RACGP
Royal Australian College of General Practitioners

Introducing mixed billing into your practice

Responses to questions from attendees

Webinar details

Date: Thursday 24 March 2022
Time: 7.00 pm – 8.30 pm AEDT
Facilitator: Dr Emil Djakic, Chair – RACGP Business Sustainability Working Group
Presenter: Adjunct Clinical Professor Karen Price, RACGP President
Recording: Click here to view. The recording is available to RACGP members only.

General comments

RACGP position on billing

General practices operate as private businesses and have tailored, sustainable business and billing models in place to ensure they remain viable and can continue to provide high-quality care to the community.

The Royal Australian College of General Practitioners (RACGP) supports specialist general practitioners (GPs) and general practices to determine billing policies and consultation fees that enable them to provide high-quality general practice services. GPs and their teams should determine a fair and equitable fee for their services to ensure their practice's sustainability.

Billing is a personal choice and there are many factors that may influence how a GP bills, including patient demographics, practice location and desired income. Whether GPs are able to privately bill some, or all patients will depend on these factors. However, the only Medicare Benefits Schedule (MBS) items that must be bulk billed at present are COVID-19 vaccination items.

GPs should abide by legislative requirements and consider the impact of billing changes on their patients when determining or changing their billing policy or model.

Patient education on billing is a necessary part of the relationship between a GP and their patient. Just as GPs need to support patients to understand out-of-pocket costs associated with medical consultants to whom they refer, GPs should be transparent about any out-of-pocket costs their patients may incur at their practice.

Visit the RACGP website to read our position statement on billing for general practice services. Please note this document is currently under review.

RACGP resources

The RACGP has developed a number of resources to support members to manage their billing. All resources are available via a central page on the RACGP website. We encourage you to bookmark this page for easy access.

The following resources/tools are available:

- General Practice Business Toolkit
- Billing calculator (currently being updated)
- Strategies to keep your practice sustainable
- Medicare Benefits Schedule online tool
- Discussing fees with your patients – Information for GPs
- Billing case studies
- Patient resources – including poster for GP waiting rooms, patient fact sheet and patient letter to MPs
- Session recorded for GP21 – Work-life balance and valuing your professional role

A new resource outlining the key considerations when moving towards a mixed billing model is being developed and will be largely based on the information contained within this Q&A document.

Responses to questions

Thank you to everyone who attended the webinar and submitted questions. We have endeavored to answer these as best we can. For ease of reading, some questions have been grouped together under common themes.

If you have further questions about billing or the business of general practice, feel free to email the RACGP's Funding and Health System Reform team via healthreform@racgp.org.au.

You might also want to consider joining the RACGP's Business of General Practice Specific Interests Group. For more information, contact RACGP Specific Interests via gpsi@racgp.org.au.

Expanding private billing to different groups/services

- *How do we approach private billing for children?*
- *How do we change paediatric presentations to mixed billing? I feel that milestone checks and immunisation consultations are very important. Paediatricians charge for these consultations and then parents become accustomed to GPs not charging. How can we change the mentality of bulk billing GPs?*

Billing is a personal choice and there are many factors that can influence how you choose to bill. You may choose to bulk bill certain patient groups, such as children, concession card holders and/or pensioners. If this is not viable, don't be afraid to branch out and start privately billing these groups. If parents value the care you provide to their child, they may not mind paying a fee. While it may be difficult to start charging patients who you have historically bulk billed, sometimes you will need to make these decisions to ensure your practice remains viable.

You should bear in mind that bulk billed consultations with children under 16 qualify for Medicare bulk billing incentives. If you see patients who qualify for incentive payments, this may influence how you choose to bill them. Rebates for MBS bulk billing incentive items for general medical services range from $6.55 in Modified Monash Model (MMM) 1 areas to $12.50 in MMM 7 areas.

- *How about a bulk billing GP only deals with what he or she deems clinically necessary and not what patients want because it is convenient to see a GP? That GP should be allowed to give patients a choice – to only address non-clinically indicated or unnecessary issues if the patient is privately billed, and to bulk bill clinically indicated consultations.*

While you are free to determine fees for services, the *Health Insurance Act 1973* stipulates that Medicare benefits are payable for professional services. A professional service is a clinically relevant service which is listed in the MBS. A medical service is clinically relevant if it is generally accepted in the medical profession as necessary for the appropriate treatment of the patient. Further information is outlined in MBS Note GN.1.3.

You should be transparent about any out-of-pocket costs patients may incur at your practice to avoid any unintended consequences, such as patients avoiding or delaying seeking care for a perceived minor issue.

The RACGP's *Standards for general practices* (5th edition) include a criterion covering costs associated with care initiated by the practice (Criterion C1.5). The indicators for meeting this criterion are:

- C1.5 A Our patients are informed about out-of-pocket costs for healthcare they receive from our practice.
- C1.5 B Our patients are informed that there are potential out-of-pocket costs for referred services.

- *What is the RACGP's advice regarding bulk billing other medical practitioners and their families?*

The RACGP does not have a position on this. You are free to determine if you wish to bulk bill other medical practitioners and their family members.

Challenges of mixed billing

- *Mixed billing is a nightmare. Some clinics have more pensioners, HCC holders, single parents, younger children, baby checks, childhood vaccinations and so on. Even with mixed billing there is not much change in*

billings. More complex patients and chronic diseases are also common in senior aged or HCC groups and pensioners. These patients take time and can't fit in a 15-minute consult.

The RACGP accepts that introducing or increasing mixed billing is not always feasible, particularly if you have a high percentage of patients who are traditionally bulk billed. You should bear in mind, however, that some patients who are on concession cards may be able and willing to contribute to the cost of their healthcare. Eligibility for some concession cards is not based on financial means.

If you aren't able to transition entire patient groups to private billing, consider charging them for some services and bulk billing the rest. Refer to Case study 3 (Intermittent charging) in the RACGP's Billing case studies for an example of a billing strategy that would not present a huge financial impost for the patient. In this scenario, the GP decides to privately bill patients for their first consultation each financial year and bulk bill all subsequent consultations. Alternatively, you may charge a very small gap fee for consultations with financially vulnerable patients. While the income generated per consultation may not be significant, you may see a noticeable increase in overall income.

- *It's all well and good charging $75 for a consult, but what if the consult becomes a mental health consult and the patient is eligible for item 2713? How can we bill that at the same time if the patient doesn't want to pay or hasn't been pre-warned about the extra payment?*

If the patient has not been pre-warned about the possibility of additional costs in a scenario like this, you may decide to bulk bill the mental health service as a one-off. In future you should make it clear that there will be an extra charge if the consultation goes longer than expected or if there is a mental health component.

