Australian Divisions of General Practice Ltd

15.11.05
Mr Mike Woods
Commissioner
Health Workforce Study
Productivity Commission
PO Box 80
Belconnen ACT 2616

Dear Commissioner Woods,

**Re: The Australian Division of General Practice Response to the Productivity Commission's Position Paper on Australia's Health Workforce**

Thank you for the opportunity to respond to the Productivity Commission's recently released Position Paper (the *Paper*) on Australia's Health Workforce.

As outlined in the Australian Divisions of General Practice (ADGP) previous submission to the Productivity Commission's Issues Paper, ADGP is the peak national body representing the Divisions of General Practice Network, which links around 95 per cent of general practitioners (GPs) across Australia and facilitates and drives change in the primary health care sector. As a result, ADGP, through Divisions, has contact with the majority of grass roots GPs in Australia. In addition to various core functions, ADGP provides national leadership and co-ordination in key primary health care priority areas such as aged care, nursing in general practice, information management, and mental health. At the policy level, there is a strong alignment between the Government's primary care priorities for Australia, the core business of Divisions and the focus taken by ADGP at the national level.

ADGP and the Divisions Network generally support the Paper's proposals as they emphasise multidisciplinary care, team work and training, innovation, better workforce planning, and highlight the needs of special groups such as rural / remote and indigenous communities and those with mental health and disability problems. However ADGP highlights the following key points in the Paper:

***The role of general practice and the overall importance of primary health care (PHC) within the health system is lacking in the Paper.*** The importance of primary health care and of primary health care workforce within the health system needs to be emphasised in the Paper. Countries whose health systems have a robust primary health care system have better health outcomes and often lower health expenditure[1] [2] Primary health care also offers the means of providing preventive care, and implementing health promotion strategies at both the individual and population level.

***Development of an overarching PHC policy by Government is still required. This should be a recommendation of the Paper.*** The lack of emphasis on PHC in the Paper further highlights the need for the development of an overarching PHC policy by the Australian Government. This

[1] *Starfield B, 1998. Balancing health needs, services and technology, Revised edition, Oxford University Press,* New York.
[2] *Health Evidence Network, 2004.What are the advantages and disadvantages of restructuring a health care system to be more focused on primary care services? World Health Organization, Europe.*

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recommendation should be included in the Paper. The Australian Divisions of General Practice have recently launched their Position Statement on Primary Health Care outlining the importance of a robust PHC to the health system and the role of general practice and the Divisions within this. A copy of this Position Statement is attached. All states and territories have contributed to the development of this document through the eight state based organisations across Australia. Many states / territories have also developed their own position statements on primary health care which you may be interested in following up on.

***More attention needs to be given to workforce activities and models (including funding models) that promote health / wellness.*** The report underlines the increasing need for health services over future years but, despite the emphasis on multidisciplinary teams, the Paper gives little attention to workforce activities and models that promote health and wellness such as population health / illness prevention behaviours. More could be made of introducing funding models and / or MBS items that support such care, or of future health delivery systems which place more emphasis on the consumer being proactive. (For instance, online mental health programs such as MoodGYM[3] and the like). The role of health consumers in self-management, and models that increase such activities also need to be considered in the Paper to further address the demand side of the workforce equation. ADGP has suggested ways in which these areas could be addressed in its recent budget submission. Examples include:

- Support for a national practice amalgamation, co-location and expansion scheme including infrastructure grants to practices to provide capacity to house practice nurses and other members of the practice team.
- Remuneration for allied health professionals for their participation in multidisciplinary health care planning and case conferencing led by the GP.
- Utilising Divisions to promote multidisciplinary team working and to provide education, training and support for GPs and allied health professionals in this area.
- Additional support and training for *Lifescripts* to promote the wellness agenda
- Introducing a new MBS item number for preventive health checks that can be performed by practice nurses on behalf of GPs.

(See: http://www.adgp.com.au/site/content.cfm?page_id=6607&current_category_code=105 for further details on the above points.)

