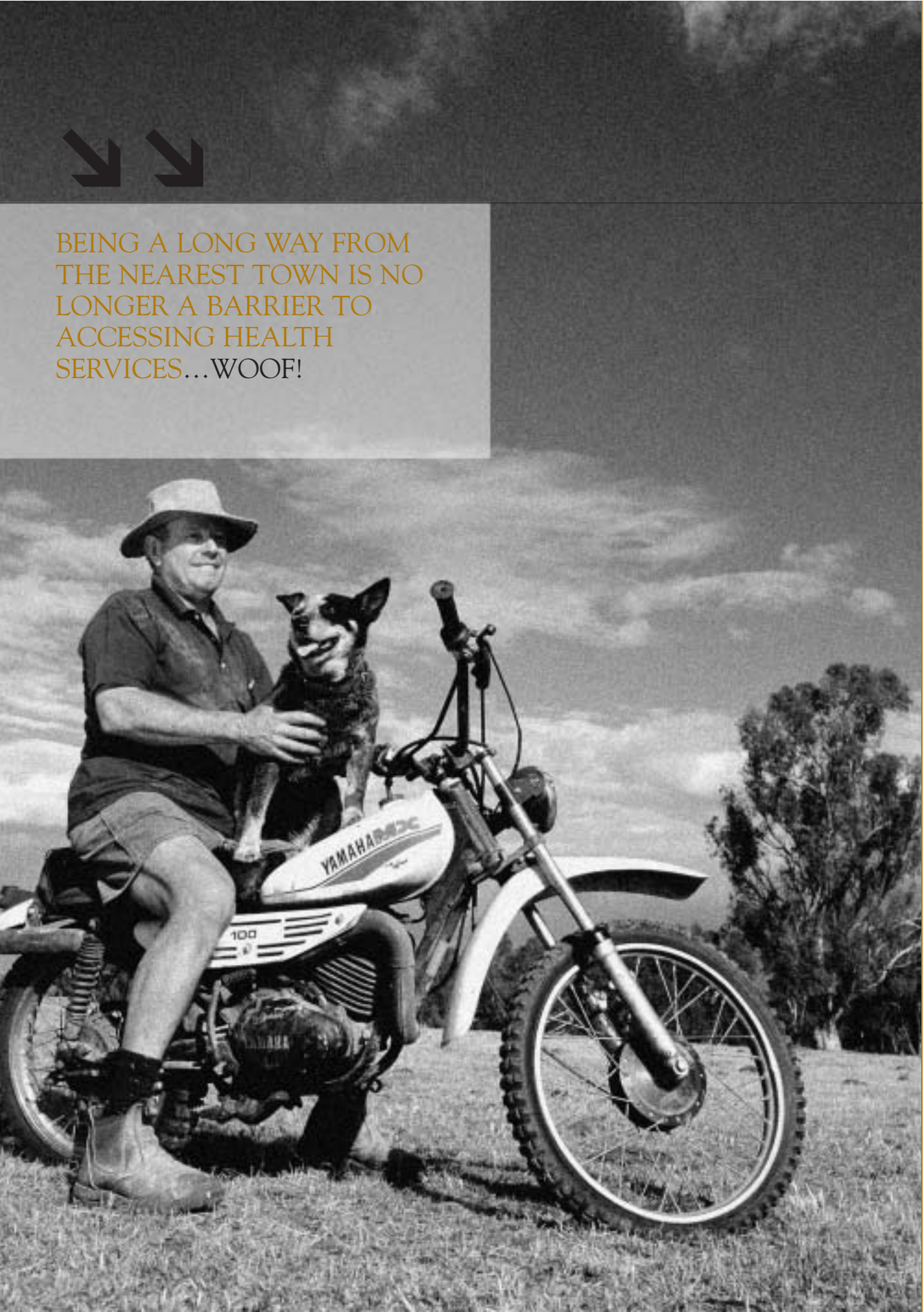
BEING A LONG WAY FROM THE NEAREST TOWN IS NO LONGER A BARRIER TO ACCESSING HEALTH SERVICES…WOOF!



8

OTHER HEALTH PAYMENTS AND ACTIVITIES

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1 Medical Indemnity

Key business results

Under new legislation, HIC is responsible for administering two schemes on behalf of the Australian Government: the Incurred But Not Reported (IBNR) indemnity scheme and the High Cost Claim Indemnity scheme.

