

14 July 2017

Human Services Inquiry
Productivity Commission
Locked Bag 2, Collins Street East
Melbourne VIC 8003

Dear Commissioner

Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services – Productivity Commission Draft Report Overview & Recommendations May 2017

The Royal Australian College of General Practitioners (RACGP) thanks the Productivity Commission for the opportunity to comment on its draft report, *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services* (the report).

This letter outlines the RACGP's response to the discussion and recommendations on:

- advance care planning in general practice
- patient referrals.

Advance care planning in general practice

Initiation of an advance care planning conversation in health assessments provided to people aged 75 years and older

Draft recommendation 4.3 asks the Australian Government to promote advance care planning in primary care by making 'initiation of an advance care planning conversation' a required part of a health assessment (Medicare Benefits Schedule (MBS) items 701, 703, 705, 707) for people aged 75 years and older. This would require change to MBS explanatory note A28 ('Health Assessment provided for people aged 75 years and older') to include an advance care planning conversation as an element of the assessment. The recommendation suggests that "at a minimum, this would require the general practitioner (GP) to introduce the concept of advance care planning and provide written material on the purpose and content of an advance care plan."

Our members have advised that advance care planning is an important but challenging area, as a patient's health trajectory is often unknown and will continue to change. The RACGP accepts that introduction of the concept of advanced care planning should be recognised as an activity within health assessments, but it should not be a mandatory requirement.

It may be appropriate for general practitioners and patients to discuss advanced care planning during health assessments (such as talking about wills or guardianship arrangements). However, our members have cautioned that it is difficult for a patient and their GP to plan for all contingencies. As such, a patient and their GP may undertake advance care planning prior to an acute issue being present, but the actions planned may no longer be appropriate when an acute issue arises.

Time needed for effective advance care planning

While introducing the concept of advance care planning is appropriate during a health assessment, any further advance care planning (including the provision of written material) requires significant time to complete. A requirement to include anything more than an introduction of the concept within a health assessment presents unreasonable expectations for the GP and patient.

Effective advance care planning requires significant time to undertake in order to achieve effective outcomes and assist a patient to understand their options. GPs would be best supported to facilitate advance care planning (including education, provision of materials and coordination) if it were a dedicated consultation with an accompanying MBS item number. As each state and territory has developed slightly different approaches to advance care planning, the Productivity Commission should take this into account when considering this recommendation.

Value in advanced care planning education for a wider cohort of patients

The RACGP recognises that there is value in discussing concepts surrounding end of life care. As such, we suggest the Productivity Commission's recommendation not be limited to people aged 75 years and older. The Productivity Commission could consider whether encouraging the initiation of an advance care planning conversation during health assessments for people aged 45-49 years who are at risk of developing chronic disease (MBS explanatory note A27) would be suitable.

Enabling practice nurses to facilitate advance care planning

Draft recommendation 4.3 also suggests introducing a new Medicare item number to enable practice nurses to facilitate advance care planning. While the RACGP supports recognition of practice nurse time in principle, we require further information on what requirements will be placed on a practice nurse to complete this in a general practice setting.

Where a practice nurse facilitates advance care planning, the patient's GP would still need to be involved in the preparation, development and sign-off of plans or directives for their patients. GP and nurse time for this service need to be recognised and reflected in any new MBS item numbers accordingly.

Patient referrals

GPs currently support patient choice when referring

GPs already support patient choice when referring. When a GP refers a patient to another medical specialist, the patient is usually presented with a choice at the time of the referral and consents to the referral once a shared decision has been reached. Having referral experience and patterns, as well as existing relationships with other specialists, GPs are already supporting patient choice and quality.

GPs are crucial to the referral decision making process

Draft recommendation 9.1 seeks to amend the *Health Insurance Regulations 1975* to make it clearer that patients referred to another medical specialist can choose the public outpatient clinic or private specialist they attend for their initial consultation. This recommendation includes clearly specifying

that referrals do not need to name a particular clinic or specialist and that any specialist can accept a referral to a specialist of their type, even if another specialist is named in the referral.

The RACGP raises concern with this recommendation, as inappropriate referrals may occur when patients make referral decisions without input from their GP. There are a variety of reasons why a GP should have input when a patient is referred to another specialist, including:

- GPs and other medical specialists have existing relationships

GPs develop working relationships with other medical specialists that benefit patients through better communication and access for urgent problems. For instance, an existing relationship between a GP and another medical specialist may allow for direct communication between doctors, and/or result in the patient getting an appointment with that specialist more quickly.

Completely removing the ability for the GP to nominate a particular medical specialist would reduce the opportunity for a patient to benefit from these existing relationships.

- GPs have a duty of care to follow up on patient attendance after referral to other medical specialists (for example, where a patient has an enlarged lymph node in the axilla where ultrasound shows it could be a metastasis from an unknown primary cancer)

If a patient chooses their own medical specialist for a referral and does not inform their GP, the GP may have no way of following up with the specialist for any required action. This raises medico-legal concerns around a GP's duty of care, which may be compromised if they are unable to determine whether a patient has followed up on a referral.

- GPs are the best equipped to guide their patients through the decision making process

Patient decisions are often informed by the recommendations of family and friends. While it is important to some patients to consider these recommendations, collaborating with their GP and taking advantage of their GP's expertise, experience and knowledge of other medical specialists will result in appropriate referrals. GPs will assist their patients to access the appropriate medical specialist based on the patient's unique health needs.

- Patients may lack the health literacy required to determine the appropriate medical specialist

While many will, not all patients have the required health literacy to choose their own medical specialist. Without the knowledge of specialists' roles, patients may choose the wrong subspecialty for their condition. This will result in waste of patient and practitioner time, as well as health resources.

- Changes may increase pressure on health expenditure

While recognising the importance of patient choice and the benefits of competition for potentially slowing growth in costs, further increase in choice may waste resources, increase fragmentation, and decrease provider and patient satisfaction. There is no evidence the proposed change is

necessary or that it addresses an existing problem. As filterers of care, general practice has promoted efficient use of scarce health resources for decades. The RACGP cautions the Productivity Commission about the unintended consequences of promoting patient choice at the expense of appropriate use of health resources.

The RACGP recognises, however, that there are situations when it may be appropriate for a patient to choose their own specialist. For such cases, we recommend the implementation of an opt in/out system. Under this system, referrals may name a medical specialist and include a phrase such as “or appropriate alternative provider”, allowing the patient to change the specialist. This feature could be easily built into referral templates available in medical record software.

As per draft recommendation 9.2, the RACGP is keen to work with the Australian Government to develop best-practice guidelines on how to support patient choice and shared decision making during the referral process.

I trust this information is of assistance to the Productivity Commission. Should you need any additional information, please contact me or Mr Roald Versteeg, Manger – Advocacy and Policy, on (03) 8699 0408 or on roald.versteeg@racgp.org.au

Yours sincerely



Dr Bastian Seidel
President