***The role of Divisions and how they support General Practice capacity need to be accentuated in the Paper.*** Several aspects of the Paper talk about advancing cohesion between different parts of the health system, including different levels of government, and emphasise the importance of strong linkages between sectors. Yet Divisions already play a key role in enhancing cohesion between different parts of the system. For instance, in North East Victoria, State funded primary mental health teams (which deal with high prevalence mental health disorders and raise awareness of mental health in the community) have merged with a local rural division. This merged team combines federal allied and mental health funding with state funds from North East Victorian Division of General Practice and North East Health Wangaratta. The teams are co-managed and governed by a business MOU between the Division and NE Health. The result is a united team which delivers better mental health outcomes in more areas with less duplication of resources. The mixed funding has additional benefits in that it increases access not only to care but also to a greater variety of services, so making the advantages of multidisciplinary care more readily available to health consumers.

[3] *The MoodGYM training program / Mark II http://moodgym.anu.edu.au/*

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Divisional roles such as this need to be accentuated in the Paper. Many of the points made about successful reform (such as collaboration, cooperation and a willingness to explore new approaches - see p29) are also core components of how Divisions already work. The existence of the Divisions Network infrastructure which provides ready access to health service innovation, change management and linkage needs to be further emphasised in the Paper as Divisions provide a key mechanism through which health service reform can be implemented and supported.

***The new committees / agencies proposed in the Paper require adequate representation from relevant parties.*** Several major changes (such as the introduction of four new bodies) are proposed in the Paper. With general practice, supported by Divisions, as the cornerstone of effective primary health care delivery it is imperative that general practice and Divisions are represented on the four new bodies proposed in the paper. In addition to the new agencies, several other changes are also proposed in the Paper, although in many cases it is difficult to assess the direct impact of these until further details about how they are to be implemented become available. This further highlights the need for adequate representation and ongoing consultation with general practice and Divisions as these proposals are progressed.

***Rural and remote issues are discussed in the Paper but the suggested proposals do little to address the crucial issues in these areas.*** Overall, although general practice is included in this section, the broader role of rural GPs needs to be accentuated in the Paper. The role of Divisions and how they assist with many rural workforce issues also needs to be included. Although there is merit in assessing which of the existing rural workforce programs best attract and retain medical workforce in these areas, this should not prevent the Commission from building on already existing evidence in this field (for doctors at least) such as the impact of spousal choice, general exposure to rural practice and recruiting medical graduates from rural areas. In general, the proposals in this section fail to adequately address the rural / remote issues in a tangible way. More concrete proposals are required.

***After hours GP services are mentioned in the paper but no proposals are suggested for this important area.*** There is talk about after hours in the Paper but no solutions are offered. ADGP highlights that, as outlined in ADGP's original submission, key enablers of the After Hours Primary Medical Care (AHPMC)[4] program to date have been the effective use of the Divisions network to address systemic issues to make substantial, sustainable and equitable changes to after hours primary care in Australia. Divisions can support the development of locally appropriate models that incorporate GP and non-medical service provision in team-based solutions to after hours care. ADGP welcomes the opportunity to further discuss such models with the commission.

Whilst the above outlines ADGP's general comments on the Position Paper, as requested, comments on the specific proposals are included in Appendix 1.

For further information about this response, please contact Rachel Yates at ryates@adgp.com.au or on 02 6228 0815.

Yours sincerely

Kate Carnell
Chief Executive Officer

[4] *The after Hours Primary Medical Care (AHPMC) program was announced in the 2001-02 Federal Budget. The* Round the Clock Medicare *initiative announced by the Government in September 2004 builds on the groundwork established by AHPMC to develop new and/or improved after hours primary care services.*

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**Appendix 1**
**ADGP Response to the Productivity Commission's Position Paper on Australia's Health Workforce Proposals**