In line with legislative requirements, HIC is developing policy and systems to support the payment of claims under both schemes and collection of contributions under the IBNR indemnity scheme.

Overview

In October 2002, the Prime Minister announced a new framework for Medical Indemnity insurance. Some of the measures under the new framework are outlined in the *Medical Indemnity Act 2002* and other associated legislation that came into effect on 1 January 2003: *Medical Indemnity (IBNR Indemnity) Contribution Act 2002*, *Medical Indemnity (Enhanced UMP Indemnity) Contribution Act 2002*, and the *Medical Indemnity (Consequential Amendment) Act 2002*.

The Government's main objective in introducing the legislation is to support the continued provision of medical services to the Australian community by ensuring health professionals have access to affordable indemnity cover.

The Medical Indemnity Act gives effect to some new measures including:

- Australian Government funding of IBNR liabilities of medical defence organisations (MDOs) that have not set aside sufficient funds to cover IBNR claims for incidents that occurred on or before 30 June 2002;
- recouping the cost of unfunded IBNR claims through a contribution from members and former members of Medical Defence Organisations (MDOs) that the Minister for Health and Ageing has determined will participate in the IBNR indemnity scheme;
- Australian Government funding for part of the cost of large claims against all MDOs or other Medical Indemnity insurers for incidents notified after 1 January 2003;
- the Australian Government subsidising the cost of indemnity cover of some groups of medical practitioners; and
- collection of payments by members of United Medical Protection Ltd (UMP) to cover the cost to the Australian Government of any payments under a deed of indemnity should UMP go into full liquidation.

Education and promotion

A comprehensive communication and media strategy is being developed for major stakeholders including:

- development of the Medical Indemnity contact centre in HIC's Tasmanian State Office;
- a Medical Indemnity website;
- information kits for health professionals; and
- consultation with key stakeholders including MDOs and the Stakeholder Advisory Committee.

2 General Practice Immunisation Incentives Scheme

Key business results

At 30 June 2003, the General Practice Immunisation Incentives scheme (the GPII scheme) had 5,487 registered practices. Using the Department of Health and Ageing's baseline figure of 6,000 practices nationally, this represents a participation rate of 91.45 per cent.

The average immunisation coverage rate for practices was calculated at 90.20 per cent for May 2003, with 67.9 per cent of participating practices achieving rates of 90 per cent or higher.

At a glance

Costs of and participation in the General Practice Immunisation Incentives scheme 2001–02 and 2002–03

General Practice Immunisation Incentives scheme	2001–02	2002–03	% change
Practices registered	5,585	5,487	1.7% decrease
Service incentive payments	$19.4 million	$19.9 million	2.5% increase
Outcomes payments	$16.7 million	$17.0 million	1.7% increase
Adjustment outcomes payments	$382,223	$298,825*	21.8% decrease
Total outcomes payments	$16.8 million	$17.2 million	2% increase
Highest quarterly outcomes payment	$11,261.95	$11,252.15	0.09% decrease
Average outcomes payment	$917.41	$913.60	0.4% decrease

*In 2002–03 only three adjusted outcomes payments were made.

Overview

The GPII scheme began in August 1997 with the introduction of quarterly immunisation coverage feedback statements to general practitioners and Divisions of General Practice.

It aims to improve levels of immunisation coverage and service delivery and encourage 90 per cent of practices to have 90 per cent of children in their practice fully immunised. Financial incentives are provided to immunisation providers who monitor, promote and provide age-appropriate immunisation services to children under seven years.

On 7 November 2002, the Federal Minister for Health and Ageing, Senator the Hon Kay Patterson, announced a number of changes to the GPII scheme.

They include:

- funding for the scheme to continue to 30 June 2004;
- vaccinations administered as catch-up schedules to be included in calculations for GPII outcomes payments from 1 July 2003; and
- the planned increase in eligibility for receiving outcomes payments from 85% to 90% immunisation coverage, due to become effective from 1 January 2003, to be postponed until 1 July 2003.

Payments and information

The GPII scheme is made up of three components:

- **service incentive payment —** an $18.50 payment is made to general practitioners and other medical practitioners who notify the Australian Childhood Immunisation Register of a vaccination that completes one of the six age-appropriate vaccination schedules for children under seven.
- **outcomes payment —** a tiered series of payments made to practices that achieve certain percentage proportions of full immunisation.
- **immunisation infrastructure funding (previously divisional funding) —** provides funds to Divisions of General Practice and state based organisations and also funds a National General Practice Immunisation Coordinator to improve the proportion of children who are immunised at local, State and national levels.

