RACGP Submission to the Effectiveness Review of General Practice Incentives

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RACGP

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1. About the RACGP

The Royal Australian College of General Practitioners (RACGP) is the voice of general practitioners (GPs) in our growing cities and throughout rural and remote Australia. For more than 60 years, we have supported the backbone of Australia's health system by setting the standards for education and practice and advocating for better health and wellbeing for all Australians.

As a national peak body representing over 40,000 members working in or towards a career in general practice, our core commitment is to support GPs from across the entirety of general practice address the primary healthcare needs of the Australian population.

We cultivate a stronger profession by helping the GPs of today and tomorrow continue their professional development throughout their careers, from medical students and GPs in training to experienced Fellowed GPs. We develop resources and guidelines to support GPs in providing their patients with world-class healthcare and help with the unique issues that affect their practices. We are a point of connection for GPs serving communities in every corner of the country.

Patient-centred care is at the heart of every Australian general practice, and at the heart of everything we do.

2. Overview

The RACGP welcomes the opportunity to provide a submission to the Department of Health and Aged Care's (DoHAC) Review of General Practice Incentives (the Review). In summary;

- Overall, GPs have many positive experiences of the General Practice Incentive program providing a much-needed additional funding stream for their practices and patient care.

Throughout this consultation, many GPs have emphasised that the practice incentive programs are critical to the viability of their practice and continuing to provide patient care.

- The Review is a significant opportunity to enhance the effectiveness of the current general practice incentives as a funding model into the future and to shape the primary healthcare system.
- We acknowledge and welcome the government's intention to move towards a greater use of a blended funding model with fee-for-service at the core.
- The Medicare Benefits Scheme (MBS) and general practice incentive funding should give all Australians access to a GP who can coordinate and manage their care in the community, while also providing high-quality, safe, comprehensive and coordinated care by expert generalists for all of their healthcare needs.

Enhancing general practice incentives with greater financial incentives and reducing their complexity is essential for their success and ultimately improving patient outcomes.

- The COVID-19 pandemic showed the ability and agility of general practice to adapt quickly to new ways of working (such as the introduction of MBS-funded telehealth and operating pandemic vaccination clinics) but also that incentives for particular aspects of care can have the unintended consequence of reducing the viability of holistic general practice care if they do not respond to these necessary adaptive workflows[1,2].

- Historically, incentives have been rigid and have not provided appropriate flexibility to enable practices to respond to evolving circumstances.

- Additionally, the constant changes in incentive arrangements have weakened the effectiveness of this program in its aim of driving an increase in practice accreditation.

- General practice is the most accessed sector of the healthcare system, and its health is essential to the health of all Australians. Each year, almost nine in 10 Australians visit a GP.

- Given general practice is proven to be highly accessible, efficient and cost-effective, the future sustainability of Australia's health system is dependent on future investment and reform in primary care.

  - In 2022 more than 179 million health services were provided by GPs, and on average, patients received 7.9 episodes of care from their GP throughout the year.[3]

  - Conservative estimates suggest a 12% reduction in hospital readmissions could save the Australian health system a minimum of $69 million per year, not to mention improved quality of life for patients.

  - A recent study revealed for every $1 spent within the primary care system, $1.60 worth of healthcare system benefits was observed.[14]

  - Governments pay more for a single patient hospital admission than the cost of that same patient visiting their GP twice a week for an entire year ($5,020 compared to $3,973 respectively).[6]

- While maximising the practice and workforce incentive programs can otherwise improve financial sustainability for general practices, continued support to navigate the complex requirements of these programs, and adequate flexibility in the future is essential.

- Any changes to funding models require careful consideration to safeguard access to appropriate care, better health outcomes for Australians and general practice business viability.

- The incentive programs have been shown to be successful when measures have aligned with improving quality and efficiency, driven by the genuine needs of general practices and the patients they serve, such as with early digital initiatives.

3. Summary of RACGP recommendations

The RACGP notes the incentives program is **critical to the viability of general practice**. In addition to an increased size of these incentives, experience shows that **if they are better targeted to high quality general practice**, including preventive, coordinated and proactive care, **the outcomes will be better.**

The RACGP recommends:

