RACGP

Funding Priorities

Position statement – June 2024

1. Position

The RACGP advocates for:

- Fee-for-service to remain the foundation of general practice funding, supplemented by innovative, blended funding models to better manage chronic disease in the community.
- Increased government funding to support high-quality general practice, noting the current Medicare rebates, which belong to the patient, do not cover the cost of providing care.
- Multidisciplinary team-based care aligned to the Strengthening Medicare Taskforce Report.

While significant investments in healthcare have been made by governments in Australia, public funding does not match levels seen in comparable countries with high-quality health systems, and patients are increasingly required to cover more of the cost.[1] Existing expenditure often supports programs and services that are not evidence-based, integrated or efficient. Current funding models prioritise throughput rather than comprehensiveness, quality and safety which can act as a barrier to innovation and collaboration.

Increased investment in effective, culturally safe and accessible primary healthcare is required to meet the growing and changing needs of the Australian community while minimising costs to patients. Improving the accessibility and capacity of primary care to promote health and wellbeing across the lifespan in a cost-effective and equitable way should be key priorities.

Australia's Primary Health Care 10 Year Plan 2022-2032 identified the value of strong primary healthcare systems which are "more adaptable and flexible and better able to respond to rapid economic, technological and demographic changes, all of which have an impact on population health and wellbeing".[2]

The Royal Australian College of General Practitioners (RACGP) calls on Australian governments to:

- **prioritise health spending which supports:**
  - **equitable access to person-centred, comprehensive, continuous and coordinated primary healthcare**
  - **integration and collaboration between the primary, secondary and tertiary healthcare systems, as well as related health and social services, such as aged care.**
- **significantly increase expenditure on health, in relative and per capita terms**
- **utilise evidence to guide investment, program development and service planning.**

The RACGP's Vision for general practice and a sustainable health system outlines the value of Australia's GP-based primary healthcare system and the long-term return on investment of prioritising support for patient-centred primary care.[3] The Vision describes an alternative model for sustainably funding modern general practice, aligned with international best practice and modern health system approaches.

2. Discussion

2.1 Our health system needs to adapt to changing needs

Australia's healthcare system needs to shift to focus on disease prevention and health promotion, with a broader emphasis on maintaining health and wellbeing across the population. Our population is ageing and other types of

diseases have come to the fore. Non-communicable diseases and mental illnesses now make up almost two-thirds of the total burden of disease and half the population has one or more chronic health conditions.[4, 5] Through the modification of behaviours, circumstances and systems, and more effective and equitable distribution of health resources, a significant proportion of illness, disability and death can be prevented.[4-8]

The location and types of services people need now are substantially different.[9, 10] The Australian Government's Measuring What Matters values health throughout life, highlighting the importance of equitable access to quality health and care services to address the prevalence of chronic conditions and mental illness.[11] Primary healthcare, which keeps people safe and well within the community at low cost, provides the optimal model for a modern health system.

2.2 Spending on preventive and integrated care needs to be prioritised

2.2.1 Fragmentation of funding

Ad hoc spending for specific services is commonly portrayed as an effort to expand access to healthcare for certain patient groups, conditions and/or reduce the costs of care. This piecemeal approach prioritises short-term solutions which can lead to compartmentalised, inflexible, fragmented, duplicated and/or neglected needs, services and funds. Examples include:

- Creating a new Medicare Benefits Schedule (MBS) item to support general practitioners (GPs) to provide a heart health assessment. The RACGP position statement on Disease-specific MBS items outlines the risks associated with this approach.[12]
- Funding to expand youth mental health services through specific organisations with limited geographical reach, at greater cost and with limited demonstrated effectiveness, rather than through promoting and supporting existing schemes providing access to psychological services.[13]

2.2.2 Effectively support general practice

Ill health imposes significant costs on the health system and the economy.[14] Maximising health and wellbeing, through prevention activities, early intervention and chronic disease management, integrated within the primary care setting, is a cost-effective use of resources. The long-term benefits of supporting holistic, comprehensive and patient-centred general practice care are likely to be far greater than irregular, ad hoc and/or issues-based efforts.[15]

In 2022-23, GPs provided nearly 170 million services at a fraction of the cost of hospital and other medical specialist services, with eight in ten people consulting a GP.[16, 17] The wide-spread reach of general practice allows for chronic disease management, urgent care, preventive care, health advice and health literacy to be delivered in the context of a trusted relationship, in the patient's community, by a skilled health professional.

