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Royal Australian College *of* General Practitioners

The role of government in supporting the Vision: A path to partnership

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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

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Acknowledgements

The Royal Australian College of General Practitioners' (RACGP's) revised *Vision for general practice and a sustainable healthcare system* (the Vision) has been developed with input, ideas and feedback from many dedicated RACGP members and key health stakeholders.

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- Ms Michelle Gonsalvez, National Manager, Policy and Advocacy
- Ms Susan Wall, Program Manager, Funding and Health System Reform
- Ms Jess Cutter, Senior Policy Officer, Funding and Health System Reform

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As well as contributions by RACGP members, the Vision was informed by several health stakeholders and peak bodies that also provided feedback during the consultation period. The RACGP extends its thanks to these stakeholders for their detailed and considered feedback.

The input provided by all contributors has led to the creation of a vital document that outlines a framework for excellence in healthcare. Input from a range of voices has been essential to identifying key mechanisms to address existing and future challenges facing the health of Australians and the Australian healthcare system.

1. Improving Australia's healthcare system together

> The Vision provides the solution to achieve long-term savings for the healthcare system and the Australian economy – through decreased secondary healthcare use, improved illness prevention and improved economic productivity.

Implementing and maintaining a sustainable healthcare system requires a shift in focus from reactive hospital-based care to proactive community-based disease prevention. The *Vision for general practice and a sustainable healthcare system* (the Vision) demonstrates how this can be achieved by supporting the general practice team to deliver sustainable,* equitable, high-value healthcare.

Collaboration between health providers and health funders is key to achieving the Vision. General practitioners (GPs) can provide the solutions to improving the healthcare system based on evidence and our experience working at the coalface of patient care. However, without the support of governments at all levels, we will struggle to see these solutions realised.

We estimate recurrent annual savings of up to **$4.5 billion** can be achieved by simply supporting GPs and their teams to undertake their important roles in the community. This is made up of:

- an annual saving of up to **$1.5 billion** if GPs and their teams were better supported to manage low-urgency emergency department presentations
- an annual saving of up to **$3 billion** if GPs and their teams were better supported to manage conditions commonly resulting in preventable hospital admissions.

Further savings would be achieved through better support for coordinated and preventive care and improved economic productivity due to decreased illness.

The potential for these savings has been long known, yet little has been done to change our healthcare system. The RACGP sees that deficiencies in the current general practice funding model are largely to blame.

*For the purpose of this document, 'sustainability' refers to business sustainability and the ability for general practices to maintain viable practices and continue providing high-quality care to their patients.

GPs are primarily funded by the Medicare Benefits Schedule (MBS) to undertake their roles through a fee-for-service model. This means that GPs are encouraged to see patients on an episodic basis (ie 'deal with the problem in front of them').

Other than the MBS items for chronic disease management, there is no funding to support GPs to prevent hospital admissions and manage patients before they present to an emergency department.

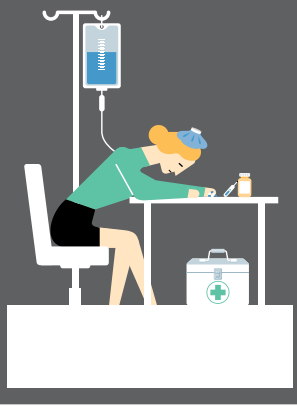
> The RACGP seeks to engage with governments at all levels to provide appropriate funding that will meet the dual objectives of implementing the RACGP Vision and saving the healthcare system billions of dollars each year.