- **Redesign of the General Practice Incentives to ensure that general practice is supported in the management of complex chronic disease** through blended funding models, integrating incentive payments with fee-for-service, and funding quality bundles of care for targeted population groups.
- **A sustained increase in investment to expand the practice and workforce incentive programs to meet the growing and changing needs of our community and minimise costs to patients.** Key funding priorities, including practice incentives, should include:
  - improving preventive, coordinated and proactive primary care to promote health and wellbeing across the lifespan in a cost-effective way
  - giving GPs the capacity to undertake the coordination role needed to increase integration and collaboration
  - integrating services across the health system to ensure comprehensive and coordinated care.
- **Simplifying the program and reducing administrative barriers to GP participation**. This includes ensuring all administrative aspects reduce red tape and are streamlined, seamless, and that interoperability is prioritised.
- **Investigating opportunities to expand the incentives,** potentially including incentivising 4 year old health checks, along with incentives to support optimal development of children during the first 2,000 days.
- Consideration of socioeconomic deprivation when generating Standardised Whole Patient Equivalent (SWPE) values on which practice incentives are calculated to fund according to patient complexity.
- Government share high-level, de-identified data on all general practice incentives and regularly report on outcomes, particularly longitudinal data on uptake and locations of participation for greater transparency and to ensure accountability.
- Appropriate support be provided for general practices to analyse their own data and draw meaningful and actionable insights, along with support to implement any identified quality improvement activities.
- The Indigenous Health Incentive should be increased to provide funding per patient that reflects the complexity of care, noting this has recently decreased and the inclusion of mental health has not increased funding as it was planned to.
- **It is critical that the redesign of the General Practice Incentives and associated funding programs does not result in a net loss in funding for general practice.**[1]

4. Response to the Review of General Practice Incentives

4.1 Domain 1 – Impact

General practice incentives are critical to the viability of general practices and should be better aligned to quality of care. They must be simplified to create more impact, incentivise innovation and foster efficient multidisciplinary teams that enable better health outcomes for patients. The RACGP is committed to working with government over the coming months to guide the redesign of general practice incentives for the sector. Throughout this re-design, we encourage consideration of the RACGP *Vision for general practice and a sustainable healthcare system* (the Vision), which describes a sustainable model of high-quality, cost-effective and patient-centred care that aims to address many of Australia's healthcare challenges.

Overall, there is a lack of publicly available data to determine the areas of greatest impact for the incentives. This demonstrates the need for the government to share high-level, de-identified data on all general practice incentives and report on outcomes, particularly longitudinal data on uptake and locations of participation (including categories of rurality and deprivation) for greater transparency and to ensure accountability. When evaluating general practice incentives, we note that numbers may only be part of the story and qualitative approaches may help to meaningfully understand the statistics around the PIPs as 'not everything that counts is counted'.[4]

In the recent Measuring What Matters statement the Federal Treasurer, the Hon Dr Jim Chalmers stated the need to 'put people and progress, fairness and opportunity at the very core of our thinking about our economy and our society, now and into the future'.[5] This focus along with the wellbeing theme of 'a healthy society' can be realised by supporting general practices and the better health outcomes they provide for all Australians. In this statement, Minister Chalmers placed emphasis on the importance of fairness, and we know that in deprived areas there are higher rates of chronic disease and disability.[6] General practice is crucial in providing equity in health care to all Australians. These socioeconomically deprived areas are locations where practices are more likely to need to bulk bill, however they are likely to generate less income due to increased complexity. In these areas general practice incentives are highly likely to play a key role in ensuring the government's fairness agenda.

A key consideration for the review should be that initiatives aligned with GP workflows and business models have been more effective and impactful than those that are misaligned. Generally, if the incentives are designed with GP input and directed towards supporting general practice patient care activities they have greater impact.

4.2 Domain 2 – Effectiveness

As general practices vary greatly in scale and with consideration to the diversity in location and population cohorts, some general practice incentives will be more appropriate funding mechanisms to influence change than others. GPs value the general practice incentives that are most aligned with the needs of their location and community they serve. While some incentives may appear to be ineffective in changing behaviour, we consider this may result from inadequate funding provided and increasing this is likely to encourage general practices to participate at higher rates. These perspectives must be considered as part of the review process.

Indigenous Health Incentive

The RACGP recommends a strong commitment to improving the health and wellbeing of Aboriginal and Torres Strait Islander people as one of Australia's highest health priorities. Increased support must be provided to practices and Indigenous health services to provide better health care for Aboriginal and Torres Strait Islander patients. We strongly support the Aboriginal Community Controlled Health Organisations (ACCHOs) model of comprehensive primary healthcare as well as efforts to further develop and support the Aboriginal and Torres Strait Islander health workforce via the Indigenous Health Incentive.

Across the ACCHOs, the Aboriginal health sector and practices that see a large number of Aboriginal and Torres Strait Islander patients, the Indigenous Health Incentive brings a significant amount of funding that supplements the fee-for-service Medicare benefits. Medicare funding is currently inadequate as fee-for-service funding does not account for the complexity of care provided to the Indigenous community within typically longer consultations. Additionally, recent changes have meant there is less funding from this incentive per patient, and we recommend this to be increased. While the Indigenous Health Incentive increased the number of patients who are eligible with the inclusion of mental health, the overall funding does not appear to have consistently increased. This is deeply concerning for ACCHOs and rural and remote communities with a large proportion of Aboriginal and Torres Strait Islander people, as this incentive holds promise to deliver a significant amount of essential funding for practices serving those areas and communities.

The Indigenous Health Incentive must remain. There are real health equity implications for this incentive and ensuring it is effective must be a key focus of any future changes.

It has been important in funding Aboriginal medical services and in funding general practices that care for high numbers of Aboriginal and Torres Strait Islander patients, along with encouraging other practices to set up and deliver care in that location.

