Medicare data linked to ALSWH: Notes for users

What is Medicare?

Medicare is the basis of Australia's health care system and covers most or all of many health care costs. The Medicare system has three parts: hospital, medical and pharmaceutical. The hospital part covers services provided under the Commonwealth Medicare agreement with the States/Territories – mainly services in public hospitals. The medical part covers services which are eligible for rebate according to the Medical Benefits Schedule (MBS), including GP visits. The pharmaceutical part covers medicines subsidised by the Pharmaceutical Benefits Scheme (PBS). You can choose whether to have Medicare cover only, or a combination of Medicare and private health insurance. Only Australian residents (citizens and permanent residents) and certain categories of visitors to Australia are eligible for Medicare.

What Medicare does not cover:

- private patient hospital costs (for example, theatre fees or accommodation),
- medical and hospital costs incurred overseas,
- medical and hospital services which are not clinically necessary, or surgery solely for cosmetic reasons,
- ambulance services
- home nursing

Hospital

Under Medicare you can be treated as a public patient in a public hospital, at no charge, by a doctor appointed by the hospital. You can choose to be treated as a public patient, even if you are privately insured. As a public patient, you cannot choose your own doctor and you may not have a choice about when you are admitted to hospital.

These services may also include specialist outpatient treatment at a public hospital provided by a medical officer employed by the hospital – e.g., a diabetic clinic. (These services shouldn't be confused with private practice clinics which operate out of some public hospitals and provide services to public patients and are bulk billed.) Data on these services are NOT included in the MBS data.

Medical

When you visit a doctor outside a hospital, Medicare will reimburse 100% of the Medicare Benefits Schedule (MBS) fee for a general practitioner and 85% of the MBS fee for a specialist. If your doctor bills Medicare directly (bulk billing), you will not have to pay anything.

Medicare provides benefits for:

- consultation fees for doctors, including specialists,
- tests and examinations by doctors needed to treat illnesses, such as x-rays and pathology tests,
- eye tests performed by optometrists,
- most surgical and other therapeutic procedures performed by doctors,

- some surgical procedures performed by approved dentists,
- specific items under the Cleft Lip and Palate Scheme,
- specific items under the Enhanced Primary Care (EPC) program,
- specified items for allied health services as part of the Chronic Disease Management Plan.

Medical benefits do not cover:

- examinations for life insurance, superannuation or memberships for which someone else is responsible (for example, a compensation insurer, employer or government authority),
- most dental examinations and treatment,
- most physiotherapy, occupational therapy, speech therapy, eye therapy, chiropractic services, podiatry or psychology services,
- acupuncture (unless part of a doctor's consultation),
- glasses and contact lenses,
- hearing aids and other appliances.

Things to consider when using MBS data.

Although MBS data are a rich source of information regarding health service use by Australians it must be remembered the datase was created for administrative purposes – i.e., processing of eligible claims arising from Medical Benefits Scheme. It must also be noted that the MBS data **do not cover all medical services funded by Medicare**. Ignoring this may affect the research question and could result in misleading conclusions. This point is illustrated by the two figures below. Figure **Error! No text of specified style in document.**-1 shows mean MBS claims for all services by age for the three ALSWH cohorts classified by private insurance status (Yes, No). It is clear that for all cohorts, women with private insurance have more claims. Figure Error! No text of specified style in document.**-2** shows the same information but only for unreferred claims, mostly GP visits. It shows virtually no difference. What might be happening here? Firstly, in Figure Error! No text of specified style in document.**-2** almost all claims are GP visits, which are covered by Medicare. Those on private insurance will have no additional advantage as private insurance does not pay for these services. Figure **Error! No text of specified style in document.**-1 on the other hand includes both referred and unreferred services, and while referred medical services are also not insured, they are almost always provided in private hospitals or specialist clinics. The difference observed in the figures arises because women with private health insurance are much more likely to use private hospitals than those without private insurance. Medical information for women who use the public hospital and outpatient clinic system, and are more likely not to have private insurance, does not appear in the MBS data. Since not all service use data are available from MBS, no conclusion can be made regarding health service use. A similar situation also arises with services funded by the Department of Veteran's Affairs (DVA).