Education and promotion

A quarterly information sheet is sent to practices and Divisions of General Practice to provide comprehensive and regular program updates.

3 Practice Incentives Program

Key business results

At 30 June 2003, 4,624 registered practices were participating in the Practice Incentives Program and $244 million in payments were made.

At a glance

Services provided by general practices participating in PIP 2001–02 and 2002–03

Practice Incentives Program	2001–02	2002–03	% change
Number of practices participating at 30 June	4,513	4,624	2.5% increase
Provision of data to the Australian Government	4,513	4,624	2.5% increase
Electronic prescribing	3,978	4,158	4.5% increase
Capacity for electronic transfer	3,950	4,121	4.3% increase
After-hours care			
Ensuring patients have access to 24-hour care	4,418	4,514	2.2% increase
Provision of at least 15 hours care from the practice	3,147	3,177	0.95% increase
Provision of all after-hours care for practice patients	1,302	1,333	2.4% increase
Teaching			
Number of teaching sessions	43,868	60,950	39% increase
Targeted incentives			
Quality Prescribing Initiatives	1,211	1,422	17.4% increase
Total amount paid	$202 million	$224 million	10.9% increase

Overview

The Practice Incentives Program replaced the Better Practice Program on 1 July 1998 following a series of recommendations from the General Practice Strategy Review conducted by the Department of Health and Ageing.

It aims to recognise and provide financial incentives to general practices that provide comprehensive, quality care and are working towards meeting the *Royal Australian College of General Practitioners Entry Standards for General Practices*. Payments made through the program are in addition to other income earned by general practitioners.

HIC assesses all applications from general medical practices for participation in the program and administers the day-to-day operations. The Department of Health and Ageing manages program policy development, including eligibility criteria.

Types of incentive payments

There are five broad elements to the payments:

- **Information management —** practices receive incentives for providing data to the Australian Government, using electronic prescribing software to generate scripts, and for having the capacity to send and receive data electronically. An additional payment was made in May 2003 to all practices to assist them with the move towards the capture and electronic storage of patient records.
- **After-hours care —** payments are available to practices that ensure patients have access to 24-hour care or provide 24-hour care from within the practice. This includes the provision of after-hours home visits where necessary and appropriate.
- **Rural status —** a rural loading is paid to all practices where the main location is situated outside a capital city or other major metropolitan area.
- **Teaching —** an incentive payment is available for general practices that host undergraduate students for teaching placements.
- **Targeted incentives — Quality Prescribing Initiative —** this helps practices to keep up-to-date on the quality use of medicines.

New incentives

The 2001 Budget provided incentives to general practices to improve the management of diabetes, mental health, asthma and cervical screening, and incentives for employment of practice nurses in rural and remote Australia and other areas of need. These incentives, beginning with 'sign on' payments for practices indicating a willingness to meet certain criteria for diabetes, asthma and cervical screening, have been progressively implemented under the Practice Incentives Program from November 2001.

The diabetes outcomes payment was implemented in the May 2003 quarter (providing back-payment for the November 2002 and February 2003 quarters). The cervical screening outcomes payment will be introduced in the August 2003 quarter which will include back-payment for the previous three quarters. These incentives were developed in close consultation with the General Practice Memorandum of Understanding, other professional representatives, expert advisory groups and consumer groups.

Eligibility

Practice accreditation provides a mechanism for acknowledging the quality of a general practice. Practices undergoing the accreditation process are assessed against the *Royal Australian College of General Practitioners Standards for General Practices* 2nd Edition.

In line with the 1988 general practice strategy review recommendations, access to the Practice Incentives Program is only available to accredited practices. Practices joining the program must be either fully accredited or registered for accreditation with one of the two accrediting bodies, and be fully accredited within 12 months of joining.

Program integrity

A comprehensive review of general practices currently enrolled in the Practice Incentives Program was undertaken in 2002–03 in line with the Strategic Partnership Agreement between HIC and the Department of Health and Ageing.

There were 195 practices audited nationally, including rural and metropolitan practices in each State. Of these, 29 practices did not meet the program's eligibility criteria, mainly in the areas of electronic data and provision of after-hours services. In some instances recovery of Practice Incentive Program (PIP) payments was undertaken.

In late 2002 HIC completed additional review activity of 139 practices by specifically examining payments to practices for the provision of after-hours care. The report of the review has gone to the Department of Health and Ageing.