Since the introduction of MyMedicare, there are now two registration processes for Aboriginal and Torres Strait Islander people with a chronic disease, which bring about different benefits and have different timing. We recommend working closely with the RACGP to ensure the Indigenous Health Incentive and MyMedicare programs work seamlessly together to improve care without being administratively burdensome and enhance outcomes for Aboriginal and Torres Strait Islander people.

Quality Improvement Incentive (PIPQI)

As discussed, there is a need for the government to share high level, de-identified data on all general practice incentives and report on outcomes. In particular, GPs need reliable and actionable data, on each individual incentive, to ensure efficient and sustainable general practices and to improve patient care. The lack of recurrent funding models for these types of activities is a serious omission. GPs must be supported to interpret, understand, and respond to health data trends and patterns. However, the PIPQI payments must not be based on outcomes from reported data.

A firm commitment is needed to new funding for this type of activity (ie. data-driven insights and digital integration), continued funding for a reformed PIP QI and investigating future focus areas for the PIPQI with GPs individually – who must be engaged to achieve their desired goal. As discussed, GPs must have ownership of and lead governance over their curated data and intellectual property.

We recommend increasing the payment values for the program to practices, supporting practices to engage with quality improvement and deliver on the PIPQI aims. An initial intention of the PIPQI was to be a driver to encourage practice accreditation, however this has been capped and has not increased over time. It no longer functions as an incentive for ongoing accreditation. More funding over time is needed for the PIPQI to become a strong driver for quality improvement and accreditation, rather than solely sharing data with the DoHAC. The funding available for this incentive must support all activity which results in meaningful quality improvement, for example, participating in the Primary Care Collaboratives. Future opportunities for the PIPQI include a focus on providing support and activities (exceeding data sharing as a standalone offering) in the areas of mental health, health promotion and illness prevention, chronic disease and public health issues which will support quality improvement in general practice as health concerns continue to change into the future.

eHealth Incentive

The RACGP is supportive of eHealth Incentive (ePIP) reform. Elements encouraging participation in My Health Record (MHR) should remain, with the focus broadened to include interoperability and uptake of electronic prescribing and secure messaging. For example, interoperability of MHR with clinical information systems (CIS) used by general practice will unlock the value of uploading shared health summaries, particularly when important patient information such as discharge summaries can be seamlessly imported directly into general practice CIS.

Any new ePIP outcome measures must be aligned to safe and high-quality healthcare, rather than arbitrary numbers and/or percentages to better support general practices to keep up to date with digital health and adopt new health technology. All IT system deployment needs on-going investment and maintenance; thus the ePIP is not only welcomed, but critical to general practice. A majority of this funding goes back to the practice to help maintain and upgrade the systems so they keep functioning properly and are safe to interact with other systems as well as minimising the ever increasing risk of cyber-attacks.

While progress has been made with the support of the ePIP, it is time to consider how this could be improved. It would be beneficial to explore how the ePIP could be a mechanism to incentivise practitioners responsible for the work required

for practices to be eligible for the payment. For example, the uploading of shared health summaries to MHR. A separate payment for individual practitioners could resolve this issue.

Rural loading incentive and Procedural General Practitioner Payment

The RACGP believes that targeted funding is needed to improve general practice workforce concerns into the future, including in rural and remote areas. Further mechanisms to provide practical support for rural GPs such as greater incentives, rebates, and scholarships are required to support general practices in rural and remote areas to maintain local access to surgical, anaesthetic and obstetric services, while recognising the challenges of providing care in rural and remote areas.

Resuming payments to GPs facilitating specialist telehealth visits for their patients would also allow patients to remain in their community rather than travel long distances, while also enabling the coordinating GP to participate in the consultation with the treating specialist. This facilitates communication across the healthcare team and provides continuity of care via interim follow-up, with appropriate clinical handover.

There is a clear need for practices in rural and remote locations to be supported and for practitioners to be incentivised to gain adequate skills to flourish. We recommend the Procedural General Practitioner Payment (PGPP) to be expanded from the standard surgery, anaesthetics and obstetrics focus to include further services for eligibility. With the expanded scope of Rural Generalist GP, many GPs may pursue upskilling in other areas that reflect the needs of their particular community and location. GPs also need incentives to support their participation in an emergency upskilling placement to fulfill the Rural Generalist definition.

While the new Rural Advanced Skills Payment Workforce Incentive Program recognises the non-procedural additional skills such as Additional Rural Skills Training (ARST) in mental health and Aboriginal and Torres Strait Islander Health, rural doctors require locum support so they can take time off to upskill. This must be considered within the general practice incentives focussed on rural health.

While geography is a major barrier, a similar situation exists in under resourced urban areas that have large populations where patients face challenges to accessing the health services they need. A lack of affordable services in deprived areas means that non-GP specialist care and allied health care is out of reach for many. GPs, by necessity, often take on an extended scope of work that is often underfunded and they are not allowed to undertake procedural work in urban hospitals. Developing a similar incentive for deprived areas could provide an opportunity to these issues.