This resource provides a high-level overview of the supports that are required to address the challenges facing general practice and the healthcare system. It is intended to guide the conversation about how GPs and all levels of government can work in partnership to achieve a sustainable high-performing healthcare system that benefits all Australians. It outlines potential changes in two broad categories:

1. Improvements to existing general practice services
2. Introducing innovative models of care

The health system now

- GPs and general practices receive limited support for providing comprehensive and complex health services
- Focus on treatment rather than prevention of illness and improving patient wellbeing
- Coordinating care is complicated due to inadequate support for multidisciplinary team-based care
- No support for basic patient use of technology to follow up with care from their GP
- Patient access to innovative, evidence-based medical services is obstructed by few incentives for quality improvement and research initiatives
- Lack of communication between general practice and hospital services
- Inadequate indexation of patient rebates leading to increasing costs for providers and patients
- Patients in rural and remote areas experience difficulty accessing health services



A vision for change

- Health services are integrated
- Funding is targeted to the delivery of preventive care and wellness advice
- Patients can access their GP using modern methods
- Patient rebates reflect the cost of providing safe, high-quality care
- Information is shared between all facets of the healthcare and social systems
- A larger proportion of research is undertaken in the health setting patients access most, general practice
- The future medical workforce is prioritised through the highest level of education and training required to provide high-quality patient care
- Patients are supported to form ongoing relationships with a GP

2. Improving existing general practice services

An appropriately supported and well-resourced general practice will have the financial ability to absorb the cost of care for patients who cannot afford to pay an out-of-pocket expense

2.1 Modernising the MBS

The MBS has remained largely unchanged since its inception in 1984 and as a result does not adequately support modern general practice. The MBS was designed before the management of chronic diseases was commonplace, and before the technology existed to facilitate the delivery of healthcare safely without face-to-face consultations.

> A fee-for-service model is, and should remain, the foundation platform for general practice funding and the primary means of support for patients accessing Australian general practice services. This model ensures that care can be provided to patients regardless of practice size, structure, infrastructure, geographic location or any other limiting factors.

Patients must have access to affordable general practice services. This is especially important for patients with limited resources. Patient rebates for general practice services provided through the MBS need to be reviewed as they have failed to keep pace with the increasing time and complexity of general practice care, and do not reflect the cost of providing safe and high-quality care.

Furthermore, the MBS overvalues procedural medicine compared with consultation medicine, and also values rapid throughput more highly than longer time spent with patients. All of these perverse incentives within the MBS make the provision of high-quality, patient-centred general practice less and less viable.

Although the MBS Review Taskforce has reviewed the appropriateness of individual MBS item numbers, it has not been successful in correcting the long-known fundamental imbalances within the MBS.

As well as increasing patient rebates for MBS services, Medicare regulation requires reform. Under the current Medicare system, when doctors need to charge a fee to cover additional expenses related to a service (eg dressings, disposable equipment), patients are required to pay the whole fee rather than the patient rebate. The patient then has to wait for reimbursement from the government. This administrative burden is unnecessary and results in larger out-of-pocket expenses for patients on the one hand, and increasing costs for practices on the other.

Coordinated Comprehensive Accessible High-quality

2.2 Appropriate recognition of GPs as medical specialists

The MBS fails to recognise GPs as specialists. General practice has evolved as a speciality since the inception of the MBS. However, the MBS still significantly undervalues GP services compared with services provided by other medical specialists, and this disparity requires urgent correction.

2.3 Supporting payments through appropriate indexation

The 'Medicare freeze' and subsequent inadequate indexation has led to the loss of more than $1 billion of general practice Medicare funding. This funding has never been reinvested back into general practice, and as a result general practice is losing tens of millions of additional funding dollars annually.

> Even as the Medicare freeze has slowly been lifted, rebates continue to decline in value as a result of inappropriate indexation.

Medicare is not indexed against the consumer price index (CPI); it is instead indexed against the wage cost index 5, which is considerably lower than both the CPI and health inflation.

All general practice payments, including patient rebates and additional support payments, must be appropriately indexed. Suitable indexation of current patient rebates and new support payments will help build genuine sustainability for general practice service delivery.

2.4 Teaching: Ensuring the sustainability of the general practice workforce

Recent medical workforce data indicate that for every GP graduate trained in Australia, there are nearly 10 non-GP specialist graduates.[1] With increasing workloads and decreased financial viability, many practices are unable to accommodate teaching and training without a financial loss. Without positive exposure and experience in primary care, health professionals (doctors, nurses, allied health professionals) are more likely to pursue a hospital-based career than one in primary care.

Enhanced funding for GPs and practices to undertake teaching is needed to better support the education of students, registrars and junior doctors working towards a career in general practice. This not only includes those working towards a career as a GP, but also students of nursing, pharmacy and allied health.