Effectively supported general practice has significant benefits, not only in terms of health outcomes for patients and communities but also for equity within and sustainability of the health system.[18-33] General practice also has the capacity to address other determinants of health.[28, 33-36] The Lumos study investigated the benefit to cost ratio of high connectivity general practices. For every $1 spent within primary care, $1.60 worth of healthcare system benefits was observed.[37] The RACGP has previously estimated that better support for general practice could achieve savings of up to $4.5 billion a year by reducing low-urgency emergency department presentations and hospital admissions from preventable conditions.[15]

The MBS Review recognised that the central funding mechanism of the MBS (fee-for-service) does not adequately support the advanced role of GPs in providing collaborative, continuous and coordinated care.[38] It also acknowledged that fee-for-service does not reward or encourage GPs to spend extra time with patients or support prevention.[38]

Australia's Primary Health Care 10 Year Plan 2022-2032 recognised the role of the Practice Incentives Program (PIP) in supplementing fee-for-service funding and proposed a greater proportion of primary care funding should be directed towards payments incentivising quality and outcomes.[2] In alignment with the recommendations of the Strengthening Medicare Taskforce Report, the RACGP believes fee-for-service should remain the foundation of general practice funding but needs to be better supported by innovative, blended funding models, such as MyMedicare.[39]

The RACGP acknowledges the strengths and successes of Aboriginal Community Controlled Health Organisations (ACCHOs). ACCHOs are uniquely positioned to provide high quality health and preventive care to their community.[40] The complexity, skill and time required to deliver these services is not always recognised or supported through the current MBS structure or rebate values.

Funding arrangements for general practice and general practice training should also work to minimise any barriers to attracting and retaining the GP workforce, including via pay parity for GPs in Training with their hospital-based counterparts.

2.3 Increasing patient costs in the Australian healthcare system

While expenditure on health in Australia from all sources has continued to increase to a total of $220.9 billion in 2020-21, this burden is not being equally shouldered by all in the healthcare system.[41] In 2020-21, individuals spent $33.2 billion in out-of-pocket costs for their healthcare, representing a 9.3% increase over 2019-20 spending. As bulk billing rates decline, patient contributions to GP consultations increase.[42] This is a symptom of an overall degradation of the public health system and trend towards the privatisation of healthcare in Australia.

2.4 Government funding for the health system must increase

Australian governments must increase relative levels of healthcare funding across a range of indicators (e.g. investment in primary care as proportion of total health expenditure, per capita expenditure and increased contributions to total health expenditure) to ensure cost barriers to accessing healthcare are removed. It is important that health inequities are not perpetuated and that vulnerable sections of our community are able to access timely and high-quality care.

Australian government health spending is expected to grow significantly in the future due to Australia's ageing population, even without proactive investment by government. The Intergenerational Report 2023 has identified that health spending is projected to grow from 4.2% of GDP in 2022-23 to 6.2% in 2062-63.[43] Investing in higher quality services and more efficient systems will increase the value received by the Australian community.

It is acknowledged that expenditure is not an end in itself and does not sufficiently deliver an effective health system in isolation. For instance, the United States has spent more than any other OECD nation on healthcare, yet has a life expectancy of 76.4 years compared to Australia's 83.3.[44] As such, the more effective and efficient targeting of health spending should also be a key focus of governments.

2.5 Consider opportunity costs and the evidence for population-level health outcomes

While funding must be needs-based, it must also be evidence-based, promoting effective and efficient use of resources. The quintuple aim of healthcare (improving the patient experience, population health outcomes, cost-efficiency of healthcare, provider wellbeing and health equity) is a useful approach to ensure a broad view of healthcare improvement.[45]

The National Health Reform Agreement (NHRA) outlines public hospital funding arrangements between the Federal Government, and the states and territories. There is an opportunity cost associated with the focus on tertiary care and the segmented approached to healthcare funding. A shift in funding is needed to achieve a more sustainable system and improve patient outcomes.[46]

Efficient resource use relies upon the collection and implementation of high-quality evidence. Consistent monitoring and evaluation should be used to inform decisions about the distribution of healthcare resources.[47-49] Strategic investment in general practice research will reduce hospitalisation rates, enhance preventive care and deliver positive patient outcomes for a healthier Australia.