Teaching Payment

Government must ensure adequate compensation to practices for the reduced number of consultations performed by a general practitioner due to the presence and participation of a student. The payment has stagnated at $200 per each 3 hour teaching session, and practices are limited to claim a maximum of 2 sessions per GP daily. Practices can only claim $200 for each session, regardless of how many students are in a teaching session. The RACGP supports this being increased to encourage more GPs to provide medical student education.

In addition to supporting medical students, support for practices that train registrars is critical with payments needed for both practices and supervisors in GP training. This is essential for graduating safe and competent GPs that can skilfully meet community needs. We note that within the RACGP, registrars can train within the Australian General Practice Training (AGPT) Program or the Fellowship Support Program (FSP). The AGPT program has government funding while the FSP program is self-funded. There are three key areas of supervisor activity that need support, and where existing programs are not providing support there is opportunity for the incentives program to address these:

1. *Teaching*

   The PIP only applies to teaching and supervision of medical students. Teaching payments are through the National Consistent Payments Framework (NCP) to teachers of AGPT registrars only (this also includes details on particular registrar support payments for rural registrars ie MMM2 and above). Teaching of FSP and Independent Pathway (IP) registrars is through a self-funded program and is not available to practices and supervisors with registrars in that program. This is a gap that needs to be addressed.

2. *Supervision*

Supervising medical students is supported via the PIP. There are no payments for assisting a supervised doctor. This imposes a cost to practices in terms of supervisor time spent with registrars rather than patients. An incentive payment could reward supervision in all programs.

3. *Professional Development (PD)*

   There is only payment for PD of AGPT supervisors through the flexible funds available within that program. Shifting the cost from flexible funds to an overarching payment through incentive programs administered by the Medical Colleges would support both AGPT and FSP supervisors.

The Teaching Payment also holds potential to widen its scope for encouraging increased exposure to and understanding of GP care, for example, enabling medical registrars to rotate through general practice as part of their training. Recruitment of GPs to provide a positive experience for medical students is critical to address future workforce needs.

Medical student teaching incentives have been fixed for several years and no longer adequately reflect reduced earnings from consulting. The incentives do not 'reward' the extraordinary work involved in supervising, training and showcasing the best of general practice. Practices that dedicate a room for students to initially consult with patients do so at a net loss of income. Without a room to consult, student experience can often be more observational resulting in dissatisfied students who will generally choose an alternative career path.

After Hours Incentive

There are several key issues influencing access to after-hours care, including availability, continuity of care, accessibility, awareness and cost.[7] Patients often present to after-hours care services due to perceived need and convenience.[8]Emergency department (ED) activity has grown faster than population growth in terms of presentations and the length of time each person spends waiting for treatment in ED.[9] It is clear that after-hours care delivered as part of general practice needs to be further prioritised. We believe patients should be able to access safe, high-quality after-hours services that prioritise continuity of care, particularly for communities experiencing additional barriers to access. We acknowledge that telehealth is also expanding healthcare access in the after-hours period and this must be provided based on best practice principles outlined in our position statement on *The use of telehealth in general practice*.

Workforce Incentive Program (WIP)

The quadruple aim of healthcare encompasses improved patient experience, improved population health, reduced healthcare costs and improved provider experience, which can be enhanced by team-delivered care allowing all providers to work to their full scope of practice.[10] The support of suitably qualified team members enables GPs to delegate more within the coordinated multidisciplinary care team (MDCT) in general practice, freeing up more time for complex or urgent care, resulting in improved access to general practice. Patient safety is paramount and best protected where MDCTs within a patient's regular general practice are working together to provide coordinated, comprehensive, collaborative and continuous care. To achieve this, significantly increased funding is required for general practices to have more flexibility to employ, coordinate and provide oversight to a team of qualified health professionals, as based on the unique needs of each practice and the patients they care for.

The WIP partially facilitates patient-centred, MDCT care within general practice by essential funding to employ additional health professionals within the MDCT team. As part of the Federal Budget 2023-24, the Australian Government announced an investment of $445.1 million over five years to increase the WIP Practice Stream. This commitment is valued by general practice and will enable more to invest in their care teams. However, further strengthening of this commitment is needed.

High-functioning MDCT's require appropriate funding and staffing. While the RACGP strongly supports increasing funding for the WIP, we recommend any boosts to this program should incorporate both the Doctor stream and Practices stream. The RACGP also supports further consideration of how the WIP could specifically support the important role of non-dispensing pharmacists within general practice teams. It would be beneficial to further investigate how flexible pooled funding for team care arrangements could fund clinician time (via the WIP) with patients, as well as funding care coordination activities including MDCT's.

Further, the RACGP notes the WIP Doctor Stream has not received a meaningful increase in funding many years. The WIP Doctors Stream is a valued incentive payment to rural GPs that provides a balanced mix of rural loading and time in

community. Increasing this incentive is required to catch up for the years of funding stagnation along with a commitment to index.

