04 Estimating Private General Practice Earnings

July 2024

This information sheet describes methods for estimating potential Medicare billings for a private general practice based on the population profile of a community and the number of doctors intended to be employed in the practice. These revenue estimates can be used to support a business case to establish an integrated private general practice.

Caution – the actual billings achieved will be reliant on the effectiveness of the practice management system, the accreditation status of the practice, the vocational registration of the doctors undertaking private practice and the extent to which practice nurses and Indigenous health practitioners are involved in care coordination.

Overview

Until recently, HHS' have had little need to understand general practice operations and funding arrangements, including the best practice principles that underpin a systematic and coordinated primary care health service delivery model.

Primary health care services focus on planned and preventative care framed on the health care needs of the individual and the community. The model invokes health education and patient self-care; health assessments and care planning by the practice; and the coordination of care across primary, secondary, and tertiary providers.

In Australia, medical general practices are largely financed by the Australian Government in a highly regulated (though uncapped) fee-for-service model. The income streams flow from:

- Primary care practice Medicare billings
    - Routine and standard consultations
    - Chronic disease care plans and team care arrangements
    - Health assessments
    - Mental health treatment plans
- Primary care practice quality initiatives
    - Practice Incentives Program (PIP)
    - Workforce Incentive Program (WIP)
- General practice grants (as and when announced)

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Medicare billing has a complex set of rules and pre-requisites that require learned understanding and experience to optimise. Approved rural hospitals will have some familiarity in billing Medicare for non-admitted services using COAG and RRMBS exemptions permitted under Section 19(2) the *Health Insurance Act 1973*. Adopting a practice management approach, a HHS will likely be able to optimise its hospital Medicare billing and may include this increase in its business case for establishing an integrated general practice model.

1. Estimating private practice earnings

Private practice is a business that requires attention to all sources of income for sustainable operations. However, unlike many business enterprises, medical practices are largely reliant on a single revenue stream – Medicare and related government incentives programs and grants. Only a small portion of a practice's income in regional Queensland is derived from patient co-payments or commercial income (for example, pre-employment health assessments).

The earnings of a practice are influenced by a number of factors such as the size of the practice, the existence of other practices including the availability of allied health practitioners, the health profile of the community, and the skills and interests of the general practitioners.

Routine and standard consultations

Nationally, routine and standard (Level B) consultations comprise around 90% of a practice's billing activity[1,2]. The remaining 10% is billed to complex/chronic disease, health assessment and mental health items, home visits, case conferences and other items.

There are two simple methods that use the standard consultation rate for estimating earnings from private practice consultations:

(a) **Population based**. This method estimates the potential practice earnings if sufficient GPs were available. Multiply the community population with the state average number of services per person and the state average Medicare benefit paid. In 2022-23 Queenslanders averaged **7.5**[3] GP services with the average Medicare benefit of **$53.14**[4].

Practice patient population[5]	Services per person	Annual services	Average Medicare benefit ($)	Total ($)
	7.5		53.14	

1 General practice activity in Australia 2015–16, 40 Table 5.4: Summary of GP only MBS/DVA items recorded, General Practice Series No. 40, Bettering the Evaluation and Care of Health, University of Sydney.
2 Remote general practices will likely bill a significant larger percentage of Level C and D consultations
3 General Practice Workforce Providing Primary Care Services in Australia, https://hwd.health.gov.au/resources/data/gp-primarycare.html
4 Average benefit based on Non-referred GP attendance www.health.gov.au/resources/publications/medicare-annual-statistics-state-and-territory-2009-10-to-2022-23?language=en
5 More accurate forecasts could be made with weighted population estimates – contact Queensland Country Practice for further details at ProgramServicesQCP@health.qld.gov.au

(b) **Workforce based**. This method estimates practice earnings based on the medical staff available in the practice. Multiply the available medical FTE allocated to primary care by the state average number of annual services provided per GP FTE and the Queensland average Medicare benefit paid. For 2022-23, these were **5,814**[6] consultations and **$53.14**.

Medical FTE	Services per FTE	Annual Services	Average Medicare benefit ($)	Total ($)
	5,814		53.14	

Bulk billing rates in regional Queensland continue to be well over 85%, with many patients likely to be concession card holders, children under 16 or vulnerable persons who would attract a rural bulk billing incentive. Bulk billing incentives are available to general practices to encourage concessional care, with additional rural and remote loadings[7] applying to practices based on the Monash Modified Model (MMM)[8] area in which the practice operates. Rates for items billed by vocationally registered general practitioners as at July 2024:

MMM 3 and 4 – $34.50 MMM 5 – $36.65
MMM 6 – $38.70 MMM 7 – $41.10

Bulk billing incentives were tripled in the May 2023 budget and are not reflected in the average Medicare rebate for 2022-23 included in the previous section to estimate earnings. The additional income may be estimated by multiplying the proportion of annual consultations that are bulk billed by 2/3rds of the applicable MMM bulk billing incentive (as 1/3 will already have been included in the average rebate last year).