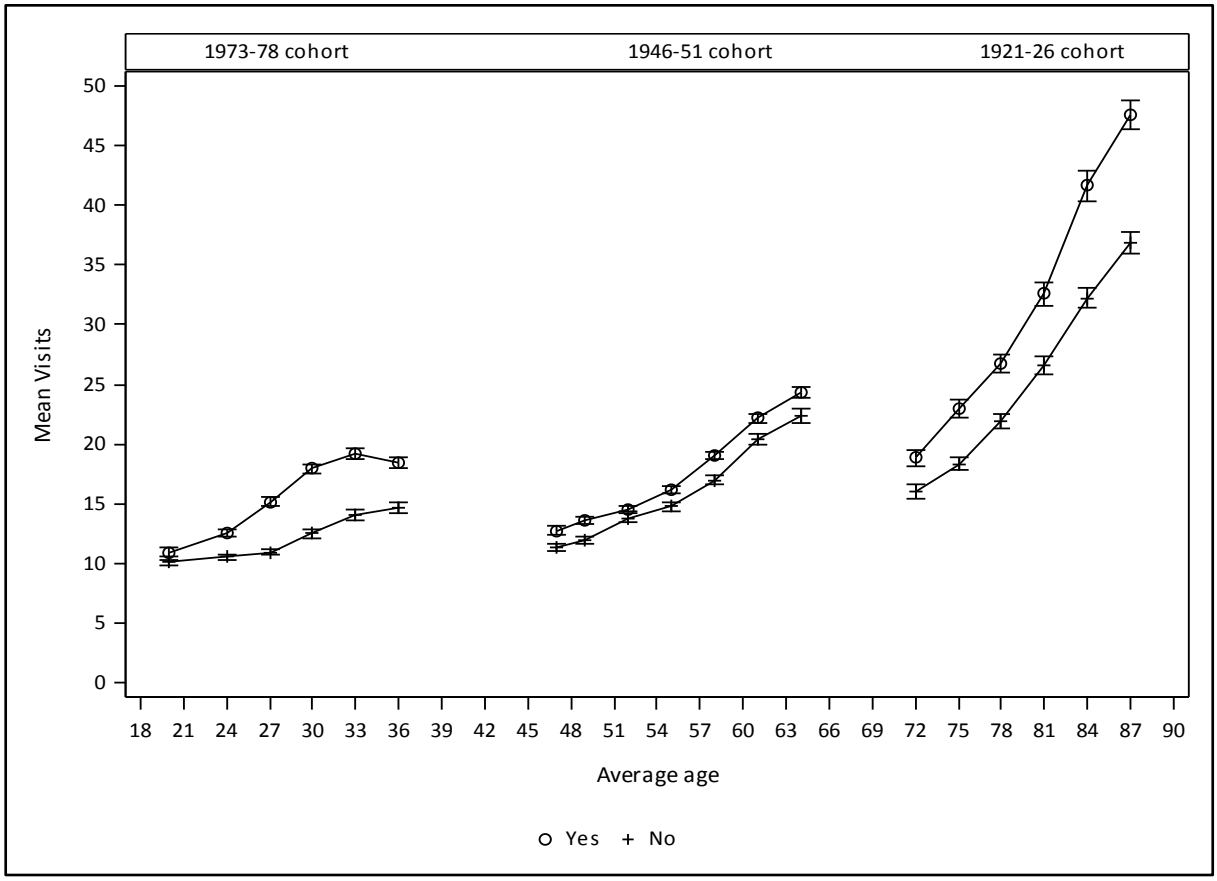

Figure Error! No text of specified style in document.**-1 All MBS claims by health insurance status**