The majority of practices audited this year responded favourably, with many finding the process useful and productive.

Education and promotion

Providers are kept up to date on changes to the Practice Incentives Program by:

- *News Update* — a quarterly information sheet about current and future program activities and incentives that are accessible on the Practice Incentives Program website;
- the website — displays statistics, general program information and downloadable forms for providers and Divisions of General Practice; and
- staff — provide support to practices and providers through the Practice Incentives Program enquiry line.

4 Rural Retention Program

Key business results

HIC made 1,907 payments totalling $18.0 million to 2,309 medical practitioners participating in the Rural Retention Program during 2002–03.

At a glance

Medical practitioner participation in the Rural Retention Program 2001–02 and 2002–03

Rural Retention Program	2001–02	2002–03	% change
Eligible medical practitioners participating	2,147	2,309	7.5% increase
Total payments made	1,966	1,907	3% decrease
Total amount paid	$22.9 million	$18.0 million	2% decrease
Total percentage paid	99.5%	99.7%	0.2% increase

Overview

In the 1999 Budget, the Australian Government committed $171 million over four years (2003–04 to 2006–07) to a range of programs to strengthen the rural health workforce including an amount of $60 million to help retain long serving doctors in rural and remote Australia.

The Rural Retention Program aims to improve health care for people in rural and remote areas of Australia through a system of incentive payments to medical practitioners practising in these areas. It encourages medical practitioners to remain in rural and remote practices beyond the current average of two years and rewards those who do. This is expected to result in improved access to primary health care, greater stability and continuity in medical services and improved health outcomes for Australians living in these areas.

The Rural Retention Program comprises two components:

- **Central Payments System** administered by HIC since December 1999. It seeks to recognise general practitioners, based on their Medicare service data in rural and remote locations, over a number of years; and
- **Flexible Payments System** administered by State and Territory-based Rural Workforce Agencies since December 2000. It recognises long serving general practitioners who do not receive a fair and equitable level of support under the Central Payments System because their services are not captured by Medicare or their locations are not adequately taken into account.

Achievements and outcomes

This year payment rates have increased by 25 per cent.

Prior and revised qualifying periods and maximum payment rates by Retention Payment Category

Retention payment category	Qualifying periods	Payment rates	
		Prior maximum payment	New maximum payment
A	6 years	$4,000	5,000
B	5 years	$8,000	10,000
C	3 years	$12,000	$15,000
D	2 years	$16,000	$20,000
E	1 year	$20,000	$25,000

5 General Practice Registrars' Rural Incentive Payments Scheme

Key business results

HIC made payments totalling $5.5 million to 374 medical practitioners participating in the General Practice Registrars' Rural Incentive Payments Scheme during 2002–03.

At a glance

Medical practitioner participation in the General Practice Registrars' Rural Incentive Payments Scheme 2002–03

General Practice Registrars' Rural Incentive Payments Scheme	2002–03
Medical practitioners paid	374
Total number of payments	695
Total amount paid	$5.5 million

Overview

The Government's commitment to major reform in the area of general practice vocational training is reflected in the allocation of $102 million over four years in the 2000 Budget. This will be used to boost general practice training in rural and remote areas by creating a dedicated 200-place Rural Training Pathway, which operates alongside a (primarily urban) general training pathway.

The Rural, Remote and Metropolitan Area (RRMA) location categories are:

1. Capital City;
2. Other Metropolitan Centre;
3. Large Rural Centre;
4. Small Rural Centre;
5. Other Rural Area;
6. Remote Centre;
7. Other Remote Area; and
8. Offshore Island.

Financial incentives are offered to medical practitioners who commit to undertake training in the rural training pathway in practices located in Rural, Remote and Metropolitan Area (RRMA) classification 4–7. Up to $60,000 is available per registrar over the three years of general practice training. (Incentive payments are not available to registrars for undertaking their mandatory hospital training year.)

Further information on the RRMA can be found at **www.health.gov.au**.

6 Compensation Recovery Program

Key business results

Changes in legislation, implemented from 1 January 2002, streamlined the operation of the program for all customers (insurers, lawyers and compensable persons). This resulted in the number of Compensation Recovery cases processed by HIC falling from a peak of 81,275 in 2000–01 to 65,970 in 2002–03. Actual recoveries have subsequently fallen from $42.1 million to $38.1 million.