Additional comments

The RACGP does not support funding models that are based on block payments linked solely to quality and outcome measures, for example, team-based care indicators. Indicators of this type do not necessarily reflect the delivery of high-quality care, do not align with the flexibility required in general practice, and can needlessly restrict funding for general practices that are delivering high-quality health services.

There needs to be recognition that there are many varied ways practices manage income from incentive payments. We note many GPs are not practice owners. For some, the income is not shared effectively with GPs therefore incentives cannot incentivise the behaviour changes they are intended for. We note that general practice incentives may positively influence the infrastructure of practice if this is appropriately administered, thus influencing behaviour of GPs. Payroll tax concerns have further impacted the confidence of practices to work together as a team and share rewards for that work.

The DoHAC must closely consider the split between funding to individual GPs and other providers and to the practice, cognisant of the payroll tax issue as some incentive payment flows are a potential concern for payroll tax.

Practice Incentives Program Advisory Group (PIPAG)

The PIPAG has also played a key role in reviewing the impact of this program over recent years. It was an important mechanism to support the effectiveness of the incentive design and the delivery of incentive programs. Importantly, this group encouraged consultation with the profession in the choosing of the incentives and their implementation. Lessening this collaboration will lead the incentives to be less relevant and effective.

Bulk billing incentives

Bulk-billing rates have declined substantially over the past two years, with many general practices across the country moving towards mixed and private billing to keep patient care sustainable in the face of stagnating rebates and rising costs. *In our pre-Budget submission*, released in January 2023, the RACGP requested the tripling of the bulk-billing incentive. When the Budget was announced in May 2023, we welcomed the investment in this incentive to counter the drop in bulk billing. It is clear there is a long way to go in strengthening Medicare, but this is an important first step and a major investment for families and our most vulnerable patients.

4.3 Domain 3 – Efficiency

In a recent survey of **over 1,000 newsGP readers, 87% found the current General Practice Incentive Programs to be administratively burdensome**.

Many general practices are under significant stress due to high patient volume. Administrative processes for the General Practice Incentives and the After Hours Programs should be streamlined so they do not create an additional administrative burden on practices and providers (this includes the issues of payroll tax and assignment of benefit).

The RACGP recommends using existing platforms for any new or re-designed practice incentives so that most practices will not need to register for new software and will be able to quickly adapt and adopt incentives, should they choose to do so. We also recommend that digital interoperability be a priority, including for general practice incentive programs. This includes ensuring all administrative aspects are streamlined, interoperable and seamless to ensure the secure transfer of information across all clinical information systems (CIS) used across general practice, residential aged care facilities and equivalent software used in hospitals.

The RACGP recognises the administrative burden practices faced by practices in order to integrate incentives into their businesses and sign-up patients. Often this administrative time must be paid for at cost to the practice, reducing the

financial incentive to participate in the scheme. The RACGP support the provision of additional funding alongside incentives to compensate practices for the administrative workload of participating in the incentive.

Simplified, one-off registration procedures, that are flexible, enabling patients to change registered practices or to be able to share their care across practices are critical. Further work must ensure barriers for GPs to provide these services are reduced and many incentives would benefit from being substantially increased. For example, if the PIPQI was sufficient to fund the administration required for active participation, the general practice Incentives may be more efficient when engaged with.

We note there are some general practice incentive activities, such as Rural Loading, that occur in a GP's everyday work, and others that require more active engagement and behaviour change, which may require additional administrative support and funding. The administrative burden is particularly prominent in smaller practices and takes times away from GPs providing essential care to patients.

4.4 Domain 4 – Sustainability

Australia's population is ageing and complex with chronic conditions and mental health conditions, are becoming more prevalent. Furthermore, almost half of Australians have a chronic disease, such as heart disease, diabetes, asthma or depression. More than half of Australians over 65 years have two or more chronic diseases.[11] In addition, chronic conditions must be considered from a health equity perspective as these are more prevalent at a younger age in Aboriginal and Torres Strait Islander people and also in deprived communities. Chronic conditions are long term and require early identification and care that can be provided appropriately in the community. However, our current health system focuses on episodic, acute treatments and costly hospital care, rather than on chronic disease management or preventive care. Governments pay more for a single patient hospital admission than the cost of that same patient visiting their GP twice a week for an entire year ($5,020 compared to $3,973 respectively).[6]

Healthcare costs for patients, providers and funders are increasing at above the rate of inflation. This is partly due to the misalignment between how the current healthcare system is structured and the type of care needed (ie. to address the rising rates and chronic conditions and Australia's ageing population).

> General practice is the most efficient and cost-effective part of the healthcare system. **A well-resourced general practice sector is essential to addressing the existing and future challenges facing patients, funders and providers.**

The RACGP conservatively estimates that well-coordinated GPs could manage nearly one-third of all emergency department presentations, saving $1.5 billion a year.[12] To ensure success of the General Practice Incentive Programs, it is critical payments match the complexity of patients and are targeted to patient groups that will most benefit from wraparound general practice care.