Absence of evidence is not evidence of absence, however; more research must be conducted in all Australian healthcare settings to better identify system efficiencies and improve health outcomes.[50] Many important research questions are unique to the general practice environment, where patients present with early and/or undifferentiated disease and multiple co-morbidities. The Strengthening Medicare Taskforce Report recommends investment in research that identifies models of high value primary care excellence.[39]

2.6 Innovation, collaboration and funding models

Fee-for-service funding models incentivise providers to deliver high patient throughput. Hospitals receive more funding the faster they can complete treatment episodes and discharge patients. While these funding models are effective at allowing each part of the health system to operate efficiently, many parts of the system need to work together to effectively treat a patient. However, the MBS and the NHRA both operate under the assumption that, predominantly, a single provider is providing care to a patient, potentially discouraging collaboration. This could be managed through blended funding models which include flexible funding that can be spent collaborating with other services in a patient's care. The implementation of any new funding models must be accompanied by a consideration of relevant financial and legal implications, at state and national levels, to ensure patient outcomes are not compromised.

The Strengthening Medicare Taskforce Report encourages collaborative, coordinated and patient-centred multidisciplinary teams.[39] Current Medicare funding arrangements mean health professionals in the primary care setting often work independently of each other. The full benefits of multidisciplinary care can only be achieved within a primary

care team, ensuring interventions are done by the most appropriate professional, and the scope of care for the patient is enhanced, not fragmented.

3. References

1. Organisation for Economic Co-operation and Development. Health expenditure and financing Paris: Organisation for Economic Co-operation and Development; 2024 [Available from: https://stats.oecd.org/Index.aspx?DatasetCode=HEALTH_STAT.
2. Department of Health. Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022-2032 Canberra: Australian Government; 2022 [Available from: https://www.health.gov.au/sites/default/files/documents/2022/03/australia-s-primary-health-care-10-year-plan-2022-2032-future-focused-primary-health-care-australia-s-primary-health-care-10-year-plan-2022-2032.pdf.
3. Royal Australian College of General Practitioners. Vision for general practice and a sustainable healthcare system East Melbourne: Royal Australian College of General Practitioners; 2019 [Available from: https://www.racgp.org.au/getattachment/e8ad4284-34d3-48ca-825e-45d58b2d49da/The-Vision-for-general-practice.aspx.
4. Australian Institute of Health and Welfare. Australian Burden of Disease Study 2022 Canberra: Australian Government; 2022 [Available from: https://www.aihw.gov.au/reports/burden-of-disease/australian-burden-of-disease-study-2022/contents/summary.
5. Australian Institute of Health and Welfare. Chronic conditions and multimorbidity Canberra: Australian Government; 2023 [Available from: https://www.aihw.gov.au/reports/australias-health/chronic-conditions-and-multimorbidity.
6. Australian Institute of Health and Welfare. Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2017–18 Canberra: Australian Government; 2019 [Available from: https://www.aihw.gov.au/reports/primary-health-care/potentially-preventable-hospitalisations/contents/about.