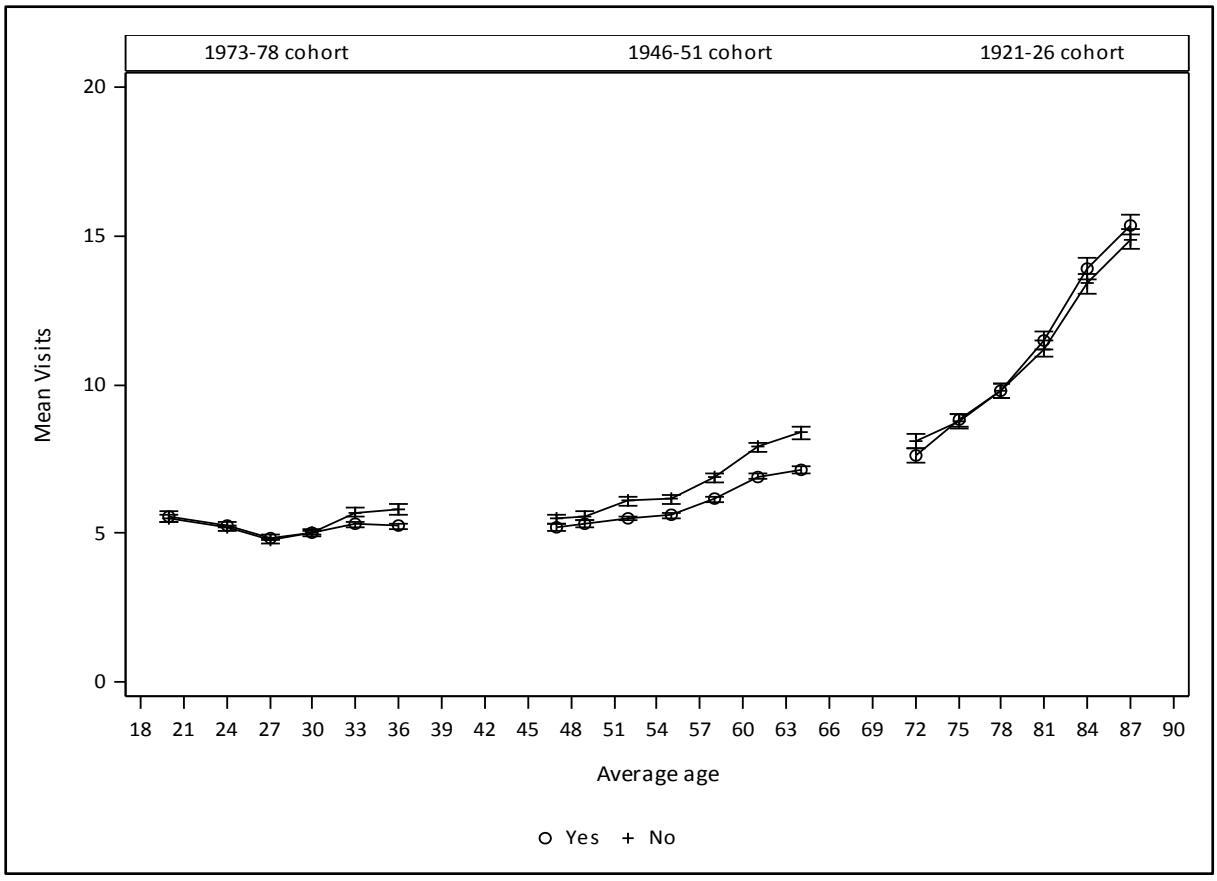

Figure Error! No text of specified style in document.**-2 Unreferred MBS claims by health insurance status**

Helpful links

Medicare

http://www.humanservices.gov.au/customer/dhs/medicare

MBS online – for MBS item numbers.

http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Home

Broad type of service (BTOS) to MBS item mapping.

http://medicarestatistics.humanservices.gov.au/statistics/do.jsp?_PROGRAM=/statistics/std_btos_map&start_dt=0&END_DT=0

