RACGP

Royal Australian College *of* General Practitioners

2016–17 pre-budget submission

February 2016

General practice, front and centre

www.racgp.org.au

Healthy Profession.
Healthy Australia.

The RACGP's 2016–17 pre-budget submission

Disclaimer

Assumptions and recommendations in this submission are based on the evidence available at the time of writing. References to this evidence are provided throughout this submission.

Published by
The Royal Australian College of General Practitioners
100 Wellington Parade
East Melbourne, Victoria 3002 Australia

Tel 03 8699 0510
Fax 03 9696 7511
www.racgp.org.au

Published February 2016

We recognise the traditional custodians of the land and sea on which we work and live.

Introduction

The Royal Australian College of General Practitioners (RACGP) would like to thank the Federal Government for the opportunity to contribute to discussions regarding the 2016–17 Federal Budget.

About the RACGP

The RACGP is Australia's largest professional general practice organisation. We represent more than 30,000 members working in or towards a career in general practice in urban and rural areas. The RACGP is responsible for:

- defining the nature and scope of the discipline
- setting the standards, curriculum and training
- maintaining the standards for quality clinical practice
- supporting general practitioners (GPs) in their pursuit of excellence in patient care and community service.

This submission

GPs and their teams provided more than 140 million Medicare Benefits Schedule (MBS)-subsidised services to the Australian population in 2014–15.[1] They are integral to the Australian healthcare system, with more than 83% of the Australian population consulting a GP during that same period.[2]

This submission presents four strategies for investing in patient healthcare through better supporting general practice:

1. Reversing the freeze on MBS indexation
2. Establishing Learning hubs for general practice training with additional community training places
3. Piloting a voluntary patient enrolment and coordination of care program
4. Prioritising general practice research

Summary of recommendations

Reversing the freeze on MBS indexation

The Royal Australian College of General Practitioners (RACGP) recommends that the Federal Government reverses the freeze on indexation of the Medicare Benefits Schedule (MBS) and commits to ensuring indexation keeps pace with the costs of providing quality healthcare services

Establishing Learning hubs for general practice training with additional community training places

The RACGP recommends that the Federal Government:

- creates an additional 200 full-time equivalent (FTE) intern, and postgraduate year 2 and 3 (PGY2 and PGY3) placements in community settings in 2016–17, increasing by 50 places per year to 400 places by 2020–21
- establishes Learning hubs, potentially co-located within Primary Health Networks (PHNs), to coordinate and support community placements across urban, regional and rural areas

Piloting a voluntary patient enrolment and coordination of care program

The RACGP recommends that the Federal Government commits $162.3 million over three years to pilot a voluntary patient enrolment and coordination of care program across 500 urban, regional and rural general practices and Aboriginal Medical Services (AMSs)

Prioritising general practice research

The RACGP recommends that the Federal Government prioritises primary healthcare research and:

- commits $27 million over nine years to establish a general practice research fellowship program, offering eight 4–5-year fellowships to develop general practitioner (GP) research leaders
- allocates 10% of the National Health and Medical Research Council's (NHMRC) project grants budget to general practice-specific research projects (ie projects with direct relevance to general practice and which involve one or more GPs as chief investigators)
- invests $2.5 million to establish an NHMRC Centre for Research Excellence in General Practice/Primary Care
- invests $200,000 per annum to support the maintenance of practice based research networks, specifically the Australian Primary Care Research Network (APCReN)
- provides $2 million per annum across university departments of general practice and rural health to facilitate practice-based research networksprovides
- implements a practice incentive payment to enable practices to facilitate and implement research

1. Reversing the freeze on MBS indexation

Issue

The indexation of MBS patient rebates is inextricably linked to the MBS's capacity to function as a mechanism to support universal access to healthcare, regardless of a patient's financial circumstances.

However, MBS patient rebates have not kept pace with the costs of providing high-quality primary healthcare services, and the indexation freeze imposed from July 2015 worsens this. Evidence has comprehensively shown that primary healthcare services, including Aboriginal and Torres Strait Islander primary healthcare services, prevent expenditure on expensive hospital services.[3–6]

The RACGP reiterates that the Government must reverse the freeze on MBS indexation. The freeze will increase out-of-pocket costs for patients, affecting their access to quality general practice services while driving an increase in hospital expenditure.

