

Guide for Patients on How the Health Care System Funds Medical Care

The AMA has prepared the following information for patients seeking medical treatment so they may better understand how the health care system works to fund their healthcare.

Medicare rebates

The Medicare Benefits Schedule (the MBS) is a list of the medical services for which the Australian Government will pay a Medicare rebate, to provide patients with financial assistance towards the costs of their medical services.

Medicare rebates do not, and were never intended to, cover the full cost of medical services. The Government sets a Medicare Schedule Fee to determine the amount of the rebate that patients receive from the Government. Medicare rebates are paid as a percentage of the Medicare Schedule Fee as follows:

- 100% for consultations provided by a general practitioner;
- 85% for all other services provided by a medical practitioner in the community; and
- 75% for all services that are provided by a medical practitioner during an episode of hospital treatment when the patient is admitted as a private patient.

Medical practitioners are able to set their own fees for their services. The Medicare Schedule Fee and the Medicare rebate do not reflect the value of a medical service or an amount that medical practitioners should or must charge.

The fee charge by a medical practitioner covers not only their own personal income, but also his or her practice costs – the wages for practice staff (nurses, receptionists, administrators), and other costs for running a medical practice such as equipment, medical supplies, cleaning, rent, electricity, computers, continuing professional development, accreditation and insurance.

Since Medicare began 40 years ago, Government indexation of Medicare Schedule Fees have not kept pace with real increases in practice costs. This is why today patients will find there is a difference between the amounts of the fee their doctor charges and their Medicare rebate. These are commonly called ‘out-of-pocket costs’, because the patient must make up the difference out of their own pocket.

The AMA encourages medical practitioners to charge a fair and reasonable fee having regard to their practice costs and the particular individual circumstances of their patients.

Medicare rebates are not payable for any medical service that is not listed on the MBS, or when the service is not considered to be ‘clinically relevant’, that is the service is not generally accepted in the medical profession as being necessary for the appropriate treatment of the patient. In both cases, the payment arrangements are a private matter between the treating medical practitioner and the patient.

Medicare Safety Nets

Medicare Safety Nets provide additional relief to those patients who incur higher than usual medical costs for out-of-hospital services in a calendar year. Once a patient’s out of pocket

costs reach a certain threshold, the Government will provide additional financial assistance as follows:

Original Medicare Safety Net – the Medicare rebate is increased to 100% of the Medicare Schedule Fee (up from 85%). The threshold from 1 January 2015 is \$440.80 and applies to all Medicare eligible singles and families.

Extended Medicare Safety Net (EMSN) - covers 80% of the out-of-pocket costs, or the EMSN cap amount, whichever is the lower. The thresholds in 2015 are: \$638.40 for concession card holders and families that are eligible for Family Tax Benefits Part (A); and \$2,000 for all other singles and families.

Hospital treatment

The Australian health care system supports hospital treatment for patients in two ways:

1. As public patients in public hospitals; and
2. As private patients in public or private hospitals.

Public patients

The Australian Government has agreements with the State and Territory Governments to fund public hospital services. All eligible Australians are able to access hospital treatment as a public patient in a public hospital. The government funding agreements require public patients to be provided with treatment that is free of charge.

Australians who elect to be public patients are not able to choose the hospital that they are admitted to or the medical practitioners who will treat them.

Private patients

Australians who have purchased private health insurance for the cost of hospital treatment can elect to use their private health insurance for hospital treatment instead of electing to be a public patient.

Private patients can usually choose the hospital that they are admitted to and the medical practitioners who will treat them. However, this is subject to the following:

- Medical practitioners will usually only work in a limited number of hospitals, where they have been credentialed to work; and
- Surgeons have long standing working relationships with the medical practitioners who provide anaesthesia, surgical assistance and pathology and diagnostic imaging services during the hospital treatment, who must also be credentialed to work in the hospital.

The patient will not be asked to choose:

- from hospitals that the treating practitioner is not credentialed to work in; or
- the medical practitioners who work with the treating surgeon to provide their care.

The costs of hospital treatment includes accommodation, operating theatres, prostheses, medical services, allied health services and pharmaceuticals. It is a common misunderstanding that private health insurance covers the entire cost of hospital treatment.

Similar to the MBS arrangements, private health insurance will not always cover the full costs of hospital treatment provided to private patients. There are primarily two reasons for this:

1. Private health insurance products

There is an enormous range of private health insurance products. The general rule is that the cheaper the premium the less the product will cover. For example, products will exclude cover for specific medical treatments, such as obstetrics, cardiac procedures, neurosurgery and hip and knee replacements. Some products will only cover treatment provided in public hospitals. The premiums for these products are lower than the products that cover all medical services listed on the MBS and in any type of hospital.

The private health insurers categorise their products into four levels of cover: top; medium; basic private hospital cover; and public hospital cover. Top cover means only that all medical services listed on the MBS are included in the policy. Medium cover means that there will be medical services that are excluded from those policies.

Private health insurers are required to produce Standard Information Statements for each of their products, which clearly sets out what the product does not cover. Private health insurers send these statements to their policy holders each year. The statements are also available from www.privatehealth.gov.au and the private health insurers' websites.

The AMA encourages people with private health insurance to review the Standard Information Statement for their policy every year to make sure it meets their needs.

2. Hospital and medical benefits arrangements

By law private health insurers are required to pay minimum benefit amounts for hospital costs and medical services.

For hospital costs, private health insurers and hospitals enter into contracts that mean that the private health insurer pays an amount to the hospital that is higher than the minimum benefit amount. In these situations, the patient would usually not have an out-of-pocket cost for hospital costs. If there is no contract between the patient's private health insurer and the hospital, the hospital is able to set their own charges and the patient may incur an out-of-pocket cost.

For medical services, private health insurers are required to pay a benefit of at least 25% of the Medicare Schedule Fee, and will only cover 100% of a medical practitioner's fee when the medical practitioner agrees to charge a fee that is equal to the level of medical benefit set by the patient's private health insurer.

If the treating medical practitioner is not able to accept the benefit amount set by the private health insurer, the patient will be required to pay the difference between the doctor's fee and the benefit amount paid by their private health insurer.

This is why having top cover doesn't guarantee that you will not have any out-of-pocket expenses if you need hospital treatment.

Only a few private health insurers will pay a benefit with a 'known gap'. This is where the private health insurer will permit the medical practitioner to charge a fee that is a specific amount above their medical benefit level.

Examples of how Medicare and private health insurance might cover a medical service

The following table illustrates the Medicare and private health insurance coverage of a total hip replacement – MBS item 49318.

	Doctor's fee	MBS fee	MBS rebate (75%)	PHI medical benefit	Out-of-pocket cost
Doctor does not accept PHI medical benefit level	\$2,610.00	\$1,317.80	\$988.35	\$329.45	\$1,292.20
Doctor accepts PHI medical benefit	\$2,000.75	\$1,317.80	\$988.35	\$2000.75	\$0.00
Doctor accepts PHI known gap arrangement	\$2,500.75	\$1,317.80	\$988.35	\$2000.75	\$500.00

Some private health insurers publish lists of medical practitioners who charge according to the private health insurer's schedule of medical benefits.