To avoid situations like this and inform patients of billing arrangements and any changes to fees, you may find the tips below helpful.

- Agree on a policy and allow sufficient time for patients to be advised.
- Add a notice to your website (have on homepage as part of transition process, then move to fees section).
- Have a notice in the waiting room and/or back of toilet door.
- Send a mass SMS to patients via practice management software or appointment booking system. For example: *As of <date>, our practice will be moving to <policy>. Patients will be required to pay on the day and we are able to process the Medicare rebate immediately at the practice.*
- Promote Medicare Easyclaim – the rebate goes in the patient's bank account on the same day as the consultation.
- Receptionists should remind patients about fees at the time of booking.
- Include a message about fees in SMS appointment reminders.

- *The problem with changing to mixed/private billing is that patients gather their complaints and want them all addressed in the one visit.*

The RACGP is advocating for greater funding for longer GP consultations, as the current Medicare rebate structure does not adequately support patients with complex care needs. Our Federal Election Statement calls for a 10% increase to Medicare rebates for Level C (20–40 minutes) and Level D (40-minute plus) GP consultations and the introduction of a Level E (60-minute plus) GP consultation.

Means testing patients

- *What do others find effective to reduce unneeded bulk billing for "altruistic" reasons or "emotional discounting"? Having thought a great deal about this, I decided I didn't want to be the decision maker. I introduced a short, web-based, opt-in means test to calculate an estimated/recommended discount which is seen only by the doctor. I'm surprised how few people seek a discount when a proactive step is needed. The means test is accessed via a QR code, and patients answer 3–4 of 20 possible questions based on their answers. It has enabled me to confidently bill larger gaps knowing that those who might need reduced fees can access them easily. What do others do in this space?*

GPs should exercise their own judgement on what is an appropriate fee for a patient in a 'vulnerable' cohort. While patients in these groups may be financially vulnerable, the eligibility for some concession cards is not based on financial means. Many patients in these groups can therefore afford the fees set by a practice for its services.

The RACGP does not provide advice on means testing patients to determine your billing policy. It may be easier to bulk bill specific groups that are clearly defined (eg children, pensioners), however you can choose to narrow this down

further by eliciting information on each patient's financial circumstances. GPs may also implement different billing arrangements for different patients depending on how much they know about a patient's personal circumstances.

Billing rules/Medicare benefits

- *Are we allowed to charge patients if they wish to have a specified appointment time and bulk bill them for the consultation? Anyone not wishing to pay for a designated appointment time waits patiently for a first come, first served consultation.*

You are unable to charge patients a separate fee if you choose to bulk bill them for a consultation. No additional costs can be passed on to the patient in this scenario. Raising a service fee for the transaction on the day or later automatically precludes bulk billing or any use of bulk billing incentives. Visit the Services Australia website for more information.

If you wish to charge the patient in this scenario, you can privately bill them for the consultation. The patient will then be reimbursed the rebate amount.

- *How can we pressure government to change the Medicare billing rules – allowing GPs to charge for some item numbers and not others at the same time to make it more affordable for the patient?*

Where you provide multiple services on a single occasion, you can choose to bulk bill some or all of those services. The exception is when the Multiple Operational Rule affects the services. In this case the provider can use only one claiming channel. This also applies to the diagnostic imaging multiple services rules (DIMSR). Visit the Services Australia website for more information.

- *What services have no Medicare rebates other than pre-employment checks?*

A list of services that do not attract Medicare benefits is included in MBS Note GN.13.33.

- *Are we able to charge a practice membership fee and bulk bill members?*
- *How about regular annual fees for pensioners/health care card holders? Mixed billing practices are still bulk billing these patients.*
- *If a co-payment is not allowed, can we introduce a membership model where patients pay a nominated fee and in return receive bulk billing services for 12 months?*
- *Is a membership model acceptable on an annual basis?*
- *Can I charge membership fees annually and bulk bill for the whole year?*

You cannot charge patients a fee if they are being bulk billed for a consultation. However, one way to incorporate a membership fee into your billing policy is to privately bill the first consultation with a patient each year, and then bulk bill any additional consultations. You could also privately bill more consultations if you like. See Case study 3 in the RACGP's Billing case studies for an example of how this could work in practice.

- *Can I bulk bill patients but charge a fee for dressings/procedures?*
- *What about facility fees and dressings?*

If you bulk bill a patient, no additional costs (eg dressing costs) can be passed on to that patient. This automatically precludes bulk billing or any use of bulk billing incentives. If you find that the costs of dressings and other consumables are prohibitive, consider privately billing the patient to cover your expenses.

As part of the federal government's MBS Review, the Wound Management Working Group recommended that the restriction prohibiting practitioners from charging patients for the cost of a wound dressing applied during a bulk billed consultation be removed. The RACGP supported this recommendation in our 2020 submission. The Working Group also recommended that a Commonwealth-funded wound consumables scheme be developed to ensure patients have access to appropriate wound care products with reduced out-of-pocket costs. Both recommendations have been endorsed by the MBS Review Taskforce. The recommendations are currently being reviewed by government.

You can privately bill procedures that are listed on the MBS. You may find that bulk billing standard consultations and privately billing procedures is one way to make mixed billing work for you.

Claiming Medicare rebates

- *Why are we allowed to claim the Medicare rebate on the patient's behalf? Why not make it mandatory for the patient to pay the rebate and then reclaim it – even if it is ceremonious only – so they understand how the rebate system actually works?*
- *Why can't we just charge the patient an appropriate fee and then get them to claim back their Medicare rebate? That would certainly make the government interested.*

The current system is designed to make claiming Medicare benefits as administratively simple as possible for patients. It is unlikely that the government will change this so that patients who are bulk billed must pay the rebate amount and then claim it later. It is important to remember that many patients who are bulk billed are financially vulnerable and may not be able to afford the rebate amount on the day of the consultation.

Discussing fees with patients

- *Can you suggest how we manage the conversation? Could you put a guide on the RACGP website?*
- *Are there any examples of ways to have conversations with our patients to explain/justify charging a gap?*
- *Unfortunately, it feels as if government has left the hard decision to us by not increasing Medicare rebates properly. How can we convey that message to patients so they don't assume we are "greedy"?*
- *Can you please tell us in simple words what to say to a patient who asks us "why do I want to pay today?"*

The RACGP has an information sheet which provides advice on how to communicate with patients about fees, including tips for engaging in conversations about why patients are being charged a gap fee or why their fees have increased.

Many patients are starting to recognise the value of the care they receive from their GP, particularly as GPs have been there for their patients during the COVID-19 pandemic and their doors have stayed open. Patients have also valued the flexibility that telehealth consultations provide. The amount that people pay for general practice care compared to other health services is quite small. Patients who are paying out-of-pocket costs often don't see this as a problem if they feel they are receiving value for money.