Previous attempts at primary health reform have shown that these schemes are a significant undertaking for practices to implement. Support for that implementation can go a long way in promoting participation and ensuring practices do not incur a loss for participating in reform programs. For example, practices participating in the *Health Care Homes (HCH) trial* found these payments insufficient to cover the care of very complex patients with some practices avoiding enrolling these patients altogether.[13] Since many of the practice incentives reforms will intend to serve patients with complex conditions and circumstances, the funding currently being provided is unlikely to be sufficient, resulting in a loss for the practice.

Various RACGP members have expressed the PIPs play an important role in keeping their practices viable and their doors open. Changes to funding models require careful consideration and a smooth transition to reduce risk around access to appropriate care, poorer outcomes for Australians and general practice business viability.

GPs must be equal partners in the design of any new payment models and are engaged to achieve the desired outcomes of the various incentive programs.

New funding models or mechanisms must be trialled or implemented in a staggered approach to ensure proof of concept in the Australian healthcare system, and ensure GPs are further consulted in the design of any new models of care or funding.

Opportunities

Future areas and opportunities that can be addressed by general practice incentives may include those which encourage longer consultations, with a payment to support GPs when they have reached over a certain threshold via fee-for-service funding.

Continuity of Care and Care Coordination

An incentive that effectively encourages greater continuity of care could also be effective and sustainable, noting MyMedicare and the Indigenous Health Incentive are beginning to work towards this aim. GPs are uniquely placed to provide comprehensive, continuous and coordinated care to patients, bridging the information gap between primary, secondary and tertiary care and other health and social services. Care coordination funding, including asynchronous consultation options, is required to enable GPs to consult with specialist and allied health professionals. This may also include conferences, arranging appointments, follow-ups, organising Webster packs or further investigations required.

The Lumos data collection project investigated the benefit to cost ratio of high connectivity general practices, defined as those where greater than 30% of patients visited at least 12 times in two years. It was determined that the benefits of coordinated care outweighed the additional costs associated with higher visitation. More specifically, for every $1 spent within the primary care system, $1.60 worth of healthcare system benefits was observed.[14]

Proactive, continuous, team based coordinated care for complex patients has also been successfully demonstrated by the Department of Veterans Affairs Coordinated Veteran Care (CVC) Program when it was first initiated. An independent review of the CVC Program identified the benefits of an increased focus on coordination including improved quality of life and social connectedness, as well as avoided hospitalisations. Additionally, CVC participants reported improvements in their ability of navigate the healthcare system and self-manage, alongside related increases in health literacy. The investment in general practice also built capability in the system through enhanced collaboration between GPs and their teams, and other providers.[15]

Gender pay gap

The RACGP is calling for reforms to address equality and pay parity for female GPs.

Women are expected to make up a significantly larger proportion of Australia's GP workforce in the future with the number of female GPs growing more quickly. One of the key issues is that women GPs tend to spend longer with their patients because they see more people with complex needs. Female GPs spend 19 minutes on average with patients compared to 16 minutes for their male counterparts. However, Medicare pays less per minute for longer consultations, meaning women GPs and their patients are being unfairly penalised. Research shows this amounts to $11 less per hour on average, without accounting for maternity leave or pro rata earnings.[16]

More funding for longer consultations will make a real difference for people with complex needs across Australia. Women GPs are significantly more likely to see patients for psychological issues and women's health issues than male GPs and access to women GPs is important for communities across Australia. The General Practice Incentives have a significant opportunity to partially offset some of the high quality complex care required by many patients and to close gender pay gap that fee-for-service Medicare rebates presents.

GP Trainees Incentive

As the *2023 RACGP General Practice: Health of the Nation* report has shown Australia is facing a looming shortage of GPs, that is exacerbated by a maldistribution of the current GP workforce.

Junior doctors make crucial decisions about their career based on a range of factors, including remuneration, available entitlements and their family and personal circumstances. GPs in training face a number of financial pressures when they transition from the hospital training environment to general practice in community settings. The RACGP considers direct incentive, parental and study leave payments as the most expeditious, effective and efficient pathway to improving the conditions of registrars, preserving the direct engagement of relationships between registrars and practice owners and boosting the long-term GP workforce.

A GP registrar's true income during their community general practice training is somewhat opaque. This is due to varying percentages of billing negotiated with/by prospective junior doctors considering general practice as a career choice. The RACGP recommends a new incentive payment for GP trainees in the form of direct payments via Nationally Consistent Payments Framework and paid via Services Australia. It is critical to not just introducing innovative approaches to funding the health system but give a clear signal to future GPs that their training will be valued.