Action required

The indexation of MBS patient rebates should keep pace with the cost of providing quality healthcare services. This would require indexation at a rate greater than the traditional indexation measure (Wage Cost Index [WCI5]) applied prior to the commencement of the indexation freeze in 2015.

Recommendation

The RACGP recommends that the Federal Government reverses the freeze on indexation of the MBS and commits to ensuring indexation keeps pace with the costs of providing quality healthcare services.

2. Establishing Learning hubs for general practice training with additional community training places

Issue

There is growing and unmet demand from Australian and New Zealand medical students, and post intern medical officers for medical placements in Australia. The number of Australian and New Zealand medical school graduates has risen by 79% in the past seven years. In 2014, 3437 domestic and international medical students graduated from Australian universities, while an additional 396 medical students graduated from universities in New Zealand.[7] At the same time, there are many post-intern medical officers seeking placements due to a shortage of places in specialist medical training.

This large increase in graduates seeking internships and post-intern medical officers seeking placements in Australian hospitals has not been mirrored by an increase in hospital resourcing capacity. As a consequence, hospitals are facing overwhelming pressure to provide placements and training for junior doctors.[8] Anecdotally, this has impacted on junior doctors' development and career pathways, with significant implications for patient care and capacity. Projections of graduate numbers show that this issue will continue to worsen.[8]

Junior doctors' exposure to community-based medicine varies between states and territories, but is generally limited. Improving exposure for junior doctors is critical to ensuring all doctors have an understanding of community-based medicine, whether they progress to specialise in general practice or another specialty.

The RACGP welcomes the recent funding announced in the 2015–16 Mid-Year Economic and Fiscal Outlook (MYEFO) for 60 full-time equivalent (FTE) prevocational training places through the postgraduate medical training pathway in rural and regional areas. As a large cohort of RACGP Fellows and Members

were closely involved in the Prevocational General Practice Placements Program (PGPPP), the RACGP is ideally placed to coordinate these placements. The brightest and best doctors are required in general practice. The journey from rural clinical student to intern and general practice specialist should be seamless, encouraging community-based practice while addressing workforce maldistribution issues.

Additionally, a national strategy is required across all geographic and socioeconomic areas to meet intern demands, embed community placements as part of internships and junior doctor training, and address workforce shortages in underserved areas.

Action required

An immediate increase of an additional 200 FTE intern, PGY2 and PGY3 places can be achieved through the creation of community-based placements with general practices and community-based specialists.

'Community placement learning hubs' (Learning hubs), potentially co-located within Primary Health Networks (PHNs), would be required to support community placements, and integrate the training within community settings and local contexts. A focus on developing placements in areas of identified need could be a feature of this program. The Learning hub approach will use pre-existing infrastructure to deliver on-site and off-site training, independent of community placement posts, which would focus on supervisory activities.

The benefit of this approach is the separation of teaching and supervisory roles, a major impediment to the recruitment of appropriate placements.

Training participants would continue to be paid through the responsible hospital, with general practice patient consultation fees retained by the practice. Learning hubs would receive an administrative and education fee commensurate with their scope of operation. This remuneration model is similar to many international programs, where trainee doctors are supernumerary staff members in community training settings, which allows learning opportunities without the impediment of commercial pressures.

Recommendations

The RACGP recommends that the Federal Government:

- creates an additional 200 FTE intern, PGY2 and PGY3 placements in community settings in 2016–17, increasing by 50 places per year to 400 places in 2020–21
- establishes Learning hubs, potentially co-located within PHNs, to coordinate and support community placements across urban, regional and rural areas.

