RACGP

Royal Australian College *of* General Practitioners

RACGP Submission:

Report from the Medicare Benefits Schedule (MBS) Review's General Practice and Primary Care Clinical Committee

8 March 2019

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Report from the Medicare Benefits Schedule (MBS) Review's General Practice and Primary Care Clinical Committee

1. Executive Summary

The Royal Australian College of General Practitioners (RACGP) cautiously welcomes a number of recommendations in the Report from the General Practice and Primary Care Clinical Committee (the Committee) (GPPCCC Report), and calls on other recommendations to be amended or removed.

Given the scope of the GPPCCC Report, the RACGP consulted members on the Committee's 18 recommendations and addresses each recommendation in this submission. This submission also provides additional feedback and recommendations relating to the Committee and MBS Review.

1.1 Key recommendations

The RACGP calls for the Committee to:

- endorse the RACGP's Vision for General Practice and a sustainable healthcare system as the preferred patient-centered primary care model supporting general practitioner (GP) stewardship
- revise the phrasing referring to patients as experts in their care, and instead refer to patients as partners in their care
- state that funding for patient enrolment should support continuity of care, as opposed to the process of enrolment
- undertake modelling to determine the value of differential rebates for enrolled and non-enrolled patients
- recommend amendments to Medicare rules that stipulate that general practice consultations must be conducted face to face
- amend recommendation to equalize rebate value across General Practice Management Plans and reviews, to ensure that it does not result in a net loss of funding for general practice patients
- remove the recommendation of a 40 minute timeframe for General Practice Management Plans
- encourage patient attendance at case conferences, but not make this mandatory as part of the item descriptor
- remove the recommendation to delete health assessments lasting more than 30 minutes and instead recommend that the rebate of this service be increased to accurately cover the cost of providing the service
- expand the eligibility for the proposed health assessment for prisoners on discharge to apply to all prisoners on discharge, as opposed to limiting to those who have had a sentence of six months or more
- remove the recommendation for a reduction in the rebate for Domiciliary Medication Management Reviews and Residential Medication Management Review items
- recommend an increase to the rebates for all patients requiring hospital, institution and home visits, not just those who are enrolled with a General Practice Management Plan. In addition, the same increase should be applied to residential aged care facility visits
- remove the recommendation for a minimum of six minutes for a Level B consultation

- provide further recommendations aimed at increasing support for longer consultations through reweighting time tiers and reducing time intervals of consultation items
- recommend an urgent increase to the rebate value of new item numbers for residential aged care visits (items (90020, 90035, 90043, 90051) – in addition to recommending a flag fall fee
- provide further recommendations aimed at ensuring that patient rebates accurately reflect the cost of providing care
- recommend an MBS item to support shared care appointments
- recommend that the MBS better recognise and remunerate the skills and experience of specialist GPs.

2. Introduction

The RACGP thanks the Medicare Benefits Schedule (MBS) Review Taskforce for the opportunity to comment on recommendations made in the Report from the General Practice and Primary Care Clinical Committee (the Committee).

The RACGP is Australia's largest general practice organisation, representing over 40,000 members working in or toward a career in general practice. The RACGP advocates for affordable, equitable and safe access to high quality health services, which facilitate the best possible health outcomes for all Australians.

To date, the RACGP has provided several submissions to the MBS Taskforce and various clinical committees regarding recommendations relating to general practice. The RACGP also reviewed the MBS items commonly used in general practice, identifying where the MBS can better support general practice patients. Recommendations from this review were provided directly to the MBS Review Taskforce in March 2017. We note that a number of our recommendations have been considered by the GPPCCC.

When discussing general practice funding there needs to be a clear delineation between acute and chronic condition care. The fee for service model is appropriate for acute episodic care. Patients with chronic or complex medical conditions may have better outcomes with a different model of care, this seems to be the focus of this paper.

3. Feedback on recommendations 1-18

3.1 Recommendation 1 – A patient-centred primary care model supporting GP stewardship

The RACGP supports the move to a patient-centered primary care model supporting GP stewardship in principle. However, this would represent a significant change for the sector and as such the Committee and Taskforce (or anyone responsible for designing, developing and implementing a model) must undergo rigorous consultation with the RACGP.