Children's health checks

Evidence indicates the first 2,000 days of life are a critical period. Interventions during this time can result in significant improvements to children's early life experiences, health and development.[17] Good health in childhood also has a long-term impact, as problems that become more apparent in adulthood often have their origins in childhood.[18] E[19]arly detection, screening and surveillance facilitated by a family's GP during these years leads to better outcomes and early intervention to give children a better chance at achieving normal ranges of development.[19]

General practice plays a significant role in providing ongoing care to women, children and their families during pregnancy and the early childhood years, along with providing the support, information and referrals to services needed to thrive.[19] GPs provide holistic family centred care pivotal to the child's long-term health and wellbeing. While all states and territories include wellbeing milestones in their early childhood health checks, there is no nationally consistent approach.[17] The final *Working together to deliver the NDIS report* from the National Disability Insurance Scheme (NDIS) review states that all Australian governments should agree as a matter of priority to expand universally available child development checks, to ensure the early identification of children with developmental concerns and disability and enable early intervention. The report also recommends this approach should be implemented by mainstream services working with children including maternal child health, early childhood education and care and general practice.

A 'children's health' general practice incentive could support consistency, assist in picking up emerging challenges children are experiencing, and support GPs to provide timely support and advice to families. The *First 2,000 Days Implementation Strategy 2020-2025* provides recommendations that could form the foundation for children's health based incentives to ensure a seamless transition from maternity to child and family health services as facilitated by their GP and to encourage every family to have a consistent relationship with a general practice that works closely with maternity and child and family health services.[19]

Another way to facilitate this could be incentivising year old health checks to encourage attendance at the recommended schedule of health checks and screenings would support optimal development of children. Prevention and health promotion in the early years, from conception to 5 years of age, is critical for an individual's lifelong health and wellbeing.[20] It may also be an opportunity to redress health inequalities.[21] Reinstating the 4 year old health checks could incentivise GPs to screen the child's functional development, capacity, independence, and participation in daily activities, along with developing early intervention goals, if needed, in collaboration with the child's family.[22] Incentivising the early childhood approach will enable best practice care to support children and their families.

General practice research

Despite GPs providing the majority of medical care in Australia, most medical research is hospital based and conducted by non-GP specialists.[23] GPs who engage and contribute to primary care research could receive incentive payments, and this may encourage more GPs to undertake research. As self-employed practitioners, time spent contributing to primary care research is incredible valuable but comes at a direct income loss for GPs. In Australia, there is a shortage of academic GPs, as well as GPs embarking on this career path.[23] Research conducted in the general practice

environment, led by GPs, has several advantages including ensuring evidence based guidelines are applicable in a practice based context.[23]

Incentivising and improving general practice-based research will enable the development and use of contextually relevant evidence-based medicine and recommendations in general practice, ultimately benefitting the patients across Australia who access general practice services.[23]

Other opportunities

Other opportunities for general practice incentives include:

- implementing Social Prescribing Programs and employing link workers
- proactive outreach for patients who are poor attenders within the practice population
- women's health
- domestic and family violence
- mental health
- access incentives for having capacity to see patients when they want to be seen
- population and community health
- preventive health.

MyMedicare

MyMedicare linked incentives have the potential to strengthen the relationship between GPs and their patients and create an environment where preventative comprehensive care is provided across the lifespan. The RACGP welcomes 'support for general practice in the management of complex chronic disease through blended funding models integrated with fee-for-service, with incentives that better promote quality bundles of care for people who need it most' as per the *Strengthening Medicare Taskforce Report*.

While we acknowledge the design of the Frequent Hospital Users (FHU) Incentive and General Practice Aged Care Incentive MyMedicare incentives are underway, further progression towards the *Primary Health Care 10 Year Plan* and *Strengthening Medicare Taskforce Report* is required to ensure funding arrangements that better reflect the increasingly complex needs of Australians and that appropriately incentivise the GPs and practice teams who care for them.

MyMedicare holds potential to meet similar goals of the general practice incentives but is currently in early stages and is reported to be administratively burdensome. We recommend an urgent priority is to increase investment in the general practice incentives program until MyMedicare is functioning optimally. This includes addressing barriers to MyMedicare's implementation such as its limited functionality and high administrative burden. There also needs to be shared and agreed upon collaborative goals for the MyMedicare program more broadly.

Conclusion

In closing, we also highlight chronic illness and pain, obesity and nutrition and social issues were raised by GPs as key concerns for the future in RACGP's *General Practice Health of the Nation 2023 report*. Revised general practice incentives hold great potential to address these concerns and better support the health of all Australians through continuous and high quality care from a well-supported general practice.

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5. References

[1] Hall J., Wright, M, Versteeg, R. General practice's early response to the COVID-19 pandemic. Australian Health Review. 2020 Sep 3;44(5):733-6.

[2] Wright, M., Hoffman, R., Petrozzi, MJ., Wise, S. General practice experiences of Australia's COVID-19 vaccine rollout: lessons for primary care reform. 2022 Oct;46(6):595-604. Available at: https://pubmed.ncbi.nlm.nih.gov/36116826/ [Accessed 14 September 2023].