| ***Chapter and proposal(s)*** | ***Support*** | ***Concerns*** | ***General Comments*** |
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| **Chapter 3: Objectives and strategies** | | | |
| ***DRAFT PROPOSAL 3.1:*** *In its upcoming assessment of ways to improve the level of integration within the health care system, the Council of Australian Governments (CoAG) should consider endorsing the National Health Workforce Strategic Framework (NHWSF), subject to broadening of the self sufficiency principle, in order to enhance cohesion between the various areas and levels of government involved in health workforce policy.*<br><br>***DRAFT PROPOSAL 3.2:*** *CoAG, through its Senior Officials, should commission regular reviews of progress in implementing the NHWSF. Such reviews should be independent, transparent and their results made publicly available.* | This proposal is generally supported although the non-acceptance of health workforce national self sufficiency needs further consideration. This statement also needs to highlight the need for ethical recruitment of OTDs according to the Melbourne Manifesto. | Divisions of General Practice already play a key role in enhancing cohesion between different parts of the system, including different levels of government. This role needs to be accentuated in the response. | This chapter endorses and highlights key points from the National Health Workforce Strategic Framework. It is of note that many of the points made about successful reform (eg see p29) are core components of how Divisions already work – (innovation, change management, working in collaborative / cooperative fashion, having a willingness to explore etc). The existence of the Divisions Network infrastructure which provides ready access to health service innovation, change management and linkage needs to be further emphasised in the Paper. |
| **Chapter 4: Workforce innovation** | | | |
| ***DRAFT PROPOSAL 4.1:*** *The Australian Health Ministers' Conference should establish an advisory health workforce improvement agency to evaluate and facilitate major health workforce innovation possibilities on a national, systematic and timetabled basis. Membership of the board should consist of an appropriate balance of people with the necessary health, education and finance knowledge and experience.* | There is general support for the idea of the advisory health workforce agency which, if established, should include a Divisions Network representative. However, ADGP questions the suggestion (p 53) that members of this agency act as individuals rather than as representatives and further questions whether a new body is necessary rather than aiming for better articulation between existing ones.<br><br>The emphasis on team work throughout the chapter is supported.<br><br>ADGP suggests a role for | The language around substitution needs to be carefully considered. Delegation is a more acceptable expression and retains the sense of distinct skill sets between professions which can complement each other.<br><br>Some access to MBS items for non-doctor personnel already exists (eg through the allied health items). However, other models to Increase access to allied health professionals should also be considered eg the More Allied Health Services (MAHS) initiative.<br><br>ADGP suggests that further consideration of different work roles and job redesign is needed and would especially highlight the role that practice | It is proposed that the new Agency look broadly and nationally rather than at specific examples. The Commission may like to consider here the already existing Collaboratives methodology (not mentioned in the Paper) which:<br>▪ Is a national program that can be locally applied<br>▪ Looks at access as an issue and<br>▪ Aims to be self-sustaining |

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| | Divisions in trialling opportunities for change in particular settings (p52). | nurses can play in general practice as:<br>▪ There is evidence that such team working in general practice has professional and patient benefits.<br>▪ There are currently very few nurse practitioners working in general practice in Australia.<br>However, the Commission needs to consider the need for different approaches and models in different areas – especially remote areas where nurse practitioners are more frequently used. ADGP refers the Commission to the submission from General Practice and Primary Health Care Northern Territory (GPPHCNT) in this regard.<br><br>Workforce innovation is clearly needed. However, there is a danger that too many new positions and roles would fragment the system even further and lead to less efficiency. Additionally, while the Commission's suggestions around substitution may assist with flexibility there is a need to consider blurring of professional boundaries and "new" professions versus appropriately qualified different team members working together as a team with complementary skills. | |
| **Chapter 5: Education and training** | | | |
| ***DRAFT PROPOSAL 5.1:****The Australian Government should consider transferring primary responsibility for allocating the quantum of funding available for university-based education and training of health workers from the Department of Education, Science and Training to the Department of Health and Ageing. That allocation function would encompass the mix of places across individual health care courses, and the distribution of those places across* | ADGP supports better communication between DoHA and DEST but questions whether moving responsibility of workforce training to DoHA will facilitate the improvements required. | P 77: *"Though access to both undergraduate and postgraduate clinical training is becoming increasingly difficult in some key areas, in others there is reasonable balance between demand and supply, or even unfilled training places (eg, geriatric medicine, psychiatry, renal medicine, GPs)."* Whilst it is true that a number of GP training places are currently under-filled, | The approach recommended in the Paper of joint training and various members of practice teams training together is generally supported, especially where this will enhance improved multidisciplinary team working. However, Divisions main area of involvement in GP education and training is in Continuing Professional Development (CPD) and in certain cases through their relationships with regional training providers. Much of this |