Annual consultations	Percentage of consultations bulk-billed	Bulk billed annual consultations	2/3rds MMM Bulk billing incentive ($)	Total ($)

Estimating Practice and Workforce Incentives

Practice Incentives Program (PIP) and the Workforce Incentive Program (WIP) encourage general practices to continue providing quality care, improve access to primary care, promote and encourage practitioners and other workforce to work in rural areas and help to defray higher practice costs in regional areas.

Participation in these incentive programs is essential to ensuring the continued viability of the general practice and to support workforce retention.

To be eligible, the practice must be continuously accredited or be registered for accreditation.

6 Australian Government Department of Health and Aged Care GP workforce statistics at https://hwd.health.gov.au/resources/data/gp-primarycare.html
7 Rates current as at 1 July 2023
8 www.health.gov.au/health-topics/rural-health-workforce/classifications/mmm

The PIP comprises a number of individual incentives to enhance practice quality, improve access to care and to defray service costs. Most of the incentives are calculated by reference to the practice's "standard whole patient equivalent" (SWPE)[9], a measure of the practice population size taking into account the proportion of total patient care provided by medical practitioners in the practice over the preceding 12 months. PIP payments are automatically calculated by Services Australia and paid directly to the practice each quarter.

A rural and remote loading is available for practices located in Rural, Remote and Metropolitan Areas[10] classifications 3-7 to recognise the difficulties of providing care, often with little professional support, in rural and remote areas. These rates are:

RRMA 3 (Large rural centre) – 15%
RRMA 4 (Small rural centre) – 20%
RRMA 5 (Other rural area) – 40%
RRMA 6 (Remote centre) – 25%
RRMA 7 (Other remote area) – 50%

Further details on eligibility and incentive requirements of the PIP are available in the Australian Government's Practice Incentives Program guidelines.

The value of PIP will vary from based on the programs the practice elects to participate in, the effort made to optimise incentives, and the location of the practice (rural loading). The following table is provided as an *indicative estimate* only to highlight the importance of PIP and to support the preparation of business cases. Simply add your RRMA loading against the relevant practice size below:

Patient population (SWPE)	Potential PIP incentive	RRMA Loading %	Total ($)
1,000	*$30,000*		
2,000	*$60,000*		
3,000	*$90,000*		
4,000	*$120,000*		
5,000	*$150,000*		

Estimates based on participation in Quality Improvement, eHealth and Indigenous Health Incentives (for practice with 10% eligible Indigenous patients) only. The estimate may still represent a challenging target.

The WIP provides financial incentives to retain doctors and employ nurses, health practitioners and Indigenous health workers in a multi-disciplinary practice.

- The WIP – Doctors stream provides a retention incentive payment to an eligible doctor who provides a minimum level of services (including telehealth) in a practice located in an MMM 3-7 area.

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9 www.servicesaustralia.gov.au/calculating-practice-incentives-program-payments?context=23046

10 Rural, Remote and Metropolitan Areas (RRMA) Classification, 1991 Census Edition (Department of Primary Industries and Energy and Department of Human Services and Health, November 1994)

The incentive increases annually with continuous service at the practice, to a maximum of between $12,000 and $60,000 per annum[11] after five years of service, depending on the MMM area. From January 2024, eligible non-vocationally registered doctors will be introduced attracting a payment of between $3,600 and $48,000 per annum[12]

The incentive is payable directly to the doctor and accordingly should not form part of revenue in a business case.

- The WIP – Practice stream supports the engagement of nurses, allied health and Aboriginal and Torres Strait Islander Health Workers and Practitioners located in an MMM 3-7 area.

  The incentives are based on the practice size (SWPE), practice staff type, and the hours practice staff are employed/engaged in the practice.

  The incentive is capped at a maximum of $130,000 per annum.

  A rural loading of up to 60% is available for rural and remote practices on the total of the WIP practice stream incentive.

Further details on eligibility and other requirements of the WIP are detailed in the Australian Government's Workforce Incentive Program Guidelines.

The following table shows the available incentive for various practices sizes. The incentive amounts when employing enrolled nurses or Aboriginal and Torres Strait Islander health workers are in lieu of the amounts for RN or allied health professionals (that is, they are not additive).

Patient population (SWPE)	Minimum hours for maximum incentive	RN or allied health professional (max)	EN or ATSI health worker or practitioner
1,000	12 hours 40 minutes	$32,500	$16,250
2,000	25 hours 20 minutes	$65,000	$32,500
3,000	38 hours	$97,500	$48,750
4,000	50 hours 40 minutes	$130,000	$65,000

Rural loadings apply to workforce practice stream incentives located in MMM 3-7 locations, increasing the amounts in the table above based on rural/remoteness. The loadings were most recently updated in the May 2023 federal budget and are effective from 1 July 2023. The loadings are:

MMM 3 – 30%
MMM 4 and 5 – 40%
MMM 6 and 7 – 60%

11 www.health.gov.au/initiatives-and-programs/workforce-incentive-program/doctor-stream/payment-amounts
12 www.health.gov.au/our-work/workforce-incentive-program/doctor-stream

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This information sheet provides an indicative (general) assessment of potential practice earnings. For a more detailed analysis, please contact the Queensland Country Practice Service and Workforce Redesign by email at ProgramServicesQCP@health.qld.gov.au or telephone 3199 3950.