[3] Australian Government, Department of Health and Aged Care. General practice workforce providing primary care services in Australia: General practice workforce 2015-22 financial years. Canberra: DoH, 2023. Available at https://hwd.health.gov.au/resources/data/gp-primarycare.html [Accessed 12 July 2023].

[4] Gupta G, Hays R, Larkins S, Reeve, C. Producing a general practice workforce: Let's count what counts. Australian Journal of General Practice. 2018;47(8):514-517. Available at https://www1.racgp.org.au/ajgp/2018/august/producing-a-general-practice-workforce [Accessed 5 December 2023].

[5] Commonwealth of Australia. Measuring what matters – Australia's first wellbeing framework. July 2023. Canberra, Australian Government. Available online: https://treasury.gov.au/policy-topics/measuring-what-matters/framework [Accessed 5 December 2023].

[6] Hardin J, Lopez-De Fede A, Stewart, J, et al. Comparison of small-area deprivation measures as predictors of chronic disease burden in a low-income population. Int J Equity Health 15, 89 (2016). https://doi.org/10.1186/s12939-016-0378-9 [Accessed 13 December 2023].

[7] Consumers Health Forum of Australia, What Australia's Health Panel said about After Hours Primary Care - February 2020, Consumers Health Forum of Australia, 2020. Available at https://chf.org.au/ahpafterhoursprimarycare [Accessed 28 9 2023].

[8] K. Barnes, D. Ceramidas and K. Douglas, Why patients attend after-hours medical services: a cross sectional survey of patients across the Australian Capital Territory. Australian Journal of Primary Health, 2022, 28(6):549-555.

[9] Australian Institute of Health and Welfare. Emergency department care, Australian Government, 2023. Available at https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care [Accessed 20 9 2023].

[10] The Royal Australian College of General Practitioners. Vision for general practice and a sustainable healthcare system. East Melbourne, Vic: RACGP, 2019.

[11] Australian Institute of Health and Welfare. Chronic conditions and multimorbidity, Australian Government, 30 June 2023. Available at https://www.aihw.gov.au/reports/australias-health/chronic-conditions-and-multimorbidity [Accessed 14 November 2023].

[12] Gibson N, Jelinek G, Jiwa M. Frequent attenders at emergency departments: a linked-data population study of adult patients. Med J Aust 2008;189(10):552–556. doi: 10.5694/j.1326-5377.2008.tb02177.x.

[13] J Pearse, D Mazevska, P McElduff, C Stone, J Tuccia, O Cho, et al. Health Care Homes trial final evaluation report, Volume 1: Summary report. 2022 Available at www.healthpolicy.com.au [Accessed 4 April 2023].

[14] NSW Health. Lumos Report – Continuity of care benefits patients and the system. August 2023, NSW Government. Available at https://www.health.nsw.gov.au/lumos/Factsheets/lumos-high-connectivity-cba.pdf [Accessed 6 December 2023].

[15] Grosvenor Management Consulting. (2015). Independent Monitoring and Evaluation of the Coordinated Veterans' Care (CVC) Program. Canberra: Australian Government Department of Veterans' Affairs.

[16] AMA New South Wales. Are we there yet? 7 May 2019. Available online https://www.amansw.com.au/are-we-there-yet/ [Accessed 12 December 2023].

[17] Australian Government. National Guidelines for inclusion of wellbeing in early childhood checks. National Mental Health Commission. 2023. Available at https://www.mentalhealthcommission.gov.au/projects/wellbeing-in-early-childhood-checks [Accessed 12 December 2023].

[18] Australian Institute of Health and Welfare. Australia's children. Australian Government, Feb 2022. Available at https://www.aihw.gov.au/reports/children-youth/australias-children/contents/health/health-australias-children [Accessed 13 December 2023].

[19] NSW Government. First 2000 Days Implementation Strategy 2020-2025. NSW Ministry of Health, 2021. Available at www.health.nsw.gov.au/kidsfamilies/programs/Publications/first-2000-days-implementation.pdf [Accessed 12 December 2023].

[20] Centre for Community Child Health. Early childhood and the lifecourse. Parkville, Vic: The Royal Children's Hospital, Melbourne, 2006 au/ emplibrary/ccch/PB1_Earlychood_lifecourse.pdf (http://www.rch.org.) [Accessed 25 May 2016].

[21] Marmot M. Fair society, healthy lives – The Marmot review. London: University College London, 2010(http://www.instituteofhealthequity.org/projects/fairsociety-healthy-lives-the-marm ot-review) [Accessed 25 May 2016].

[22] National Disability Insurance Scheme. Early childhood intervention provider reports. 30June, 2023, NDIS. Available at https://www.ndis.gov.au/understanding/families-and-carers/early-childhood-approach-children-younger-9/early-childhood-intervention-provider-reports [Accessed 13 December 2023].

[23] Abalo C, Douglas K, Heal C, Manski-Nankervis, J et al. Improving general practice research in Australia, A Journal of Gen Prac, 2023, 52(10) 734-736.