Billing strategies/recommended fees

- *Could we have a case study of a practice switching from bulk billing to mixed billing?*

The RACGP's Billing case studies outline possible ways for GPs to introduce mixed billing in their work. They are fictional examples only and are intended to provide different options for GPs to consider.

- *What gap fee was used in the case studies? I am wondering how the balance of losing the 10991 item number vs the out-of-pocket cost was determined to set the gap?*

The RACGP's Billing case studies include different gap fees in each example. For instance, in Case study 1 the GP charges $75 and in Case study 2 they charge $60. The RACGP does not recommend specific fees – this is a decision for individual GPs/practices. If you rely heavily on bulk billing incentives, you should consider whether it is more profitable for you to bulk bill patients who qualify for the incentive or charge them a gap fee that is higher than the incentive payment.

- *Is it common to consider introducing small gaps to avoid shock in existing patients (and slowly increasing the gap over time), but charging a larger gap (AMA recommended rates) to all new patients to a practice?*

The RACGP does not have advice on this, however it could be a way to retain patients who have been seeing you for a long time. Remember, however, that many patients are happy to pay for healthcare if they feel they are receiving a high-quality service and value the expertise of a GP they know and trust. Ultimately, you may need to weigh up the risk of some patients leaving your practice with the extra income you will generate by transitioning to mixed billing.

If you are concerned about how existing patients might react to fee changes, please view the RACGP's information sheet on discussing fees with your patients.

- *What do you think about charging a gap that is proportionate to time spent (especially relevant for long 23s, 36s and 44s)?*

Charging different gap fees depending on the time you spend with a patient is a sensible way to improve practice viability and increase your income. While most GP consultations are less than 20 minutes, it is logical to increase your fees if you

are conducting longer consultations (over 20 minutes) and feel that Medicare rebates are not sufficient to cover your costs.

- *Can we take petrol stations an example? They increase the petrol price together. Wherever I go there is only a 1–2 cent difference. Could the RACGP provide a guide to setting private fees so that practices can follow the same fees? This will make patients understand what a normal amount is to pay.*
- *What is a suitable private fee for item 23?*

The RACGP does not recommend specific fees for services. Our view is that it is up to individual GPs to determine what their desired income is and what they need to charge patients to achieve this.

Our billing calculator can help you to meet your financial goals. It is designed to demonstrate the mechanics of fee-for-service and help you understand how practice billing may affect your income and the lifestyle you wish to achieve. The calculator will help to guide you on setting an appropriate consultation fee, as well as the number of services you would need to bill to meet your goal. Experimenting with different calculations will help you determine how many sessions, individual consultations and thus the number of clinical staff your practice will need to meet your ideal financial goal.

The Australian Medical Association (AMA) Fees List is a schedule of items and fees for over 5000 medical services. The Fees List is a resource provided for free to AMA members and as a paid annual licence for non-AMA members. The Fees List is updated regularly in response to the changes arising from the federal government's MBS Review. It is used by medical practitioners for guidance on determining appropriate fees for medical services. It is also used by state health departments, state and federal workers' compensation schemes and health insurers as a resource to determine fees they may pay to medical practitioners under their respective jurisdictions and schemes.

Further information on the AMA Fees List is available via the links below.

Fees List website
Demonstration YouTube video
Contact email address: feeslist@ama.com.au

Gap fees/co-payments

- *Is there any way for the patient to only pay the gap rather than pay the whole amount and then have to claim back from Medicare?*
- *Can you charge the patient a gap rather than the full fee?*
- *It is hard for patients to pay the full fee and get the rebate. Is there any possibility in future they can pay the gap only? This would definitely improve private billing.*
- *What would be the risk if the patient just paid the gap fee after a consultation?*

Unlike other forms of health insurance, current legislation prevents patients from paying the difference between their benefit (patient rebate) and the total fee for the service. Instead, privately billed patients are required to pay the whole fee and subsequently obtain reimbursement for their benefit from Medicare. The *Health Insurance Act 1973* provides the legislative framework for the payment of Medicare benefits.

The RACGP recognises that only being required to pay the gap amount would make it easier for patients to afford fees. We have written to the Department of Health to express concern about the continued operation of the 90 day pay doctor cheque scheme. We understand the federal government plans to phase out the cheque system by July 2023.

The RACGP recommends the system be abolished by 1 July 2022, allowing GPs to be paid immediately via Electronic Funds Transfer (EFT) even if the account has not been settled in full. This archaic system is an added administrative and financial burden that GPs and patients simply do not need, particularly during a pandemic.

Unfortunately, there are no plans currently to phase out cheques before 2023 or remove the 90-day timeframe, as the government sees this as supporting bulk billing. This is because if a patient is unable to pay the full amount on the day of the consultation (rebate + gap fee), the GP could be left waiting up to 90 days to be paid. In that case the GP may choose to bulk bill the patient as a one-off.

The RACGP will continue to advocate where possible for this scheme to be reviewed.

It is important that practices clearly advertise their fee policy so that patients understand the need to pay in full on the day of the consultation.

- *Is there a difference between a gap and a co-payment?*

A gap payment is the patient's out-of-pocket amount if they have been privately billed. This is calculated by deducting the Medicare rebate from the total service fee. See below for an example.

Service fee: $80.00
Rebate: $39.10
Gap payment: $40.90

While the terms 'gap' and 'co-payment' are sometimes used interchangeably, a co-payment is a fixed amount contributed by the patient to cover the cost of their healthcare. An example of this was the Abbott Government's proposed $7 co-payment for bulk billed GP consultations.

- *Do we have to bill Medicare if we only want to charge out-of-pocket fees?*

GPs can privately bill services and not claim the Medicare rebate, however the patient would need to be willing to forgo their right to a rebate if the service being provided is listed on the MBS.

Managing competing views on billing

- *How does one start privately billing in a large practice where everyone else bulk bills? I already offer longer appointments than the other doctors.*
- *What if different practitioners in the practice have different views on bulk billing? How do we handle that if one doctor wants to implement mixed billing?*
- *I have just introduced private billing in my practice and one doctor is refusing to privately bill and is continuing with bulk billing. How should we approach this doctor?*
- *We have to bulk bill to attract patients as there is huge competition between clinics and GPs in the same practice.*
- *I have been working in a bulk billing medical centre for the past 17 years – started as an IMG and continued due to patient care. How do we change to mixed billing now?*

If you are an independent contractor rather than a salaried employee, you should be free to determine your own billing policy, even if other doctors in your practice exclusively bulk bill.

If you are experiencing backlash from other doctors, talk to the practice owner/s about your intention to move away from bulk billing and your rationale for this.