3. Piloting a voluntary patient enrolment and coordination of care program

Issue

One in every three Australians has a chronic disease. Two in three have at least three or more risk factors for heart disease, diabetes or chronic kidney disease.[9,10] Multimorbidity, the presence of multiple chronic conditions in a single individual, is increasingly common.[11]

The population is also ageing. Currently, one in seven people is older than 65. By 2060, this will increase to one in four people. Older people have more encounters with GPs and need more time during consultations.[12]

Urban–rural disparities in Australia across health status, life expectancy and prevalence of disease are also widely documented.

These factors will lead to increased and sustained health service demand, requiring a more coordinated approach to preventing and managing chronic and complex health issues.

At the same time, waste of scarce resources is abundant in the healthcare system. The Australian Institute of Health and Welfare (AIHW) reports that more than 600,000 patient admissions to hospitals were preventable.[13] Of the seven million emergency department presentations during 2013–14, 760,000 (10%) presentations were for care that could have been provided in general practice.[14] Together, these cost up to $3.2 billion in health spending each year.[15] While reducing this waste cannot be considered as 'cashable savings' to the Federal Government, reducing waste will improve efficiency, sustainability and, most importantly, the health of Australians.

Action required

The RACGP's *Vision for general practice and a sustainable healthcare system* (the Vision) presents the solution to these issues. The Vision advocates for the adoption of the patient-centred medical home (PCMH) model in Australia. Health organisations who adopt the PCMH model place the patient at the centre of care, provide a comprehensive and accessible range of services, coordinate patient care and focus on quality improvement.[16]

Evidence shows that the PCMH model has positive outcomes across a range of measures, including lower use of emergency departments, increased provision of preventive services, and improved experiences for patients and staff.[17–22]

The first steps for implementing the Vision are to:

- introduce a system for voluntary patient enrolment with a preferred GP and general practice
- establish a better approach to coordinating care for enrolled patients with chronic diseases.

Voluntary patient enrolment for all Australians

Why?

- Voluntary patient enrolment promotes stable and enduring relationships through creating a formal link between patients and their GP
- Continuity of care (seeing the same healthcare professional consistently) reduces emergency department use and preventable hospital admissions[23]
- Continuity of care contributes to an overall lowering of costs, increased patient satisfaction and greater efficiency[24–26]
- Patient enrolment can minimise unnecessary duplication of service

How?

- All Australians should be allowed to voluntarily enrol with a GP and general practice of their choice
- Patients would enrol during a consultation with their preferred GP
- Patients would be encouraged to access services from their enrolled practice and preferred GP, but not prevented from accessing care from other providers if necessary
- A GP would assume responsibility for an enrolled patient's care (with defined parameters)
- The practice would support access to a range of services in line with the needs of their enrolled patient population, while also facilitating continuity of care (eg through maintenance of recall and reminder systems, advising of after-hours arrangements, providing immunisation and preventive care)
- Continuity of care for enrolled patients would be measured and recognised

Coordination of care for patients with chronic disease

Why?

- Improving patient transitions between healthcare providers and sectors will help patients to stay in the community longer and reduce hospital admissions
- Patients who have chronic and complex diseases require longer consultations, with a significant amount of work done outside a face-to-face consultation

How?

- GPs and general practices play a role in supporting a system for coordinating and integrating care
- Health service coordination requires comprehensive needs assessment, collaborative planning and regular follow-up and review
- Enrolled patients with chronic and complex health needs who require care coordination should have access to three tiers of care coordination, with services allocated based on assessment of need
- Patients with the most complex needs receive higher intensity coordination of care
- Dedicated care coordinators (GPs, general practice nurses, other qualified members of the general practice team) would actively coordinate care for patients with the highest level of need
- Only enrolled patients would have access to coordination of care services through their enrolled practice
- Remodeled Chronic Disease Management MBS items would allow better targeted care, with streamlined administrative processes (refer to page 24 of the Vision)

Recommendation

The RACGP recommends that the Federal Government commits $162.3 million over three years to pilot a voluntary patient enrolment and coordination of care program across 500 urban, regional and rural general practices and Aboriginal Medical Services (AMSs).

Table 1. Pilot funding over three years to 2018–19

	2016–17	2017–18	2018–19
Pilot funding ($ millions)	$48.5	$56.0	$57.8

Spending on existing MBS item numbers, including chronic disease management items, is not included in these estimates.