> Due to the interactions between general practice and other parts or the healthcare system, other health and medical practitioners would benefit greatly from experience in and understanding of general practice.

General practices should also be supported to provide placements for medical students or registrars working towards a career in another medical speciality.

Funding must support coordination, infrastructure and administrative duties related to placing students within general practice. For individual GPs who provide teaching and supervision, payments will support them to provide these activities and compensate for any potential loss of income from their regular practice.

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2.5 Quality improvement: Supporting practices to provide evidence-based, safe and high-quality care

> Funding for both GPs and practices through a quality improvement payment would increase the capacity of practices to undertake data analysis and to monitor and improve the quality and safety of patient care.

GPs have an important role in monitoring their patients over time. The information gathered through multiple interactions is used to guide ongoing care. The use of this data is currently restricted to individual practices in most cases, but could have a role in guiding development of health systems and appropriate allocation of resources. The capacity to re-use existing general practice data will depend on the support practices are given to improve and review the quality of their data.

The Practice Incentives Program Quality Improvement (PIP QI) provides payments for practices to share data, but additional payments are needed to support GPs in collating and analysing high-quality data. This payment should recognise the clinical leadership role GPs assume in leading quality and safety improvements and research activities. It should also recognise the role of practices in undertaking and supporting quality improvement activities.

There is a role for government to help practices maintain a high standard of safe care by supporting them to gain accreditation against the RACGP's *Standards for general practices*, 5th edition.[2]

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3. Introducing innovative models of care

In addition to modernising existing services as described in section 2, there is the potential to introduce additional funding to encourage high-quality care as described in the RACGP Vision. These payments can be made to practices and GPs who are providing continuous, comprehensive, coordinated and team-based care.

In order to encourage flexibility of care by practices, including care provided appropriately in non–face-to-face settings and by multiple members of the practice team, payment for additional services could be provided through the existing Practice Incentives Program (PIP). Care could also be provided through an enhanced Service Incentive Payment (SIP) to GPs. Alternatively, a modernised MBS could provide additional fee-for-service payments for non–face-to-face care, or for care delivered by the broader practice team.

3.1 Continuity of care: Formalising the relationships between patients and their GP by introducing voluntary patient enrolment

> Over 80% of Australians have a usual GP and 90% a usual practice.[3] However, in the current system there are high levels of fragmentation, with no formal system for practice enrolment and patients frequently attending multiple general practices.[2]

The Australian Government and state and territory governments have a role in supporting:

- the provision of continuing care rather than episodic treatment of illness
- preventive healthcare
- monitoring of health outcomes
- better coordinated care within practices as well as across the broader healthcare system.

Continuity of care can be facilitated by formalising the relationship between patients and their GP and practice through voluntary patient enrolment (VPE). Under a voluntary system, patients will be able to choose whether to enrol with a practice, and GPs and practices will choose whether they wish to offer enrolment.

3.1.1 VPE will bring benefits for patients, providers and funders

It is important that all patients have the opportunity to enrol with a preferred practice. An ongoing relationship with a regular GP is highly valued by all patients. The Australian Government's Health Care Homes trial involved VPE for patients with chronic and complex conditions. However, limiting VPE to patients with chronic disease will reduce the opportunity for other patients to benefit and will restrict wider improvements to the healthcare system.

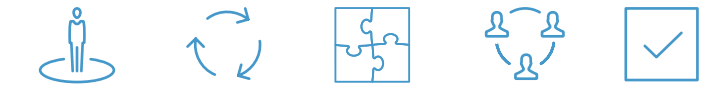
VPE will facilitate practices to better understand the population that they are caring for, allowing for effective planning and use of resources.

Implementing VPE

VPE is a mechanism to enable continuity of care and direct additional funding outside of fee-for-service to support the provision of high-quality, comprehensive and coordinated care.