Appendix

MBS data items

Idalias	IDAlias
enrol_pcd	Enrolment postcode at time claim processed
enrol_type	Enrolment type
item	MBS item
dos	Date of service
hosp_ind	Hospital indicator
btos	Broad type of service
bill_type	Bill type
services	Services
benefit	Benefits ($)
charge	Charge ($)
safety_net	Safety Net ($) (old and extended combined)
prov_scram	Scrambled rendering provider no.
prov_state	Rendering provider state
prov_age	Provider age (age turned in calendar year)
prov_sex	Provider sex
	provider specialty code (specialty list attached)
ref_prov_scram	Scrambled referring provider
dor	Date of referral (where relevant)
type	'M' for (MBS data)
modifier_flag	Modifier flag
prov_age_flag	Provider age flag

"modifier_flag" is set to 'M' where the item is a bulk billing incentive item (or other item not counted as a service)
or blank when not a modifier/incentive (i.e. an MBS service)

The service count for these items with value 'M' should be set to 0 [zero] when summing service counts

Note: this is how the claim record arrives from DHS, and also enables counts of incentive items etc. if required

"prov_age_flag" is set to 'D' where provider information is missing year of birth.

for these providers **year of basic qualification - 25** was used as a proxy for year of birth and flag set to 'D' [derived]

Note: age is age the provider turned in the year

Bill Type (consenters)

1 = 'Cheque to cardholder'

2 = 'Cheque to provider via claimant'

3 = 'Cash'

4 = ‘Manual cheque'

5 = 'Cheque to claimant, claimant not cardholder'

6 = 'Direct bill (Bulk bill)'

8 = 'Private Health'

9 = 'EFT to claimant'

Bill Type

D = ‘Bulk bill’

P = ‘Other’

Broad type of service description (BTOS)

A = 'Unreferred attendances – VRGP/GP'

B = 'Unreferred attendances - Other'

C = 'Specialist attendances'

D = 'Obstetrics'

E = 'Anaesthetics'

F = 'Pathology Tests'

G = 'Diagnostic Imaging'

H = 'Operations'

I = 'Assistance at Operations'

J = 'Optometry'

K = 'Radiation Oncology'

L = 'Miscellaneous'

M = 'Unreferred attendances - Enhanced Primary Care'

N = 'Pathology Collection Items'

O = ‘Unreferred attendances - Practice Nurse Items’

P = ‘Other Allied Health’

X = ‘DVA items not elsewhere classified’

Note: BTOS (A, B, M and O) is used to define ‘**unreferred attendences**’.

Hospind (hospital indicator field)

. = Out of hospital

H = Service provided in hospital

A = Pre-admission or post-discharge

R = DVA service ‘Rooms’

V = DVA service ‘Visit’

N = DVA non-hospital

State

2 = ‘NSW’

3 = ‘VIC’

4 = ‘QLD’

5 = ‘SA’

6 = ‘WA’

7 = ‘TAS’

8 = ‘NT’

9 = ‘ACT’

Provider sex

M = ‘Male’

F = ‘Female’

U = ‘Unknown’

Type

M = ‘Medicare’

D = ‘DVA’

Enrolment type

. = ‘Default initial enrolment’

A = ‘Australian’

B = ‘Academic and teaching staff (Higher Education Funding Act 1988)’

D = ‘Change of status (COS), processing entry permits (PEP), diplomat’

E = ‘Migrant’

F = ‘Fulbright scholars fund (Australian/American Education Foundation)’

G = ‘Refugee status’

L = ‘Employed in research with federal government funding’

N = ‘Employer nomination scheme’

O = ‘Employ in skill transfer scheme, Visa 412, 413 or 414’

P = ‘Provisional Resident Visa’

R = ‘RHCA (Reciprocal Health Care Agreement)’

S = ‘Overseas Subsidised Student or AIDAB (Australian International Development Assistance Bureaux)’

T = ‘Temporary Visitor, PRC Nationals Visa Codes 437 and 783’

Z = ‘Refugee Applicant, not a refugee yet’