7. Australian Institute of Health and Welfare. Social determinants of health Canberra: Australian Government; 2022 [Available from: https://www.aihw.gov.au/reports/australias-health/social-determinants-of-health.
8. Australian Institute of Health and Welfare. Disparities in potentially preventable hospitalisations across Australia, 2012-13 to 2017-18 Canberra: Australian Government; 2020 [Available from: https://www.aihw.gov.au/reports/primary-health-care/disparities-in-potentially-preventable-hospitalisa/summary.
9. Swerissen H, Duckett, S, Wright, J. Chronic failure in primary care: Grattan Institute; 2016 [Available from: https://grattan.edu.au/wp-content/uploads/2016/03/936-chronic-failure-in-primary-care.pdf.
10. Swerissen H, Duckett, S. Building better foundations for primary care: Grattan Institute; 2017 [Available from: https://grattan.edu.au/wp-content/uploads/2017/04/Building-better-foundations-for-primary-care.pdf.
11. Australian Government. Measuring What Matters: Australia's First Wellbeing Framework Canberra: Australian Government; 2023 [Available from: https://treasury.gov.au/sites/default/files/2023-07/measuring-what-matters-statement020230721_0.pdf.
12. Royal Australian College of General Practitioners. Disease-specific MBS items East Melbourne: Royal Australian College of General Practitioners; 2024 [Available from: https://www.racgp.org.au/advocacy/position-statements/view-all-position-statements/health-systems-and-environmental/disease-specific-mbs-items.
13. Productivity Commission. Mental Health Productivity Commission Inquiry Report Canberra: Australian Government; 2020 [Available from: https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health.pdf.
14. McKinsey Global Institute. Prioritizing health: A prescription for prosperity: McKinsey & Company; 2020 [Available from: https://www.mckinsey.com/industries/healthcare/our-insights/prioritizing-health-a-prescription-for-prosperity#/.
15. PricewaterhouseCoopers. Economic benefits of the RACGP's Vision for general practice and a sustainable healthcare system East Melbourne: Royal Australian College of General Practitioners; 2020 [Available from: https://www.racgp.org.au/FSDEDEV/media/documents/RACGP/Advocacy/Economic-evaluation-of-the-RACGP-vision.pdf.
16. Department of Health and Aged Care. Medicare annual statistics – State and territory (2009–10 to 2022-23) Canberra: Australian Government; 2023 [Available from: https://www.health.gov.au/resources/publications/medicare-annual-statistics-state-and-territory-2009-10-to-2022-23?language=en.
17. Australian Bureau of Statistics. Patient Experiences Canberra: Australian Government; 2023 [Available from: https://www.abs.gov.au/statistics/health/health-services/patient-experiences/latest-release.
18. Dalton A, Lal, A, Mohebbi, M, Carter, R. Economic Evaluation of the Indigenous Australians' Health Programme Phase I Melbourne: Centre for Population Health Research, Faculty of Health and Deakin University; 2018 [Available from: https://www.health.gov.au/sites/default/files/documents/2020/12/economic-evaluation-of-the-indigenous-australians-health-programme-phase-i.pdf.
19. Rigg K, Engelman, D, Ramirez, J. A Community-Based Approach to Primary Health Care. In: Arxer S, Murphy, JW, editor. Dimensions of Community-Based Projects in Health Care: Springer; 2018.
20. White J, South, J. Health together: how community resources can enhance clinical practice. British Journal of General Practice. 2012;62(602):454-5.
21. Zhao Y, Thomas, SL, Guthridge, SL, Wakerman, J. Better health outcomes at lower costs: the benefits of primary care utilisation for chronic disease management in remote Indigenous communities in Australia's Northern Territory. BMC Health Services Research. 2014;14:463.