The issue of employee contracts can be complex. GPs and practices should seek legal advice relevant to their situation if they are unsure if they or an individual is an employee or a contractor. The RACGP's General Practice Business Toolkit provides some information on the difference between an employee and a contractor in Module 5 – Your practice team. The Fair Work Ombudsman, Business.gov.au and the Australian Taxation Office also provide advice about the differences between employees and contractors.

It is important to remember that billing is a personal choice. If you have strong views on mixed billing but other doctors in your practice don't feel the same way, they are not obligated to follow your direction and change the way they bill. GPs who see a high proportion of vulnerable patients may be particularly reluctant to change their billing policy. However, the RACGP does encourage all members to think about your billing policy and whether it is sufficient to cover your increasing practice costs, as well as achieve an optimal work-life balance. Your RACGP membership gives access to a range of resources to help you manage your billing.

GPs want to do the right thing by their patients, but it is becoming increasingly difficult to sustain a successful general practice by bulk billing. We need to show our politicians that primary healthcare needs greater government investment, particularly to support patients who need longer consultations for more complex care.

Payroll tax

- *Part of the issue with working out profits and what fee to set includes the cost of running a business. However, the issue of payroll tax and independent contractors vs employees is so uncertain and an increasing concern given the latest court rulings.*

Payroll tax is an issue that is front of mind for the RACGP, and we fully appreciate that some members will be concerned about the implications of recent court decisions concerning payroll tax liabilities. We will be seeking to assist members in

clarifying the impacts of this issue and are advocating for a fair and reasonable system. We also encourage members to seek their own comprehensive medico-legal and accounting advice.

Corporate practices

- *Mixed billing becomes difficult if large corporate practices keep bulk billing patients. Do you have any suggestions for how to deal with this?*
- *Competing with corporate owned medical centres that bulk bill is difficult for small practices. Can our college lobby the government to stop these giants from eating up smaller practices? Shouldn't we as a GP group cooperate to fight this type of bulk billing?*
- *Unfortunately charging a fee/mixed billing had been jeopardised by medical centres owned by corporate organisations who are eating up the smaller businesses. Can we lobby the government on this?*
- *We need to cap the number of medical centres opening up. Put some restrictions up.*

The RACGP does not have a position on corporate general practice. Our focus is on ensuring members are properly equipped to deal with funding constraints and manage their finances accordingly. Encouraging more GPs to privately bill (where appropriate) without fearing the implications is also a key priority.

Research suggests the trend towards larger corporate owned general practices may affect access and quality of patient care, however there is considerable debate about the impact of corporate practices. The RACGP recognises that our members work in a variety of settings, including corporates. If you work for a corporate practice and are an independent contractor rather than a salaried employee, you should be free to determine your own billing policy, even if other doctors in the practice bulk bill.

Public awareness/education

- *Can the RACGP do a national advertisement on TV, social media etc to explain what bulk billing means to the general public and help pressure the government to increase patient rebates?*
- *My practice is in the process of changing from universal bulk billing to mixed billing. There seem to be ample resources available to practices and GPs from the college in terms of how to go about it, but I cannot find anything "ready-made" for patients to help them better understand the Medicare rebate and how it is the patient's rebate. Does the college intend to release brochures/posters etc to make it easier for practices to give patients written information?*
- *Are we able to educate patients through social media advertisements (Facebook) regarding billing?*
- *The main barrier to private billing is the fear that surrounding practices will continue to bulk bill. The RACGP advertising and informing the public about the value of private billing will help.*
- *Could you use some good examples of complex patients in advertisements – complex mental health who can't see a specialist, complex elderly, disabled, new mums etc?*
- *The RACGP has the resources to do an educational video and develop pamphlets that can be sent to practices which we hand out to patients. Everyone wins then.*
- *Can our college educate the public about private billing on TV?*
- *Can our college provide educational videos on this for practices to be played in our waiting rooms?*
- *Can we educate patients through social media?*
- *Is the RACGP able to generate some patient fact sheets regarding private billing and GP issues?*
- *We have abandoned mixed billing in the past because of the sheer abuse from patients. The ones who can afford it are the ones who refuse to pay – more education for the public!*
- *We could really use an RACGP poster to explain in plain English that there is a fee and there is a PATIENT rebate from the Australian Government. The doctor does not receive the entire fee. That fee pays for the nurse, receptionist, equipment etc.*
- *Although I agree on standing our ground and explaining our value and service, doing it one patient at a time seems largely inefficient – not forgetting that having conversations like these can be a challenge. Public education would probably be more effective to get the message across.*
- *We need a public campaign desperately. Come on RACGP, you need to stand up and support us.*
- *Please also make animated videos that can be played in the waiting room.*
- *Through repeated public statements, the government has created the impression that health care is "free". As GPs are at the coalface, it is natural for people to expect everything to be free. Lots of people think general practices are government establishments! That's my experience. The RACGP needs to counter this narrative before GPs have any luck changing things, especially in lower socio-economic areas.*

- *More public education is needed – even GPs with a lot of years of experience don't understand that the Medicare rebate belongs to the patient and is only "given" to the doctor once the patient "assigns their right to the GP" (bulk billed) or the patient claims their rebate after paying the full fee.*

At present the RACGP is focused on running a campaign targeting members around mixed billing and improving the viability of your practice. The webinar on mixed billing presented by Professor Price and Dr Djakic is just one of the activities we have planned over the next 12 months. Upcoming events include the plenary session at the 2022 Practice Owners National Conference on transitioning to a mixed billing practice, presented by Dr Djakic, and a webinar series later this year on improving the sustainability of your practice.

While we understand the appetite amongst members for a public awareness campaign, our view is that this may not be positively received by the public. We are therefore encouraging members to advocate at an individual level by changing the way they bill where feasible. Explaining the rebate system to patients and the reasons why you have been forced to introduce fees is a powerful advocacy tool. You should also encourage your patients to write to their local MP if they are concerned about fees.

RACGP members have access to a range of resources to support them to manage their billing. The following resources are aimed at patients. They highlight the ongoing lack of investment in general practice and rising healthcare costs.

- Poster for GP waiting rooms
- Patient fact sheet
- Patient letter to MPs

The printable poster and fact sheet advise patients to ask their GP today about how they can write to their local MP. The RACGP has developed a letter template that can be pre-filled by GPs and given to patients to send to their local MP. You will need to fill in the month and year, details of the MP for the electorate in which your practice is located, and the name of your practice. A complete list of federal MPs can be accessed here. *(Note – This list will be updated post the 21 May election).* Hard copies of the letter can be printed and given to your patients if requested. The patient simply needs to sign the letter, add their name and send.