Table 2. Pilot funding breakdown			
	2016–17	**2017–18**	**2018–19**
Voluntary patient enrolment			
Enrolment payment ($ millions) A nominal, once-per-enrolment fee would cover the administrative costs of enrolment (claimed by the GP, similar to the operation of MBS items 10990 and 10991)	$9.3	$2.5	$1.0
Continuity of care payment ($ millions) A continuity of care payment would recognise and support ongoing relationships where a patient seeks a majority of care during a specific period from their enrolled practice	$0.0	$13.7	$16.3
Coordination of care for enrolled patients			
Coordination payments ($ millions) A quarterly payment to a practice for the coordination of care for enrolled patients who require the most intensive level of care	$39.2	$39.8	$40.5

4. Prioritising general practice research

Issue

Primary healthcare is fundamental to ensuring the health of all Australians. An effective and evidence-based primary healthcare system must be underpinned by rigorous research. Traditionally, medical research has been conducted in the hospital sector. However, as the vast majority of illnesses are managed in primary healthcare settings, government investment in research needs diversification to include greater support for primary healthcare research.[27–30]

A strong primary healthcare research sector linked to practice-based research networks increases opportunities for research findings to be translated into practice.[31] Many important research questions are unique to the general practice environment, where patients present with early and/or undifferentiated disease and multiple co-morbidities. These patients tend to be excluded from other research. Primary healthcare research also provides opportunities to engage high-priority populations who need special recruitment strategies, such as Aboriginal and Torres Strait Islander patients, and low socioeconomic and other 'hard-to-reach' populations.[32]

However, there are significant barriers to GPs participating in research:[33,34]

- GPs generally receive minimal research method training
- there are no clearly defined clinical research career pathways
- general practice research infrastructure is underdeveloped
- there is a lack of support for practice-based research networks
- research funding is inadequate.

Research funding distribution is disproportionate to the clinical importance of primary care research. Between 2000 and 2008, fewer than 2% of National Health and Medical Research Council (NHMRC) grants awarded were for primary care research.[35]

Inadequate primary healthcare-relevant evidence hinders GPs' efforts to provide evidence-based medicine. Guidelines developed from research in other settings may not be appropriate for general practice patients.[36,37]

Experience in the UK, Canada and The Netherlands shows that government policy can strategically strengthen primary healthcare research and researchers, leading to improved healthcare delivery, and better patient outcomes.

Given 83% of Australians see a GP each year, funding for primary healthcare research is vital and will have the greatest potential reach and population impact.[2]

Actions required

Career support for the general practice research workforce

Facilitating the growth of a strong general practice research workforce is paramount. Developing and investing in a career structure for academic GPs will build Australia's capacity to conduct general practice research and provide support for academic GPs to become research leaders.

A program offering fellowships to GPs at different career stages (early, mid and established) would support development of the general practice research workforce, providing the following range of fellowships to GPs:

- early career
- career development
- research
- practitioner.

Similar GP fellowship models operate in a number of other countries. In the UK, the National Institute for Health Research (NIHR) offers fellowships that can be undertaken within specialist training programs, enabling registrars to undertake both research and clinical training. The NIHR In-Practice Fellowships offer academic training to qualified GPs with little formal academic training, while the Clinician Scientist Award addresses disincentives against a clinical academic career.[38] Canada has similar programs.

Flexible funding conditions are also required to attract a range of GP researchers, including allowing full-time and part-time research work.

Dedicated funding for general practice research

The level of funding provided for general practice research projects should correlate with the pivotal role of general practice in the Australian healthcare system. It must accommodate researchers from a broad range of disciplines, taking into account the differences in research output for primary care research compared to basic sciences. Funding should also cover clinical and health services research that are relevant to general practice.

Support for general practice research infrastructure

General practice research infrastructure requires support to develop through:

- ongoing infrastructure support for general practice-based research networks to function as the 'laboratories' for rigorous, high-quality general practice research[39]
- establishing collaborative research networks and forums to increase GPs' research literacy. This can be achieved through discussions of problem cases, formulation of research questions, development of experimental designs, and facilitation of the dissemination and uptake of research findings
- funding general practices to facilitate and implement research initiatives.