At a glance

Compensation recovery cases and benefits 2001–02 and 2002–03

Compensation Recovery Program	2001–02	2002–03
Cases finalised	79,945	65,970
Benefits recovered	$42.2 million	$38.1 million

Overview

The Compensation Recovery Program, which began in February 1996, aims to prevent 'double dipping' in Medicare and nursing home benefits/Residential care subsidies paid by the Government, in relation to an injury/illness where a person receives compensation for that injury/illness.

It is administered under the provisions of the *Health and Other Services (Compensation) Act 1995* (HOSC Act) by HIC on behalf of the Department of Health and Ageing. The operational requirements for the program are managed under the terms of the Output Pricing Agreement (OPA), a Strategic Partnership Agreement (SPA) and a Schedule, all agreed between HIC and Department of Health and Ageing.

Eligible people who are claiming compensation are able to claim Medicare and/or nursing home benefits and/or residential care subsidies, from the date of their injury/illness to the date of judgment/settlement of their case. However, once a case reaches judgment/settlement the HOSC Act requires insurers or other compensation payers to advise HIC of claims for compensation where the amount of compensation provided to a compensable person, is more than $5,000 inclusive of all costs.

HIC then determines the amount of Medicare and/or nursing home benefits and/or residential care subsidies, if any, that have been paid in the course of treatment of that injury/illness. This amount must be repaid to the Australian Government.

HIC's National Office is responsible for the program's policy and systems development and operational or processing aspects are carried out in the New South Wales and Queensland State Offices.

7 HECS Reimbursement Scheme

Key business results

HIC made payments totalling $459,951 to 67 medical graduates participating in the HECS Reimbursement Scheme during 2002–03.

At a glance

Medical graduates participation in the HECS Reimbursement Scheme 2002–03

HECS Reimbursement Scheme	2002–03
Eligible medical graduates participating	67
Medical graduates paid	52
Total payments made	91
Total amount paid	$459,951

Overview

The HECS Reimbursement Scheme was announced in the 2000 Budget as part of the Regional health strategy: more doctors, better health services. This initiative aims to promote careers in rural medicine and increase the number of doctors in rural and regional areas in the longer term.

Participants who undertake training or provide medical services in rural and remote areas of Australia have one fifth of their HECS debt reimbursed for each year of service. Through the Scheme, as more doctors move to work in rural areas, communities gain improved access to health services with benefits also to general health levels over the longer term.

The Scheme will use the RRMA classification 3–7 to define eligible areas (see page 105).

8 Federal Government 30% Health Insurance Rebate

Key business results

At a glance

Federal Government 30% Health Insurance Rebate 2001–02 and 2002–03

Federal Government 30% Health Insurance Rebate	2001–02	2002–03	% change
Memberships registered	4,686,455	4,816,238	2.8% increase
Total paid in cash claims	$3.5 million	$2.8 million	20% decrease
Total paid to health funds	$1,972.9 million	$2,163.43 million	9.7% increase

Overview

HIC administers the 30% Rebate on behalf of the Australian Government and works with the Department of Health and Ageing, the Australian Taxation Office, the Private Health Industry Advisory Council and health funds to do so.

The Australian National Audit Office Performance Audit Report, *Administration of the 30% Private Health Insurance Rebate*, was tabled in Parliament in May 2002. The main recommendations affecting HIC were that:

- HIC reviews its Premium Reduction Scheme registration procedures to ensure they comply with the *Private Health Insurance Incentives Act 1998*, all eligible Premium Reduction Scheme applicants are registered, and health funds are fully informed of their responsibilities with respect to the registration process;
- HIC ensures arrangements for Premium Reduction Scheme reimbursements have adequate financial controls;
- pending any changes in policy and related legislation for the Incentive Payments Scheme, HIC strengthens financial controls surrounding the scheme;
- HIC and the Australian Taxation Office review their data exchange arrangements to ensure the Australian Taxation Office obtains timely access to the data it requires to undertake adequate data matching checks for inappropriate multiple claiming under the 30% Rebate; and
- The Department of Health and Ageing and HIC develop clear performance indicators and standards in relation to the 30% Rebate payment accuracy by HIC (that is, the extent to which eligible people receive a rebate of the correct amount).

HIC generally accepted the Australian National Audit Office's assessment and has already implemented improvements to bring administration of the 30% Rebate in line with HIC's Business Improvement Program and the relevant legislation. These include:

- forming a working group to review the legislation;
- implementing new claiming procedures to allow validation of claims and facilitate identification and enforcement of registration requirements;
- establishing working groups and processing manuals for health funds to enable them to better understand their responsibilities;
- initiating an audit program;
- reviewing the Schedule to the Strategic Partnership Agreement; and
- forming a working group with the Australian Taxation Office to address data exchange issues.