The RACGP is open to exploring opportunities to communicate messages around practice viability in the mainstream media, however this must be carefully managed to avoid negative perceptions by members of the public. Professor Price was recently interviewed by Channel 7 about the lack of adequate funding for primary care and the need for practices to stay viable to provide ongoing access to care for patients.

The RACGP agrees that there are misconceptions around Medicare and what it actually funds. Australia does not have a universal healthcare system in the way that other countries do, and there is a lack of understanding that the Medicare rebate is the patient's subsidy. Medicare is a universal insurance system rather than a universal healthcare system.

While there are many patients who recognise that GPs are under no obligation to bulk bill, there are others who have always been bulk billed and may be apprehensive about the prospect of paying for their healthcare. While our information sheet on discussing fees provides some tips to assist with managing these patients, we are looking at developing further resources to help explain Medicare and the funding system to patients. We also intend to develop a reference guide for GPs to manage the transition to mixed billing. Any feedback on what information should be included in this guide can be sent to healthreform@racgp.org.au.

Medicare indexation

- *Is there any reason that Medicare rebates do not go up at the same rate that core CPI goes up? This means that our income in nominal terms might go up but in real terms is constantly going down. Can the RACGP negotiate an automatic re-adjustment of Medicare rebates based on core CPI changes with the government?*

Ongoing inappropriate indexation of Medicare rebates is contributing to higher out-of-pocket costs for patients. Indexation is currently calculated using a method (Wage Cost Index 5) that results in annual increases lower than the Consumer Price Index (CPI). The RACGP has consistently called for a better measure of indexation to ensure automatic price increases for patient rebates that fully reflect the rising costs of providing medical care.

Mandating mixed billing/privately billing all patients

- *Would it be useful to make mixed billing mandatory throughout the country? The RACGP could discuss this with Medicare/the Department of Health.*

- *Considering the issues affecting the viability of general practice, ideally all practices should be mixed or fully private billing by default unless a particular practice receives reasonable funding from government for providing services to very financially or medically disadvantaged patients.*
- *Can all GP clinics privately bill everyone nationally for a week?*
- *Should we find a way for all GPs to unite and start applying fees at the same time or on the same day?*

The RACGP's position is that billing is a personal choice and there are many circumstances that can influence how a GP bills. We do not support a shift to mandatory mixed billing due to the potential impact on vulnerable patients.

We do not currently have plans to encourage a universal shift towards private billing, including for a set period (eg privately billing all patients for a day/week).

Compliance/medico-legal risks

- *Long consults attract audits so you cannot win at all. I want to provide quality care and that takes time.*
- *Is there any medico-legal risk to the doctor who does not provide clinically indicated follow-up care to patients who refuse or are unable to pay, even when they are made aware that the service incurs fees?*

The RACGP is engaged in ongoing discussions with government about the value of Medicare rebates and the fact that these are not sufficient to cover the costs of high-quality general practice care, and has called for increased funding for longer consultations. We are also advocating strongly for a common-sense approach to Medicare compliance, with a greater focus on education.

If you plan to transition to mixed billing, you should ensure your practice has a process in place to inform patients of your billing policies. By the time the patient has booked, arrived and seen the doctor, they should be well aware of the policy and requirement to pay upfront. There will be rare cases where patients are unable or unwilling to pay on the day. If this does happen, consider how to educate patients so they remember next time.

There are vulnerable patients who can't afford to contribute to the cost of their care. A mixed billing model caters for patients who can't afford to pay fees by continuing to bulk bill those patients. Please refer to the General Practice Business Toolkit (section on patient fees) for more information.

For more specific advice on legal requirements, we suggest you contact your medical defence organisation.

- *In clinics where both bulk and non-bulk billing GPs work, patients who are on a health care card or pension expect to be bulk billed but might book with a non-bulk billing GP in the absence of other choices. What are the responsibilities of this GP if a patient does not want or is unable to pay?*

A GP who privately bills is not obligated to see a patient who is usually seen by a bulk billing GP. The practice should make it clear to the patient when they ring for an appointment and/or arrive at the practice that there will be a charge if they see a different doctor.

- *Are we allowed to advertise a bundle fee?*

We are unable to answer this question without more information. Please email healthreform@racgp.org.au if you can provide this and we will do our best to respond.

GPs as specialists

- *Maybe we should start calling specialists consultants, so that people understand we are all specialists.*
- *Can you please explain that even though we are recognised specialists, Medicare does not accept it?*

Medicare delineates between 'specialists' and 'consultant physicians'. While GPs are recognised as medical specialists by the Australian Health Practitioner Regulation Agency (Ahpra), they are not eligible for specialist rebates under Medicare. The RACGP will continue to advocate for greater recognition of the work of GPs and the fact they are trained specialists who provide comprehensive, longitudinal, holistic and person-centred care.

GP workforce

- *Would it be possible to alert the public to the shortage of GPs to increase government pressure re fees?*
- *Will 15% of graduates choosing general practice change government minds? They keep paying specialists large fees.*

Workforce is a strategic priority for the RACGP, and we are aware of the need for a long-term solution to GP workforce shortages and more immediate action to address current need. The RACGP is concerned the number of medical graduates choosing general practice as their specialty has decreased significantly. Earlier this year we launched the Become a GP campaign which aims to inspire medical students and junior doctors to specialise in general practice.

Representatives of the RACGP are frequently engaged in advocacy with decision-makers, GPs and the public on the challenges of workforce shortages. For example, Professor Price recently travelled to Tasmania to meet with GPs, practice teams and patients to hear their concerns and convey these to government. RACGP representatives also regularly appear in the media to provide commentary on key issues, including funding for general practice.

In October 2021 we provided a submission to the Senate Community Affairs References Committee inquiry into the provision of GP and related primary health services to outer metropolitan, rural and regional Australians. This inquiry is looking broadly at the impact of government reforms, the COVID-19 pandemic on workforce and other issues impacting access to primary health services. Our submission focusses on recommendations around recruitment and retention of GP trainees, Medicare underfunding and the burden of compliance, and issues with the Distribution Priority Area (DPA) classification system.

The RACGP will continue to raise issues directly with the government of the day and the Department of Health to ensure that reforms and funding reflect the needs of GPs.

- *Are the government worried re the cost of healthcare if there are no GPs? No other healthcare profession would accept such small fees.*
- *The lack of future GPs needs action to reverse. This is the government's responsibility as they choose to pay specialists so much more than us.*
- *Do you have any feedback from the government about lower GP numbers in the future?*

Insights into the Australian Government's position on the medical workforce are evident in the recently released National Medical Workforce Strategy 2021–2031.

While the strategy provides recommendations to address some of the issues raised in these questions, such as maldistribution of the workforce and the increasing specialisation of the medical workforce, there has been no significant funding announcements to support the delivery of its key objectives.