The UK has successfully supplied infrastructure support to such networks by providing coordination staff and services, such as biostatisticians, to:

- support primary care research
- undertake randomised controlled trials on research questions of clinical relevance to provision of evidence-based primary healthcare
- coordinate national research activity in primary care.[40,41]

Recommendations

The RACGP recommends that the Federal Government prioritises primary healthcare research and:

- commits $27 million over nine years to establish a general practice research fellowship program, offering eight 4–5-year fellowships to develop GP research leaders
- allocates 10% of the NHMRC's project grants budget to general practice-specific research projects (ie projects with direct relevance to general practice and which involve one or more GPs as chief investigators)
- invests $2.5 million to establish an NHMRC Centre for Research Excellence in General Practice/Primary Care
- invests $200,000 per annum to support the maintenance of practice based research networks, specifically the Australian Primary Care Research Network (APCReN)
- provides $2 million per annum across university departments of general practice and rural health to facilitate practice-based research networks
- implements a practice incentive payment to enable practices to facilitate and implement research.

References

1. Department of Health. Annual Medicare statistics. Phillip, ACT: ABS, 2014. Available at www.health.gov.au/internet/main/publishing.nsf/Content/Annual-Medicare-Statistics [Accessed 7 April 2015].
2. Australian Bureau of Statistics. Patient experiences in Australia: Summary of findings 2014–15. Belconnen, ACT: ABS, 2015. Available at www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4839.0Main+Features12014-15?OpenDocument [Accessed 1 February 2016].
3. Bazemore A, Petterson S, Peterson LE, Phillips RL. More comprehensive care among family physicians is associated with lower costs and fewer hospitalizations. Ann Fam Med 2015;13(3):206–13.
4. Thomas SL, Zhao Y, Guthridge SL, Wakerman J. The cost-effectiveness of primary care for Indigenous Australians with diabetes living in remote Northern Territory communities. Med J Aust 2014;200(11):658–62.
5. Zhao Y, Thomas SL, Guthrige SL, J W. 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 Serv Res 2014;14:463.
6. Macinko J, Starfield B, Shi L. The contribution of primary care systems to health outcomes within Organization for Economic Cooperation and Development (OECD) countries, 1970–1998. Health Serv Res 2003;38(3):831–65.
7. Medical Deans Australia and New Zealand. Student statistics. Sydney: MDANZ, 2015. Available at www.medicaldeans.org.au/statistics/annualtables [Accessed 1 February 2016].
8. Australian Health Ministers' Advisory Council. Review of medical intern training – Final report. Adelaide: COAH Health Council, 2015.
9. Australian Institute of Health and Welfare. Australia's health 2014. Bruce, ACT: AIHW, 2014.
10. Australian Institute of Health and Welfare. Cardiovascular disease, diabetes and chronic kidney disease – Australian facts: Risk factors. Bruce, ACT: AIHW, 2015.
11. Harrison C, Britt HM, Miller G, Knox S. Prevalence and patterns in multimorbidity in Australia. Med J Aust 2008;189:72–77.
12. Britt H, Miller GC, Henderson J, et al. General practice activity in Australia 2014–15. Sydney: Sydney University Press, 2015.
13. Australian Institute of Health and Welfare. Admitted patient care 2013–14: Australian hospital statistics. Bruce, ACT: AIHW, 2015.
14. Australian Institute of Health and Welfare. Australian hospital statistics 2013–14: Emergency department care. Bruce, ACT: AIHW, 2014.
15. Independent Hospital Pricing Authority. National hospital cost data collection: Australian public hospitals cost report 2011–12 (Round 16). Sydney: Independent Hospital Pricing Authority, 2014.
16. US Department of Health and Human Services. Defining the PCMH. Washington, DC: DHHS, 2015. Available at https://pcmh.ahrq.gov/page/defining-pcmh [Accessed 11 August 2015].
17. Alexander JA, Bae D. Does the patient-centred medical home work? A critical synthesis of research on patient-centred medical homes and patient-related outcomes. Health Serv Manage Res 2012;25(2):51–59.
18. Fishman PA, Johnson EA, Coleman K, et al. Impact on seniors of the patient-centered medical home: Evidence from a pilot study. Gerontologist. 2012;52(5):703–11.
19. Jackson GL, Powers BJ, Chatterjee R, et al. The patient-centered medical home – A systematic review. Ann Intern Med2013;158(3):169–78.
20. Markovitz AR, Alexander JA, Lantz PM, Paustian ML. Patient-centered medical home implementation and use of preventive services: The role of practice socioeconomic context. JAMA Intern Med 2015;175(4):598–606.
21. Nielsen M, Gibson A, Buelt L, Grundy P, Grumbach K. The patient-centered medical home's impact on cost and quality: Annual review of the evidence 2013–14. Washington, DC: Patient-Centered Primary Care Collaborative, 2015.
22. Rosenthal MB, Friedberg MW, Singer SJ, Eastman D, Li Z, Schneider EC. Effect of a multipayer patient-centered medical home on health care utilization and quality: The Rhode Island chronic care sustainability initiative pilot program. JAMA Intern Med 2013;173(20):1907–13.
23. Canadian Institute for Health Information. Continuity of care with family medicine physicians: Why it matters 2015. Ottawa, Ont: Canadian Institute for Health Information, 2015. Available at https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC2865 [Accessed 14 January 2015].
24. Worrall G, Knight J. Continuity of care is good for elderly people with diabetes. Retrospective cohort study of mortality and hospitalisation. Can Fam Physician 2011;57(1):e16–e20.
25. Hollander MJ, Kadlec H, Hamdi R, Tessaro A. Increasing value for money in the Canadian healthcare system: New findings on the contribution of primary care services. Healthc Q 2009;12(4):32–44.
26. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q 2005;83(3):457–502.
27. Horton R. Evidence and primary care. Lancet 1999;353(9153):609–10.
28. Department of Health and Family Services. Report of the general practice strategy review group – General practice: Changing the future through partnerships. Canberra: Department of Health and Family Services, 1998.