22. Starfield B, Shi, L, Macinko, J,. Contribution of Primary Care to Health Systems and Health. The Milbank Quarterly. 2005;83(3):457-502.
23. Frey J. Review: General Practitioners at the Deep End: The Experience and Views of General Practitioners Working in the Most Severely Deprived Areas of Scotland. British Journal of General Practice. 2012;62(600):373.
24. Royal Australian College of General Practitioners. Guidelines for preventive activities in general practice East Melbourne: Royal Australian College of General Practitioners; 2021 [Available from: https://www.racgp.org.au/getattachment/1ad1a26f-9c8b-4e3c-b45b-3237272b3a04/Guidelines-for-preventive-activities-in-general-practice.aspx.
25. Southey G, Heydon, A. The Starfield Model: Measuring Comprehensive Primary Care for System Benefit. Healthcare Management Forum. 2014;27(2):60-4.
26. Baird B, Ross, S, Honeyman, M, Reeve, H, Nosa-Ehima, M, Omojomolo, D. Innovative models of general practice London: The King's Fund; 2018 [Available from: https://www.kingsfund.org.uk/insight-and-analysis/reports/innovative-models-general-practice.
27. World Health Organization. The world health report 2008 : primary health care now more than ever: World Health Organization; 2008 [Available from: https://iris.who.int/handle/10665/43949.
28. Sripa P, Hayhoe, B, Garg, P, Majeed, A, Greenfield, G. Impact of GP gatekeeping on quality of care, and health outcomes, use, and expenditure: a systematic review. British Journal of General Practice. 2019;69(682):e294-e303.
29. Phillips R, Short, A, Kenning A, Dugdale, P, Nugus, P, McGowan, R, Greenfield, D,. Achieving patient-centred care: the potential and challenge of the patient-as-professional role. Health Expect. 2015;18(6):2616-28.
30. Barker I, Steventon, A, Deeny, SR. Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data BMJ. 2017;356(j84).
31. Australian Institute of Health and Welfare. Coordination of health care: experiences of barriers to accessing health services among patients aged 45 and over Canberra: Australian Government; 2016 [Available from: https://www.aihw.gov.au/getmedia/d864d80b-22cb-4356-a1f6-24c2f350004b/aihw-chc-4.pdf.aspx?inline=true.
32. Pulvirenti M, McMillan, J, Lawn, S. Empowerment, patient centred care and self-management. Health Expect. 2014;17(3):303-10.
33. Chatterjee H, Camic, PM, Lockyer, B,, Thomson, LJM. Non-clinical community interventions: a systematised review of social prescribing schemes. Arts & Health. 2018;10(2):97-123.
34. The EveryONE Project. Addressing Social Determinants of Health in Primary Care: American Academy of Family Physicians; 2018 [Available from: https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/team-based-approach.pdf.
35. Allen L. Leveraging primary care to address social determinants. Lancet Public Health. 2018;3(10):E466.
36. Hutt P, Gilmour, S. Tackling inequalities in general practice London: The King's Fund; 2010 [
37. NSW Health. Lumos: Continuity of care benefits patients and the system NSW: NSW Government; 2023 [Available from: https://www.health.nsw.gov.au/lumos/Pages/lumos-high-connectivity-cba.aspx.
38. Department of Health. Medicare Benefits Schedule Review Taskforce Final Report to the Minister for Health Canberra: Australian Government; 2020 [Available from: https://www.health.gov.au/sites/default/files/documents/2020/12/medicare-benefits-schedule-review-taskforce-final-report-an-mbs-for-the-21st-century-recommendations-learnings-and-ideas-for-the-future.pdf.
39. Australian Government. Strengthening Medicare Taskforce Report Canberra: Australian Government; 2022 [Available from: https://www.health.gov.au/sites/default/files/2023-02/strengthening-medicare-taskforce-report_0.pdf.
40. Closing the Gap. Prioritiy reforms: Australian Government; 2024 [Available from: https://www.closingthegap.gov.au/national-agreement/priority-reforms.
41. Australian Institute of Health and Welfare. Health expenditure Australia 2020-21: Spending trends by sources Canberra: Australian Government; 2022 [Available from: https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2020-21/contents/spending-trends-by-sources.
42. Royal Australian College of General Practitioners. General Practice Health of the Nation 2023 East Melbourne: Royal Australian College of General Practitioners; 2023 [Available from: https://www.racgp.org.au/getmedia/122d4119-a779-41c0-bc67-a8914be52561/Health-of-the-Nation-2023.pdf.aspx.
43. Australian Government. Intergenerational Report 2023: Australia's future to 2063 Canberra: Australian Government; 2023 [Available from: https://apo.org.au/sites/default/files/resource-files/2023-08/apo-nid324024.pdf.
44. Organisation for Economic Co-operation and Development. Health status: Life expectancy Paris: Organisation for Economic Co-operation and Development; 2024 [Available from: https://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_WFMI#.
45. Itchhaporia D. The Evolution of the Quintuple Aim. Journal of the American College of Cardiology. 2021;78(22):2262-4.
46. Huxtable R. Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025 Canberra: Australian Government; 2023 [Available from: https://www.health.gov.au/sites/default/files/2023-12/nhra-mid-term-review-final-report-october-2023.pdf.
47. Martin E. Rationing in healthcare Brisbane: Deeble Institute; 2015 [Available from: https://ahha.asn.au/sites/default/files/docs/policy-issue/deeble_issues_brief_no_8_martin_e_rationing_in_healthcare.pdf.
48. Productivity Commission. Efficiency in Health: Productivity Commission Research Paper Canberra: Australian Government; 2015 [Available from: https://www.pc.gov.au/research/completed/efficiency-health/efficiency-health.pdf.
49. McCreanor V. Active disinvestment in low-value care in Australia will improve patient outcomes and reduce waste Brisbane: Deeble Institute; 2017 [Available from: https://ahha.asn.au/system/files/docs/publications/171004_issues_brief_no_23-_disinvestment_2.pdf.
50. Manski-Nankervis J, Sturgiss, EA, Liaw, S, Spurling, GK, Mazza, D. General practice research: an investment to improve the health of all Australians. Medical Journal of Australia.212(9):398-400.