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| *universities. In undertaking the allocation function, the Department of Health and Ageing would be formally required to:*<br>*• consider the needs of all university-based health workforce areas; and*<br>*• consult with vice chancellors, the Department of Education, Science and Training, other relevant Australian Government agencies, the States and Territories and key non-government stakeholders.*<br><br>***DRAFT PROPOSAL 5.2:*** *The Australian Health Ministers' Conference should establish an advisory health workforce education and training council to provide independent and transparent assessments of:*<br>*• opportunities to improve health workforce education and training approaches (including for vocational and clinical training); and*<br>*• their implications for courses and curricula, accreditation requirements and the like.*<br><br>***DRAFT PROPOSAL 5.3:*** *To help ensure that clinical training for the future health workforce is sustainable over the longer term, the Australian Health Ministers' Conference should focus policy effort on enhancing the transparency and contestability of institutional and funding frameworks, including through:*<br>*• improving information in relation to the demand for clinical training, where it is being provided, how much it costs to provide, and how it is being funded;*<br>*• examining the role of greater use of explicit payments to those providing infrastructure support or training services, within the context of a system that will continue to rely on considerable pro bono provision of those services;*<br>*• better linking training subsidies to the wider public benefits of having a well* | The Divisions Network supports the need for more information regarding demand for clinical training etc (p 86)<br><br>The Divisions Network supports explicit payments to those providing infrastructure support or training services especially where this covers GP supervisors of registrars and trainees who are not currently receiving such payments or are receiving inadequate payments for this function. | it must be noted that, according to AMWAC GP workforce projections, even if they were filled, there would still be almost half the number of GPs trained than are required in the current system. This further reinforces the need to look at alternative models (such as multidisciplinary teams) of providing primary health care in Australia. | chapter therefore has little direct bearing on Divisions. |

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| *trained health workforce; and*<br>*• addressing any regulatory impediments to competition in the delivery of clinical training services.* | | | |
| **Chapter 6: Accreditation** | | | |
| ***DRAFT PROPOSAL 6.1**: The Australian Health Ministers' Conference should establish a single national accreditation agency for university-based and postgraduate health workforce education and training.*<br>*• It would develop uniform national standards upon which professional registration would be based.*<br>*• Its implementation should be in a considered and staged manner.*<br>*A possible extension to VET should be assessed at a later time in the light of experience with the national agency.*<br>***DRAFT PROPOSAL 6.2:** The new national accreditation agency should develop a national approach to the assessment of overseas trained health professionals. This should cover assessment processes, recognition of overseas training courses, and the criteria for practise in different work settings.* | ADGP:<br>▪ Supports national standards for assessing OTDs<br>▪ Supports an accreditation body that furthers public interest rather than the interests of particular stakeholders.<br>▪ Supports a staged approach to development of new accreditation body<br><br>ADGP:<br>▪ Supports uniform national standards for professional registration. This would have benefits to many within PHC trained overseas as well as onshore and may ease workforce transition across borders to assist with mal-distribution.<br>▪ Supports the accreditation agency in the first instance covering mainstream professions. | It is difficult to comment fully on these proposals until more details are provided on:<br>▪ The impact of the single accreditation body on the accreditation of CPD training as this would directly impact on Divisions.<br>▪ Potential "boundary line" and professional overlap issues"<br>▪ Exactly how the accreditation body would operate.<br><br>The accreditation agency's role is set clearly in the education and training context. But is also being "…charged with… developing new scopes of work and redesigning jobs..." AGP and the Divisions Network suggest that this should only be undertaken in consultation and agreement with the professions. (p 97) | Much in this proposal offers potential improvements to the complexities around registration and could especially help to ease issues around OTD registration.<br><br>In general the proposals also have the potential to enhance multidisciplinary approaches however, more detail about exactly how the agency would work and its impact on potential job redesign and CPD etc are required before full comments can be made.<br><br>Streamlining and efficiencies regarding consistent accreditation and registration processes are generally supported but the Paper needs to consider national registration and accreditation versus nationally consistent standards for these. |
| **Chapter 7: Registration** | | | |
| ***DRAFT PROPOSAL 7.1:** Registration boards should focus their activities on registration in accordance with the uniform national standards developed by the national accreditation agency and on enforcing professional standards and related matters.*<br><br>***DRAFT PROPOSAL 7.2**: States and Territories should collectively take steps to* | ADGP:<br>▪ Supports National registration principles and expanded registration processes (for professions where this is not currently required) if it enhances quality.<br>▪ Supports proposal 1 (p 105) as long as the relevant colleges | "Registration Boards will continue to have considerable influence on job design and workforce flexibility". (p 104). ADGP suggests that this is something that the whole system and professions need input into not just registration Boards.<br>ADGP requests further details on how new Board compositions and other | |