29. Thomas P. The research needs of primary care: trials must be relevant to patients. BMJ 2000;321(7252):2.
30. Van Der Weyden MB. General practice research in Australia: A timely reality check. Med J Aust 1999;173(11–12):569–70.
31. Beasley JW, Starfield B, van Weel C, Rosser WW, Haq CL. Global health and primary care research. J Am Board Fam Med 2007;20(6):518–26.
32. Bonevski B, Randell M, Paul C, et al. Reaching the hard-to-reach: A systematic review of strategies for improving health and medical research with socially disadvantaged groups. BMC Med Res Methodol 2014;14(1):42.
33. Jowett S, Macleod J, Wilson S, Hobbs F. Research in primary care: Extent of involvement and perceived determinants among practitioners from one English region. Br J Gen Pract 2000;50(454):387–89.
34. Stange KC. Primary care research: Barriers and opportunities. J Fam Pract 1996;42(2):192–98.
35. McIntyre E, Mazza D, Harris N. NHMRC funding for primary health care research, 2000–2008. Med J Aust 2011;195(4):230.
36. 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–e17.
37. 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.
38. National Insitute for Health Research. NIHR Integrated academic training programme for doctors and dentists. London: NIHR, 2015. Available at www.nihr.ac.uk/funding/integrated-academic-training-programme.htm [Accessed 16 January 2016].
39. Gunn JM. Should Australia develop primary care research networks? Med J Aust 2002;177(2):63–6.
40. National Institute for Health Research. Clinical research network – Primary care. London: NIHR, 2015. Available at www.crn.nihr.ac.uk/primarycare [Accessed 19 January 2016].
41. Scottish Primary Care Research Network. About us. Dundee: SPCRN, 2015. Available at www.sspc.ac.uk/spcrnaboutus-item [Accessed 19 January 2016].

RACGP

Royal Australian College *of* General Practitioners

Healthy Profession.
Healthy Australia.