AH&MRC Position Statement

Comprehensive Medicare Coverage for Aboriginal Community Controlled Health Services in New South Wales

About the AH&MRC

The AH&MRC is a membership-based organisation and the Peak Body for Aboriginal Health in New South Wales. We represent 49 Aboriginal Community Controlled Health Organisations (ACCHOs) across the state. The AH&MRC supports ACCHOs to ensure they have access to an adequately resourced and skilled workforce to provide high-quality health care services for Aboriginal communities. The AH&MRC is committed to the delivery of four key priorities:

1. **Aboriginal Community Control and Innovation**
2. **Education and Workforce**
3. **Research and Data**
4. **Governance and Finance**

Overview

Medicare (formerly MediBank) was established in 1975 as the first publicly funded universal health scheme in Australia providing access to primary, tertiary, and acute health care services across the public and private health systems.

The Medicare Benefits Schedule (MBS) is a list of medical services for which the Australian government will provide financial subsidisation. The MBS determines the schedule fee, that is, the percentage that the government will pay for a service through a corresponding item number. Medical practitioners will then receive payment for a service based on the schedule fee. On the patient's end, this fee sets the Medicare rebate amount and the associated out-of-pocket costs.

Since its establishment, Medicare has undergone significant changes. Services eligible for subsidisation on the MBS have changed, often based on emerging needs and health trends. The most notable shifts have included changes to the coverage of dental care, mental health, and telehealth services. However, despite a commitment to an evidence-based approach to public funding of health care, critical services continue to be excluded from the MBS.

MBS item numbers are limited across several areas, heavily impacting the operation of primary health care services including Aboriginal Community Controlled Health Organisations (ACCHOs). Many of these services run at a deficit to provide services that have high demand in communities without appropriate Medicare reimbursement.

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Dental Services

Aboriginal people are disproportionately impacted by poor oral health and the associated long-term health impacts. Aboriginal people are less likely to attend a dental service than non-Indigenous Australians, and more likely to be hospitalised for oral health conditions.[1] Engagement with the ACCHO sector and Aboriginal communities across the state has identified significant access barriers for those seeking dental services.

While the MBS provides some coverage for dental services for Aboriginal and Torres Strait Islander people, there are long wait times to access these services without cost. Current wait times for public (bulk-billed) dentistry can exceed 12 months, including for concession card holders. Extended wait times often lead to individuals' conditions worsening to acute stages, that require more invasive, complex and expensive dental procedures. ACCHOs have absorbed much of this burden, with patients often opting to access services through their local ACCHO as opposed to the Local Health Districts (LHD). The level of funding received by ACCHOs for the provision of these services varies across the state. At present, more than half of the ACCHOs in New South Wales deliver dental services yet funding sources are limited.

Accessing long term and sustainable funding is a constant challenge for ACCHOs. They use different funding sources to deliver their oral health programs, including both state and Commonwealth programs. In New South Wales, many ACCHOs receive funding for dental services through the NSW Health Partnerships for Health Funding (formerly the NSW Health Non-Government Organisations Grant Program). Other services must use their core Indigenous Australians' Health Programme (IAHP) funds for oral health programs. This may be in combination with co-payments from patients, NSW Health Oral Health Fee for Service Scheme vouchers, Child Dental Benefits Schedule (CDBS) vouchers or other limited Medicare dental income. This system has led to a lack of funding security, with many of the available avenues being short term or 'once off'.

Medicare-generated income provides an additional revenue stream for ACCHOs to 'top up' the salaries of critical health care staff, including dentists. There is a limited number of billable dental items which reduces the Medicare-generated income that services receive. This reduces the ability of services to retain dentists, with ACCHOs competing with privateer services who can offer above-market rates for dental salaries. There are currently 118 dental practitioners (dentists, oral health therapists and dental assistants) working in the ACCHO sector in NSW. Only 67% of the national dental workforce is employed at a full-time capacity, with the number of full-time dentists in the ACCHO sector making up an even smaller proportion of this.[2] While many ACCHOs have the infrastructure to provide dental care, they have been unable to recruit dentists and oral health therapists.

Medicare is a key oral health funding source for ACCHOs who rely on the income generated from billing Medicare. Notwithstanding, Medicare offers very limited dental item numbers. For example, under the CDBS, children can access a $1026 voucher over two calendar years for basic dental care, but families must be receiving Australian Government Centrelink payments to be eligible. This excludes Aboriginal parents who are not receiving Centrelink payments but cannot afford private dental. Some ACCHOs have reporting that they often cover the cost of private dental care for patients where no other treatment options are available.

ACCHOs across the state have called for the Commonwealth government to reinstate dental MBS item numbers to increase Medicare coverage and fill the gap in dental care. This will enable services to undertake long term planning and coordination for dental services and ensure that the provision of dental services does not leave ACCHOs at a shortfall.