Notably, the Australian Senate is currently undertaking an inquiry into the provision of GP and related primary health services to outer metropolitan, rural, and regional Australians. The RACGP's submission to the inquiry focussed on recommendations around recruitment and retention of GP trainees, Medicare underfunding and the burden of compliance, and issues with the DPA classification system.

An interim report was released on 4 April 2022 with nine recommendations, covering:

- options to measure and address GP workforce distribution
- addressing funding pressures through increasing Medicare rebates, as well as considering other general practice funding options
- reviewing the medical education curriculum with a view to centring general practice and improvements to training placements.

The RACGP will continue to monitor the progress of the inquiry, and advocate for prompt action to implement the recommendations which benefit general practice.

GP training

- *One of the problems I experienced as a registrar is that I did not learn anything about how Medicare works, what/how to bill and which items can be co-claimed. I feel the RACGP/training organisations completely overlooked this part of the training, and as a result we all fell into business as usual. Can the RACGP address this shortcoming in training for future GPs?*

In the Australian General Practice Training (AGPT) Program, training is provided by registered training organisations (RTOs). While there are some variations, we believe all would include billing in initial workshops and/or online options. Some use the MBS and Pharmaceutical Benefits Scheme (PBS) programs while others have developed their own. In addition, practices will do much of the teaching related to billing, especially with GPT1 registrars. This occurs at orientation and may be revisited during the term. For orientation, practices usually develop their own checklist and one of

the items on this list relates to billing. This covers the MBS, Department of Veterans Affairs (DVA), work related consultations etc. Some RTOs have a sample checklist and there is one on the GP Supervisors Australia (GPSA) website as an example.

The Practice Experience Program (PEP) has a core module that links to the gplearning module 'GP Pathway to Australian General Practice'. This includes information about Medicare and billing, and this information is also included in Module 1 of the More doctors for Rural Australia program (MDRAP).

Information about the transition to RACGP-led general practice training from 2023 is available on the RACGP website.

In terms of the RACGP Curriculum, Domain 4 relates to ethical practice while Domain 5 is most related to billing. It includes a statement about the importance of billing appropriately and the competencies include those related to ethical and legal business practice. As billing is an essential part of the business of practice, this is covered under this competency.

The Department of Health has developed educational resources to help you meet your legal obligations and reduce the risk of incorrect billing under Medicare. Available resources include:

- eLearning programs
- Health professional guidelines
- Record keeping guidelines
- Medicare billing assurance toolkit
- A range of other fact sheets and infographics

The Services Australia website has a range of MBS education resources outlining claiming requirements for medical practitioners, allied health professionals and practice staff. Available resources include education guides, eLearning programs and infographics.

Pharmacy

- *Stop pharmacists from playing doctors.*

Efforts across Australia to expand the role of non-medical professionals such as pharmacists into diagnostics, medical assessments and prescribing present significant safety concerns for the RACGP, GP community and other key health stakeholders. This issue is an ongoing advocacy priority for the RACGP, and we continue to undertake strong public advocacy against measures that will jeopardise patient safety and outcomes. For further information on this advocacy work, visit our Pharmacy advocacy webpage.

Billing trends/data

- *What change to the bulk billing rate will be needed to get the federal government to take any notice?*

The RACGP believes the government will take notice of any reduction in the bulk billing rate, however it is likely that a consistent trend in reduced bulk billing will need to emerge to prompt action on primary care funding.

- *What has historically led GPs to bulk bill at such high levels compared with non-GP specialists?*
- *I am interested to know when the Australian Government introduced bulk billing and what happened that led GPs to bulk bill but other specialists to keep privately billing?*

The Parliament of Australia website provides information about the history of Medicare and bulk billing.

GPs make decisions about their billing model in response to their individual practice and personal costs such as indemnity and other insurance. They must balance the financial capacity of patients to contribute to the cost of their healthcare alongside ensuring their practice is financially viable.

GPs are not required to bulk bill any service apart from COVID-19 vaccinations but may be doing so for various reasons. These include altruistic qualities, poor financial literacy and a fear of losing patients to other practices. Patients see their GP more than any other healthcare professional, so will often have a closer relationship with a GP than another doctor. GPs want to do the right thing by their patients, however it is becoming increasingly clear that current funding arrangements are not sustainable.

The RACGP encourages members to recognise their worth as medical specialists and bill accordingly. Medicare data shows that non-GP specialists bulk bill considerably less than GPs.

- *Is there any data showing GPs attempting to implement mixed billing but then having to abandon it after losing too many patients?*

The RACGP is not aware of any such data.

Although there may be some patients who leave your practice if you transition to mixed billing, you are likely to find that this approach will result in a higher income and reduced workload overall. The current funding system incentivises rapid care and does not support patients who need longer consultations for more complex care.

Alternative funding systems/models

- *What is the typical relationship between private billing fees (with Medicare rebates) and workers' compensation fees (which are outside the Medicare rebate scenario)? Should Level B workers' comp to a company (outside of Medicare fees) be the same as Level B private billing with a Medicare rebate?*

Workers' compensation systems are managed at a state and territory level and arrangements may differ between states. You should visit the website of the relevant authority in your jurisdiction for information on fees for workers' compensation services. A list of workers' compensation authorities is available on the Safe Work Australia website.

- *The government initiated the bulk billing system and this should be ended by government too. Can Australia learn from New Zealand about surcharging $20 universally?*

The Very Low Cost Access (VLCA) scheme in New Zealand supports general practices with an enrolled population of 50% or more high needs patients where the practice agrees to maintain patient fees at a low level. The RACGP does not have a position on this specific scheme, however we have commented extensively on the merits of a voluntary patient enrolment (VPE) model. In particular, we have provided in-principle support for a model of VPE that incorporates significant additional investment for general practice and is fit-for-purpose within the Australian healthcare system. Further information on the RACGP position on VPE is available in the RACGP's July and November 2021 submissions to the Primary Healthcare 10 Year Plan.

- *What are your thoughts on GP models run similar to other specialities – public GP clinics where registrars train (with Fellowed GPs as supervisors), then the private sector of GPs who charge gap fees? This may be less confusing for patients (registrar bulk billing vs Fellows charging a gap) and less pressure on registrars too.*

The RACGP is not currently advocating for a split between GP registrars and Fellows. While GP registrars are salaried doctors, they still bill Medicare items. This enables registrars to learn about the Medicare system while they continue their training.

- *Fee-for-service v value-based care. I feel that as a new registrar the current FFS model has perverse incentives and encourages a fundamental rethink of funding GP practices.*

We acknowledge current funding structures, including the fee-for-service system, do not adequately support the delivery of comprehensive general practice care, particularly high-quality chronic disease management, preventive care and care for people with complex needs.