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| *improve the operation of mutual recognition in relation to the health workforce. In particular, they should implement fee waivers for mobile practitioners and streamline processes for short term provision of services across jurisdictional borders.*<br><br>***DRAFT PROPOSAL 7.3:*** *Under the auspices of the Australian Health Ministers' Conference, under which the delegating practitioner retains responsibility for clinical outcomes and the health and safety of the patient.* | are driving the standards, in consultation with the various professions.<br>▪ Supports waiving of registration fees for mobile practitioners and short term waivers of re-registration requirements across jurisdictions if this assists better workforce distribution. | proposed changes might impact on Divisions and CPD if "Boards take responsibility for….overseeing continuing professional development requirements" (p 104).<br><br>There is utility in the idea of credentialing and delegating. ADGP considers however that, particularly for delegation, this will need to capture professional autonomy and skill sets that complement each other rather than that are completely interchangeable between professions. | |
| **Chapter 8: Funding mechanisms for health care services** | | | |
| ***DRAFT PROPOSAL 8.1:*** *The Australian Government should establish an independent standing review body to advise the Minister for Health and Ageing on the coverage of the Medicare Benefits Schedule (MBS) and some related matters. It should subsume the functions of the Medical Services Advisory Committee, the Medicare Benefits Consultative Committee and related committees. Specifically, the review body should evaluate the benefits and costs, including the budgetary implications for government, of proposals for changes to:*<br>*• the range of services (type and by provider) covered under the MBS;*<br>*• referral arrangements for diagnostic and specialist services already subsidised under the MBS; and*<br>*• prescribing rights under the Pharmaceutical Benefits Scheme.*<br>*It should report publicly on its recommendations to the Minister and the reasoning behind them.*<br><br>***DRAFT PROPOSAL 8.2 :*** *For a service covered by the MBS, there should also be a rebate payable where provision of the service is delegated by the practitioner to* | ADGP considers the cost benefit analysis useful, but recommends that any study / recommendations on MBS changes be augmented with comprehensive consultation with relevant groups.<br><br>ADGP supports this proposal especially if it entails an expansion of practice nurse items.<br><br>Delegation and the key role of GPs is supported although liability | The allied health items already offer MBS access to certain allied health professionals / dentists for five visits referred by a GP. However, ADGP recommends that this scheme is expanded to include more visits.<br><br>ADGP questions access to direct specialist referral by non GPs on the basis of the breakdown in the coordinated team based approach. | A register for access to MBS for different health professionals (akin to the PBS for pharmaceuticals) as proposed by the APA already occurs to some extent through the Allied Health Items register.<br><br>GPs play a central role in whole patient care, part of which requires acting as a "gatekeeper" to different parts of the system. Suggestions about removing the requirement for GP referrals to other health providers / specialists (p 130 – 131) would need to be undertaken in consultation with the profession. |

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| *another suitably qualified health professional. In such cases:*<br>*• the service would be billed in the name of the delegating practitioner; and*<br>*• rebates for delegated services would be set at a lower rate, but still sufficiently high to provide an incentive for delegation in appropriate circumstances. This change should be introduced progressively and its impacts reviewed after three years.* | issues will need careful consideration. | | |
| **Chapter 9: Workforce planning** | | | |
| ***DRAFT PROPOSAL 9.1:*** *Current institutional structures for numerical workforce planning should be rationalised, in particular through the abolition of the Australian Medical Workforce Advisory Committee and the Australian Health Workforce Advisory Committee. A single secretariat should undertake this function and report to the Australian Health Ministers' Advisory Council.*<br><br>***DRAFT PROPOSAL 9.2:***<br>*Numerical workforce projections undertaken by the secretariat should be directed at advising governments of the implications for education and training of meeting differing levels of health services demand. To that end, those projections should:*<br>*• be based on a range of relevant demand and supply scenarios;*<br>*• concentrate on undergraduate entry for the major health workforce groups, namely medicine, nursing, dentistry and the larger allied professions, while recognising that projections for smaller groups may be required from time to time; and*<br>*• be updated regularly, consistent with education and training planning cycles.* | ADGP supports the proposal for rationalising structures for numerical workforce planning and in principle supports a single secretariat to report to AHMAC. However, more information about how this would work is required. | ADGP's submission emphasised the need to consider more localised factors influencing demand – this is mentioned here (p 148) but needs to be further emphasised in the Paper.<br><br>The Report underlines that workforce planning chapter is about numbers. Even so, the importance of team working, alternative / additional models of working and the impact of inter-relationships / interdependency of one profession on another need to be emphasised, as does skill-mix modelling and the ability for service need planning and modelling at the local level. | ADGP draws attention to a potential role for Divisions in improved data collection both in terms of the data that Divisions currently collect and that they will collect as part of their performance framework implementation. |
| **Chapter 10: Rural and Remote** | | | |
| ***DRAFT PROPOSAL 10.1:*** *The Australian Health Ministers' Conference should ensure that all broad institutional health workforce* | ADGP supports an evaluation of the initiatives, programs and | The need to deal with rural, remote (and indigenous) workforce needs to be | Overall, although general practice is included, the broader role of rural GPs could |