1 Tynan, A., Walker, D., Tucker, T., Fisher, B. & Fisher, T. (2022). Managing oral health care and prevention: The experience of Aboriginal and Torres Strait Islanders living in rural community in Queensland, Australia. *Australian Journal of Rural Health*, 30(2), 228-237. https://doi.org/10.1111/ajr.12853

2 Australian Institute of Health and Welfare. (2022). *Oral health and dental care in Australia, Mar 2022*. https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/dental-workforce

Medicare Coverage for other Primary Health Care professionals

ACCHOs experience unique challenges as primary health care providers due to geographic, sociocultural, and economic factors. These are often compounded by under-resourcing. Services account for these challenges, particularly workforce shortages, by utilising a team-based model of care. This allows services to provide necessary primary health care services that leverage other health professionals. Practice Nurses (PNs) play a critical role in service delivery within ACCHOs, for which the MBS does not adequately account. The Practice Nurse Incentive Program of 2012 aimed to consolidate practice nurse funding arrangements which limited the item numbers that PNs could claim. Nurse immunisation and dressing incentives were replaced by the PNIP. This has confined PN roles to supporting health assessment and not broader clinical care, despite having the necessary qualification. This disproportionately impacts the ACCHO sector as Medicare income generated by PNs replies on General Practitioners, who are in short supply.

> In line with the RACGP recommendations on 'Professional Attendance items used in a general practice,' the AH&MRC supports the reintroduction of Practice Nurse item numbers. This should include a range of activities to reflect the scope of work PNs are able to undertake, allowing the role to support general practitioners and broader team-based models of care.

Under the 715 – Health Check for Aboriginal and Torres Strait Islander people, Aboriginal Health Practitioners (AHP) and PNs are able to provide follow up services. Under item 10987, AHPs and PNs can claim up to ten follow up services per calendar year. However, follow up care undertaken for chronic disease under item 10997 is limited to five renumerated services per patient in a calendar year. This is insufficient compensation since appropriate follow up care in chronic disease management is more complicated and extensive than support involved in preventative care under item 10987. This five-service remuneration limit financially disadvantages the broader service. Regular follow up and continuous monitoring of chronic conditions are critical, particularly noting that Aboriginal people are more likely to present in the emergency room at acute stages of an illness. Medicare can contribute to a more holistic model of chronic disease management because it helps generate additional revenue for the Practice to improve access to primary health care services for the community.

> The AH&MRC supports an increase to the number of reimbursed follow up services and AHPs and PNs are able to claim for chronic disease management.

Nurse Practitioners are also constrained by the lack of flexibility in MBS items numbers. The current schedule fee assigned to Nurse Practitioner Professional Attendance items (82200, 82205, 82210, 82215) is not financially viable. Under each of these item numbers, the schedule fee is significantly less than other health professionals with comparable clinical experience and qualification. This disincentivises the recruitment of nurse practitioners, as the position is unable to claim commensurate revenue to the cost of their employment for the service. The majority of nurse practitioners who provide MBS subsidised services are employed in priority areas, adversely impacting the ACCHO sector.

This fee schedule has not been fully reviewed against the cost-of-service provision since its inception a decade ago. Furthermore, it does not align with the level of qualification a Nurse Practitioner is required to have. The remuneration for work undertaken by Nurse Practitioners must be increased. The Medicare system should undertake a review to provide reimbursement for other health professionals that is flexible and in line with qualifications.

There has been an increasing number of GPs and primary health care providers that are not bulk billing for services. This trend towards fee-for-service health care is compounded by inadequate Medicare rebates. In a single year, 22% of mainstream GPs changed their billing model to mixed billing or completely private billing.[3] This signals an ongoing trend towards higher out of pocket costs for patients as the number of bulk-billing GPs decreases. Aboriginal people are more likely to be impacted by this due to financial insecurity. The ACCHO sector continues to provide health care to communities, absorbing the mounting costs. Insufficient Medicare coverage is placing significant strain on the sector and preventing the growth of services.

3 Ronan, J. (2022, August 11). RACGP: Free falling bulk-billing rates a sign of things to come. *RACGP.* https://www.racgp.org.au/gp-news/media-releases/2022-media-releases-1/august-2022/racgp-free-falling-bulk-billing-rates-a-sign-of-th

Conclusion

ACCHOs are significantly under resourced, despite the high demand for the services they provide to Aboriginal communities. They also face persistent workforce shortages, particularly in regional, rural, and remote areas. The current model which has required them to provide primary health care in complex and often challenging settings without stable income is unsustainable. Closing the Gap has set a mandate for government to support the growth of the community-controlled sector and in order for ACCHOs to grow and thrive, the level of funding they receive must be commensurate with the services they provide, including through Medicare. This must be a key focus for the recently established Strengthening Medicare Taskforce.

Recommendations

It is recommended that the Federal government:

1. Expand publicly funded dental care to increase the coverage of Medicare to equitably fund oral health services to ensure that Aboriginal people are able to access high quality and timely dental care must be a priority action for government.

   a Provide long term and sustainable reinvestment into the Aboriginal Oral Health Strategy.

2. Reintroduce Practice Nurse MBS item numbers and include a broad range of activities that PNs undertake, including immunisation and dressings as previously implemented.

3. Increase compensation for Chronic Disease Management provided by PN's and AHP's by expanding the remunerated follow up services to more than 5 per calendar year.

4. Increase the schedule fee for Nurse Practitioner Professional Attendance items.

Aboriginal Health & Medical Research Council of NSW
Level 4, 280 Pitt Street, Sydney NSW 2000

T 02 9212 4777
www.ahmrc.org.au