The RACGP has consistently advocated for government to modernise and simplify the fee-for-service system to reflect the cost of providing care and incorporate funding systems that support longer consultations for more complex patients and high-quality care for all. The RACGP's *Vision for general practice and a sustainable healthcare system* notes that a properly functioning fee-for-service model supports patient access to care and maintains flexibility and responsiveness, however needs to be supported with additional investment. GPs and their teams must be supported to communicate with all facets of the healthcare and social systems, making it possible and practical for patient care to be coordinated from a central point.

This is addressed further in the RACGP's July and November 2021 submissions to the Primary Healthcare 10 Year Plan, as well as our position statement on funding priorities and Federal Election Statement.

Aged care

- *Do you think the government will assist us with the cost of aged care visits? These services are loss making.*

The RACGP has been actively advocating for greater support for GPs working in aged care over the past three years. This has included numerous submissions to the Royal Commission into Aged Care Quality and Safety and ongoing engagement with government around key announcements in this sector. In 2021, the RACGP also published a new position statement on GP-led care for older people. The position statement addresses the barriers faced by GPs providing services to older people and highlights the critical role of GPs in aged care.

In the 2021–22 Federal Budget, the government did commit funding to double the GP Aged Care Access Incentive, although we appreciate this does not go far enough in supporting GPs to provide aged care services. Unfortunately, government engagement on this topic has been relatively limited so no additional funding is expected at this stage. The RACGP will continue to advocate for government to properly fund sustainable GP-led aged care and will keep members up to date with any advancements.

Mental health

- *Why does the government give such massive fees to psychiatrists for one-off assessments which provide minimal help for complex patients, but won't give us a pay rise?*

Unfortunately, there is a tendency for governments to dedicate considerable funding towards specific, isolated health issues or more costly secondary and tertiary level services. The RACGP has made it clear to government that existing support for patient access to GPs and general practice teams does not appropriately value general practice services nor reflect the true cost of providing effective general practice care. The RACGP has also directly called for greater remuneration for GPs to provide mental health services, including for patients with complex needs, in our submission to the Victorian Royal Commission, the Productivity Commission Inquiry into Mental Health and our Pre-Budget submission 2022–23.

We know that investment in general practice is critical to meet growing demand, especially for complex patients, and will result in significant savings for the health system. In 2020, we asked PwC to model the benefits of greater investment in general practice as per the RACGP Vision, and their conservative estimate was that the direct benefits would be in the order of $1.0 billion in 2021 and $5.6 billion over the next five years at a minimum. We will continue to engage with government on this key issue, pushing for appropriate funding for general practice to provide care to patients with complex needs.

Medicare advocacy

- *How can we raise the need to improve Medicare rebates?*

Medicare patient rebates is the most commonly identified priority area in the RACGP's Health of the Nation survey. Almost 50% of GPs chose this as their top priority in 2021. The RACGP is committed to advocating for improved indexation and setting of rebates to reflect the true cost of providing high-quality medical services. The RACGP Vision and Federal Election Statement provide an overview of our current focus.

Unfortunately, there is little appetite within government to increase rebates while the bulk billing rate for general practice services remains high (close to 90%). GPs must therefore learn how to adapt their billing practices and work within the current system to cover expenses and maximise revenue.

- *The government cannot subsidise the true cost for healthcare for all. If the rebates went up by 100% we would still request more. The RACGP should just focus on advocating for shared responsibility between patients and providers. This should not be about GP money making ability.*

The RACGP acknowledges that even a substantial increase in Medicare rebates may not result in all primary care services being fully subsidised. However, increased rebates that more accurately reflect the cost of providing a high-quality service would reduce out-of-pocket costs for patients and improve the affordability of care. The federal government consistently claims that high bulk billing rates are evidence that primary care is affordable and accessible for everyone – but we know that average out-of-pocket costs for patients have increased by 50% over the last decade, and the financial sustainability of practices is under increasing pressure.

The RACGP is committed to advocating for affordable primary care services for all Australians regardless of their income and personal circumstances. Unfortunately, despite our best efforts, the patient rebate for a standard GP consultation has increased by just $3.50 in the past decade. Furthermore, we are still dealing with the effects of the Medicare rebate freeze.

A reduction in bulk billing will increase our ability to advocate for higher Medicare rebates which, in turn, will also help bulk billing GPs. Those GPs who do bulk bill will be able to spend more time with their patients and get to the root of health issues they present with. Patients in economically deprived areas (including many rural/remote and Aboriginal and Torres Strait Islander communities, but also parts of our urban centres) have more complex medical conditions but cannot afford fees. There is a real risk that general practice will become unsustainable in these areas because of the lack of meaningful funding.

- *What about campaigning for smaller intervals – eg 30 minutes, 50 minutes etc? The differences in time are way too large.*

The RACGP's advocacy is currently focussed on increasing Medicare rebates for longer GP consultations, while ensuring the rebate model is as administratively simple as possible. Due to poor weighting of rebate values and overly long time intervals, the patient's rebate reduces dramatically per minute if they need to spend more time with their GP. We are also pushing for the introduction of a Level E consultation item (>60 minutes), which has been recommended as part of the MBS Review.

The RACGP has advocated on time tiered consultations previously. Around 20 years ago a Relative Value Study was undertaken by the Department of Health. Other medical professions were not supportive of shorter time intervals, and non-GP specialists also rejected this proposal when it was raised by the RACGP.

In the past, the government response has been to lower the base rate so that the tiered value across all consultations is more similar, rather than increasing the base rate. Therefore, our primary concern is that the government may lower the base rate if intervals are shortened, which is why we have focussed on increasing the value of rebates for long consultations.

Medicare Safety Net

- *How do we explain the Medicare Safety Net to patients as part of advocating for private billing, in particular for the frequent flyers?*

Medicare Safety Nets can help to lower patients' out-of-pocket costs for non-hospital services. Information about the 2022 threshold amounts for Medicare Safety Nets is available on the Services Australia website.

The Safety Net could potentially be used as a tool to encourage more doctors to privately bill. Even if a patient is bulk billed by their GP, they might reach the Safety Net threshold relatively quickly if they are seeing other specialists (eg pregnant women, people who have had surgery). Following this they could be privately billed with minimal out-of-pocket expenses, as more of their costs will be covered by the government.

If you scan a patient's Medicare card and see that the Medicare rebate is higher than usual, this indicates that the patient has reached the Safety Net threshold. You could then make a note to privately bill that patient going forward. The Safety Net may not be suitable in all circumstances, as many patients who do reach the threshold do so quite late in the calendar year (i.e. November/December). The threshold amounts are reset each year from 1 January.