Program audit

Private health funds supply an annual audit certificate on the operation of the 30% Rebate.

HIC checks claims made at Medicare offices to ensure no premium reduction has been applied to a policy.

Audits at 11 health fund entities that participate in the 30% Rebate for Private Health Insurance Premium Reduction Scheme were carried out during 2002–03. They identified the degree of congruence between HIC and health fund data relating to the registration of persons who pay reduced premiums for private health insurance cover.

The audits also established the extent to which claims for payment made by health funds are accurately calculated and in respect of persons who are valid participants in the Premium Reduction Scheme. There was a significantly lowered level of risk than existed in the previous financial year.

Where necessary, recommendations designed to strengthen and correct aspects concerning data completeness or evidence of participant validity have been made and acted upon by the health funds concerned.

Education and promotion

As part of the broader 30% Rebate campaign managed by the Department of Health and Ageing, HIC continues to provide information to consumers through articles in *Your Health Matters*. The claiming form, which is available from Medicare offices and HIC's website, has been updated.

9 Veterans' treatment accounts

Key business results

At a glance

Costs and service claims for Veterans' treatment accounts 2001–02 and 2002–03

Veterans' treatment accounts	2001–02	2002–03	% change
Cards produced	83,604	193,113	131% increase
Lines processed	19.70 million	18.11 million	8.1% decrease
Total benefit expenditure	$1,511.9 million	$1,610 million	6.4% increase

Overview

HIC began processing medical and allied health services claims for Veterans' treatment accounts on behalf of the Department of Veterans' Affairs on 1 December 1996. Hospital claims processing began on 22 September 1997. This activity is carried out in accordance with a memorandum of understanding between HIC and the Department of Veterans' Affairs that covers services, service standards and financial arrangements.

10 Family Assistance Office

Key business results

While lodgement of Family Assistance Office (FAO) forms to HIC continues to increase, the number of enquiries and HIC customer contact has decreased overall as customers make greater use of telephone and internet facilities.

At a glance

Family Assistance Office 2001–02 and 2002–03

Family Assistance Office	2001–02	2002–03	% change
Services provided by HIC	170,108	194,737	14.5% increase

Overview

The FAO is a virtual organisation in partnership between the Department of Family and Community Services, Centrelink, the Australian Taxation Office and HIC that uses existing facilities and staff from all four agencies.

It delivers assistance for families in three main areas:

- Family Tax Benefit Part A that provides help with the cost of raising children;
- Family Tax Benefit Part B that provides extra help for families with one main income, including sole parents; and
- Child Care Benefit that helps with the cost of child care.

HIC provides services such as responding to enquries on FAO services, and receiving and checking claims for benefits, before the claims are passed onto Centrelink for payment processing.

HIC is working with the Department of Family and Community Services and Centrelink to identify opportunities to extend the variety and volumes of FAO work processed through Medicare offices. A trial, including the rollout of software developed by Centrelink, will be conducted during 2003–04 to test the variability of its implementation throughout HIC's Medicare office network.

Further information about FAO can be obtained at **www.familyassist.gov.au**

11 Hearing Services Program

Key business results

The Office of Hearing Services has encouraged the use of electronic claiming by hearing service providers and this has resulted in internet facility use increasing to 91 per cent of all claims.

At a glance

Hearing Services Program services and payments 2000–01 and 2001–02

Hearing Services Program	2001–02	2002–03	% change
Services processed	722,825	769,538	6% increase
Total amount paid	$143.2 million	$153.6 million	7.2% increase

Comparison of electronic and manual hearing services claims 2001–02 and 2002–03

Claims	2001–02	2002–03	% change
Electronic data interchange	489,888	564,902	15% increase
Paper	79,619	57,036	28% decrease
Total claims	569,507	621,938	9% increase

Services processed			
Electronic data interchange	622,177	697,250	12% increase
Paper	100,648	72,288	28% decrease
Total services	722,825	769,538	6% increase

Overview

The Hearing Services program operates under the provisions of the *Hearing Services Administration Act 1997*. The Australian Government provides hearing services and products to eligible people under the Hearing Services Program administered by the Office of Hearing Services in the Department of Health and Ageing.

HIC processes and pays claims on behalf of the Office of Hearing Services to accredited hearing service contractors.