Enrolled patients will be expected to receive the majority of their care from their enrolled practice with their preferred GP. Enrolled patients should continue to be able to access all payments, including rebates via fee-for-service as currently administered through the MBS. Differential rebates for care provided at enrolled practices, versus non-enrolled practices, could also be introduced into the MBS. This would provide further incentive for patients to access the majority of their care from their regular GP or practice.

In practical terms, GPs should be supported to engage in meaningful discussion with patients to describe the benefits of enrolment and establish mutual obligations. Mechanisms must be put in place to minimise any risk of gaming, whereby patients are enrolled superficially to enable a practice to bill an enrolment fee. At the same time, this structure will support the additional time required to enrol a patient.



3.2 Health service coordination: Improving coordination between community and hospitals

As well as providing high-quality general practice care, GPs also have a significant role in supporting their patients as they encounter the broader health system. This stewardship role involves helping patients gain timely access to the health and social services they need, as well as ensuring that limited health resources are not wasted on duplication or fragmented care.

Additional funding is needed for GPs to manage patient transitions between their general practice care and the rest of the health system. This involves supporting care coordination and integration activities. This funding will also encourage improved handover when patients return from hospital if there is timely and meaningful communication between general practices and other service providers, including hospitals.

As part of their role in coordinating care for patients, GPs have a significant stewardship role in guiding patients through the complex health system. The stewardship role of GPs not only provides an essential support to patients, but also brings significant savings by providing clinically appropriate referrals to other health providers. GPs' stewardship role also reduces duplication and unnecessary care.

> The savings generated from better coordination should be reinvested to support GPs and practices to coordinate care.

Funding to support coordination of care should be available for all patients, but may be tiered in order to account for the differing needs of patients. For example, patients with chronic and complex disease(s) could require different levels of coordination and support based on whether they have low, medium or high care needs.

There has been an increase in recognition from other health professionals, other medical specialists and pharmacists of the value of liaising with a patient's GP to improve continuity and reduce fragmentation of care. Unfortunately, this recognition has not been matched with a genuine solution or commitment to ensuring that GPs are appropriately supported for their care coordination and health steward role.

All of the mechanisms outlined in the Vision recognise that care must be coordinated through a patient's GP and that GPs must be supported to undertake this central role.

Patient-centred Comprehensive Coordinated Accessible

3.3 General practice infrastructure: Ensuring that practices have the tools required to provide comprehensive care

> The indirect costs of running a practice, such as the costs associated with improving the infrastructure required to provide quality care, are not supported by the current funding structure.

Practices should be provided with funding to support physical and IT infrastructure, enabling the adoption of new technologies and increases to practice capacity, as well as:

- maintenance and improvements to physical infrastructure
- maintenance or introduction of new IT hardware/software
- the training required to ensure quality use of technology.

Enabling the adoption of these activities or supports would assist in:

- ensuring that practices have the appropriate space to provide safe and high-quality comprehensive care
- improving the management of patient information
- reducing administrative burdens
- improving service integration
- facilitating a more comprehensive range of services to be provided
- encouraging the delivery of non–face-to-face care
- recognising patient complexity and responding to health inequalities with a complexity loading payment.

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3.4 Recognising patient complexity: Responding to health inequalities with a complexity loading payment

Based on the enrolled practice population, a complexity loading payment to GPs and practices could be calculated according, but not limited, to:

- socioeconomic status of the community in which the practice operates
- rurality of the practice
- medical workforce shortage (based on state/territory/national programs)
- areas of social dislocation and poor public transport
- number of patients who identify as an Aboriginal and/or Torres Strait Islander person
- age of individual patients.

People in rural and remote Australia experience worse health outcomes, with high levels of complex conditions and chronic disease, as well as higher rates of potentially preventable hospitalisations.[4]

The GP-to-patient ratio decreases as remoteness increases, meaning that there are fewer GPs per person in regional and remote settings.[5] Addressing Australia's general practice workforce maldistribution issue will help to address these health inequities.

GP shortages in rural areas has been an ongoing issue in Australia that successive governments have yet to solve. Common responses by state/territory governments and the Australian Government, such as training more doctors, or providing monetary incentives for them to work in rural or remote locations, have failed to adequately address these issues.[6]

> An innovative and multifaceted solution must be implemented to address the maldistribution of GPs in rural and remote areas. In order to be successful, any approach taken must identify and address the root cause of maldistribution in these settings.