Private health insurance

- *Why can't private health insurance also include general practice?*
- *Does most private health insurance cover GP appointment fees?*

The role of private health insurance in primary healthcare is currently limited. The RACGP does not support amendment of the *Private Health Insurance Act 2007* to allow private health insurers to fund services for which Medicare rebates are available, or to cover gap payments, as this threatens universality of access to general practice and primary healthcare more broadly.

There is an opportunity for private health insurance to support patient access to the model of general practice care described in the RACGP Vision. This may include general practice and primary care services that are not funded under the MBS.

The RACGP shares member and community concerns that the expansion of private health insurance in the primary healthcare setting could undermine the autonomy of the treating practitioner and the options available to patients in the formulation of their individualised management plans. Adequate safeguards to maintain the separation of Medicare and private health insurance must therefore be enforced.

Services facilitated by private health insurance must integrate with, and augment, GP-led care. Services already being provided by a patient's usual GP, such as chronic disease management, should not be duplicated by private health insurers, as this will lead to fragmentation and inefficient use of health resources.

Further discussions about how private health insurance can support the delivery of high-quality and efficient patient services in the future should be held with the general practice sector and patient groups. Private health insurers should also collaborate with the sector to evaluate current programs and identify opportunities for improved service delivery.

Further information is provided in the RACGP's position statement on the role of private health insurance in primary healthcare.

Maintaining public access to primary care

- *The GP Super Clinic rollout may have been intended in part to address the issue, but are there plans afoot at a Commonwealth level to fund community or not-for-profit general practice providers who bulk bill, whilst "private" or "for-profit" GPs/practices charge private fees to patients who can otherwise afford to pay a gap?*

This is already happening to some extent through the Aboriginal Community Controlled Health Services (ACCHS) model of care and community health services.

While private GPs are free to set their own fees for services in mainstream services, many choose to also bulk bill some or all of their patients.

- *I appreciate the necessity of a mixed billing model, however if we recognise healthcare as a universal right, I feel there also needs to be a "public system" of primary care (not just ED fast track).*

With continued high bulk billing rates, there doesn't seem to be a need for the government to increase investment in general practice services. A reduction in bulk billing will increase pressure on the government to finally invest in critical general practice services, while supporting our GP colleagues to continue working in communities that can't afford out-of-pocket costs.

The RACGP supports people being able to access primary care when necessary and appropriate. We fully recognise that there are vulnerable patients who can't afford to contribute to the cost of their care. We are not advocating for bulk billing to be removed completely and encourage GPs to bulk bill when they deem it necessary to ensure all people, including disadvantaged populations, can access care as a fundamental right.

- *Is it worthwhile the RACGP advocating for an AMS type model for patients in more deprived areas (i.e. a combination of state and federal Medicare funding)? This would address the needs of genuinely deprived communities.*

The concept of an Aboriginal Medical Service (AMS)-type model was explored as a reform option in the Primary Healthcare 10 Year Plan for rural areas (a proposed model called Rural Area Community Controlled Health Organisations). The RACGP's position on the RACCHO model is that it could risk fragmenting and duplicating care. Strengthening rural general practice is a better approach to addressing workforce shortages and delivering high-quality care.

Through the RACGP Vision, the RACGP is open to exploring possible state funding options to support the provision of continuous care rather than episodic treatment of illness, preventive healthcare, monitoring of health outcomes, and better coordinated care within practices as well as across the broader healthcare system.

Anti-GP rhetoric

- *We have a few anti-GP politicians. Please help to deal with them.*
- *Hollie Hughes' comments were really depressing. Do you think there will be any apology?*

The RACGP's President, Adjunct Clinical Professor Karen Price, wrote an opinion piece in newsGP regarding recent comments about GPs being 'self-serving'. Professor Price noted that these remarks were disingenuous and offensive.

The RACGP is open to working with politicians from all sides of politics to advance our policy agenda. However, we will not stand for unwarranted attacks on the profession, particularly given the sacrifices GPs have made over two years of the COVID-19 pandemic.

Member support

- *We would like to get support from the RACGP to have a team to support and address our billing issues and questions.*

The Funding and Health System Reform team, which sits within the Policy and Advocacy business unit, is best placed to assist with queries about billing. You can contact the team via healthreform@racgp.org.au and they will do their best to assist.

You might also want to consider joining the RACGP's Business of General Practice Specific Interests Group. For more information, contact RACGP Specific Interests via gpsi@racgp.org.au.

Summary

Remuneration is a major challenge facing GPs and is deterring medical graduates from choosing general practice as their specialty. As you are well aware, GPs undertake more than ten years of formal medical training, they need to value their worth as medical specialists, just as other medical specialists do.

Medicare is a public health insurance scheme funded by the Australian Government, which provides all Australians with access to free or subsidised healthcare. The rebates included in the Medicare Benefits Schedule (MBS) were never set at a rate that accurately reflected the cost of quality service provision. Failure to set the MBS rebates appropriately from the outset, coupled with years of zero or inappropriate indexation means that the 2022 rebates provide nowhere near the funding required to spend time with patients, provide them with comprehensive, continuous and coordinated healthcare and cover the costs associated with running a practice, including staff salaries, facilities and insurance, equipment, rent and consumables. Nor do they help absorb the rising costs required of GPs such as medical indemnity insurance and continuing professional development.

The fee is the patient's rebate and it is vital that the GP community are reminded of this. While Medicare was established to provide all Australians with free or subsidised care, this arrangement is really between the Australian Government and the electorate. On behalf of all patients, the RACGP along with many other stakeholders have tirelessly advocated for improved MBS rebates, with little success to date. The RACGP will continue to pursue this advocacy work, however with the continued high bulk billing rates, there doesn't seem to be an impetus for the Government to increase investment in general practice through the MBS.

The RACGP is encouraging members to carefully reflect on their current billing model and consider whether it is sustainable in the long term. With the exception of the COVID-19 vaccines, **GPs are not obligated to bulk bill**. It is important to understand that there might be patients in your practice who are currently being bulk billed but might willing and able to be billed privately. It is a personal choice and there is no 'one size fits all' approach to billing but remember a mixed billing model can be very effective. While you may have some patients who will be upset at having to pay fees, you might also have some patients who are very happy to be privately billed given they trust and value the care provided by their GP.

Applying a mix of both private and mixed billing policies will only improve practice viability and will see further reductions in the bulk billing rate. This reduction in the bulk billing rate will ultimately increase pressure on the Government to finally invest in general practice services, supporting our GP colleagues to continue working work in communities who can't afford out of pocket costs.

Don't be afraid of change, these conversations are a big shift in thinking for both patients and GPs. Communication is key – think about how you will inform your patients about fees and how to explain why you have made this decision, it might be that more often than not, they will understand.

The RACGP is here to support you with resources to help you manage your billing and earn the income you want while improving your work-life balance.