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| *frameworks make explicit provision to consider the particular workforce requirements of rural and remote areas.*<br><br>***DRAFT PROPOSAL 10.2:*** *The brief for the health workforce improvement agency (see draft proposal 4.1) should include a requirement for that agency to:*<br>*• assess the implications for health outcomes in rural and remote areas of generally applicable changes to job design; and*<br>*• as appropriate, consider major job redesign opportunities specific to rural and remote areas.*<br><br>***DRAFT PROPOSAL 10.3*** *The Australian Health Ministers' Conference should initiate a cross program evaluation exercise designed to ascertain which approaches, or mix of approaches, are likely to be most cost-effective in improving the sustainability, quality and accessibility of health workforce services in rural and remote Australia, including:*<br>*• the provision of financial incentives through the MBS rebate structure versus practice grants; and*<br>*• 'incentive-driven' approaches involving financial support for education and training or service delivery versus 'coercive' mechanisms such as requirements for particular health workers to practise in rural and remote areas. There should also be an assessment of the effectiveness, over the longer term, of regionally-based education and training, relative to other policy initiatives.* | schemes that are currently in place to attract and retain medical workforce to rural and remote areas and draws the commissions attention to work already done in this area. (eg Laven, Beilby Wilkinson et al 2003). However, this alone is not enough and ADGP also suggests that the proposed workforce agency includes a component that specifically works to address rural and remote workforce issues.<br>(See also the separate submission from GPPHCNT) | better addressed in this section. | be highlighted more in this chapter. Also the role of Divisions and how they assist with many rural workforce issues needs to be included and taken into account in future models.<br><br>The proposals in this section fail to adequately address the rural / remote issues in a tangible way. Overall, proposals for this section need to be strengthened. Workforce models and funding that can best deliver health care to communities of need must be developed and supported. |
| ***Chapter 11: Addressing special needs*** | | | |
| **DRAFT PROPOSAL 11.1***: The Australian Health Ministers' Conference should ensure that all broad institutional health workforce frameworks make explicit provision to consider the particular workforce requirements of groups with special needs, including:* | Stronger / more specific recommendations are required from the Productivity Commission in this section to bring about meaningful change and definitive improvements to health outcomes | | Regarding indigenous health, GPPHCNT refers the Commission to the National Framework for Aboriginal and Torres Strait Islander Health (1994) and to the Primary Health Care Access Program (PHCAP), the later of which offers a logical means of |

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| *Indigenous Australians; people with mental health illnesses; people with disabilities; and those requiring aged care.* | through workforce initiatives for groups with special needs. | | expanding the Aboriginal health workforce via funds pooling between the Commonwealth and the States within a community controlled health framework. (See also GPPHCNT's separate submission).<br>More generally, ADGP:<br>▪ Underlines the need for cultural sensitivity training in mainstream practices and<br>▪ Emphasises the role that multidisciplinary teams and better linkages play in care for special needs groups.<br>These are both areas that Divisions continue to be involved in. |
| ***Chapter 12: After Hours GP services and other matters*** | | | |
| *(No proposals)* | | | Solutions to after-hours care should be addressed in a report on health workforce, as it is a major issue in primary care. Concrete proposals and actions must be made in the Paper to resolve this problem. ADGP refers the Commission to ADGP's original submission where options such as those offered in *Round the Clock Medicare* are discussed. |