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3.5 General practice research: Ensuring a high-quality and evidence-based primary healthcare system

> Inadequate evidence relevant to general practice hinders GPs' efforts to provide evidence-based care, as guidelines developed from research in other settings may not be appropriate for their patients.[7,8]

As the cornerstone of primary healthcare delivery, general practice research requires additional funding mechanisms that support:

- the maintenance of existing practice-based research networks
- a national program for research training in general practice
- a general practice research Fellowship program, offering eight 4–5-year Fellowships to develop GP research leaders

- National Health and Medical Research Council (NHMRC) grants for research projects specific to general practice (ie projects with direct relevance to general practice and that involve one or more GPs as chief investigators)
- an NHMRC centre for research excellence in general practice/primary care.

Practices should also be supported to participate in general practice research through an appropriate practice payment.

High-quality

3.6 Comprehensive care: Supporting patients to access the range of services they require

> Targeted payments support general practices to continue to offer a wide range of additional services, beyond those considered standard general practice services.

Additional services may include:

- planned preventive healthcare
- aged care in the community
- residential aged care
- palliative care
- facilitating or providing after-hours services
- home visits (where appropriate)
- minor procedures
- mental health services
- Aboriginal and Torres Strait Islander health services
- services that are appropriate to other population groups, including refugees and culturally and linguistically diverse patients.

To be eligible for payments, practices could demonstrate the comprehensiveness of the services that they provide. Provisions could also be put in place for a percentage of the payment to be apportioned to the GPs directly providing the services.

Comprehensive Patient-centred Continuous Coordinated Accessible

3.7 Team-based care: Enhancing team-based approaches to care

A team-based care payment for practices would support the employment of the entire general practice team, including nurses, Aboriginal and Torres Strait Islander health practitioners/workers, allied health professionals and non-dispensing pharmacists.

It would be vital for such a payment to be made available to all practices, regardless of their location, in order to support equity of access for patients.

Patient-centred Continuous Comprehensive Coordinated Accessible

4. Next steps

By improving existing funding arrangements and introducing further supports to introduce innovative models of care in general practice, the RACGP believes that significant savings would be achieved for funders, patients and providers.

The RACGP looks forward to working with all levels of government to collaboratively develop and introduce appropriate models for improving healthcare in the interests of all Australians.

References

1. Australian Institute of Health and Welfare. Medical practitioners workforce 2015. Cat. no. WEB 140. Canberra: AIHW, 2016.
2. The Royal Australian College of General Practitioners. Standards for general practices. 5th edn. East Melbourne, Vic: RACGP, 2017.
3. Wright M, Hall J, van Gool K, Hass M. How common is multiple general practice attendance in Australia? Aust J Gen Pract 2018;47(5):289–96.
4. Duckett S, Griffiths K. Perils of place: Identifying hotspots of health inequalities. Melbourne: Grattan Institute, 2016. Available at https://grattan.edu.au/wp-content/uploads/2016/07/874-Perils-of-Place.pdf [Accessed 22 May 2019].
5. Department of Health. GP workforce statistics – 2001–02 to 2016–17. Canberra: DoH, 2018. Available at www.health.gov.au/internet/main/publishing.nsf/content/ general+practice+statistics-1 [Accessed 3 May 2019].
6. Duckett S, Breadon P, Ginnivan, L. Access all areas: New solutions for GP shortages in rural Australia. Melbourne: Grattan Institute, 2013. Available at https://grattan.edu.au/wp-content/uploads/2014/04/196-Access-All-Areas.pdf [Accessed 3 May 2019].
7. Scullard P, Abdelhamid A, Steel N, Qureshi N. Does the evidence referenced in NICE guidelines reflect a primary care population? Br J Gen Pract 2011;61(584):e112–17.
8. Steel N, Abdelhamid A, Stokes T, et al. A review of clinical practice guidelines found that they were often based on evidence of uncertain relevance to primary care patients. J Clin Epidemiol 2014;67(11):1251–57.

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