The RACGP has developed a patient centered primary care model that can fulfill this recommendation. The RACGPs Vision for general practice and a sustainable health care system (the Vision) is a framework for excellence in healthcare and provides the solution to address a range of issues and pressures currently facing the Australian healthcare system. The Vision demonstrates how realigning funding to support internationally recognised features of high-quality general practice will facilitate the successful delivery of an equitable and sustainable healthcare system, benefiting patients, providers and funders.

The RACGP's Vision is currently open for member and stakeholder consultation and is due for final publication later this year. The RACGP recommends that the Committee endorse the Vision as the preferred blueprint for developing and supporting an appropriate model of patient centered primary care.

3.1.1 Considerations for implementing a patient-centred primary care model

Any model developed needs to support GPs and general practices to respond to the pressures faced by the Australian healthcare system, including:

- a growing and ageing population
- an increasing prevalence of chronic and complex health conditions
- changes in the delivery of general practice, including practices growing in size, and GPs working fewer hours
- an increase in costs for patients, providers and governments
- uncertain and poorly targeted funding
- lack of incentives in the current system to support care in the community and to avoid expensive hospitalisation
- poor equity of access to services for Aboriginal and Torres Strait Islander peoples, people living in rural areas, and people from culturally and linguistic diverse (CALD) backgrounds.

A patient-centered primary care model should simplify requirements for GPs, not make them more difficult. Any model developed must avoid increased red-tape and overly complicating services and processes for GPs and their teams. The current MBS is unnecessarily complicated and GPs spend too much time trying to understand its intricacies – time they could otherwise spend with patients.

Changes to funding required to implement a patient-centred primary care model should result in an overall increase in funding to primary care and not rely on shifting existing funds – as seen in the government's Health Care Homes trial. If block payments are introduced, they should support and complement, not replace, the existing fee-for-service funding component of general practice.

Consumer education must be prioritised when implementing a patient-centered primary care model. Patients will need to understand the model and its value to them so they can appreciate the holistic approach to their care and what is required of their GP and practice to provide such care.

3.1.2 Patients as 'experts'

In its definition of patient-centered care, the Committee refers to 'putting people and their *families* at the centre of decisions and seeing them as *experts*, working alongside professionals to get the best outcome.' The RACGP recommends that the Committee rephrase this statement. The RACGP supports *patients as partners* in their healthcare and decision making.

One of the established fundamental issues with regards to the doctor-patient relationship is the "asymmetry of information" that exists between the doctor and the patient. By this very definition the patient cannot and does not want to be the 'expert'. Modern medicine has rejected the paternalistic approach to medicine where the doctor tells the patient what is best. It is important to note that GPs do take a shared decision making approach when planning patient care.

It must be recognised that families do not always want the same things that patients want. Considering a patient and their family as equal and experts has medico-legal implications in the event of an adverse outcomes.

In the same vein, it is not fair and equitable to say the GP and patient are together equal and expert if something goes wrong and the GP is deemed at fault. Shared decision making is critical but this is not the same as using the term 'expert'. The patient's needs and wants are not always aligned and failing to meet a patient's wants must never be a performance indicator for expert GPs providing specialist medical advice.

3.2 Recommendation 2 – Patient enrolment

3.2.2 Payment of enrolment fees

The RACGP supports a move toward patient enrolment, however does not support a single 'fee for enrolment'.

The model proposed by the Committee intends to pay a practice for each patient it enrols. This will:

- emphasise a reward for the initial enrolment, rather than support ongoing continuity
- create a risk of predatory enrolments or financial gaming of the system.

Patient enrolment is a mechanism for encouraging the development of continuity of care. Therefore, funding for enrolment must be directed toward encouraging continuity of care as opposed to funding the process of enrolment. The benefits of continuity of care relate to a long term doctor patient relationship, and while some funding needs to be provided to support the extra time taken to explain enrolment to patients, ongoing payments to practices are needed to provide enhanced care for enrolled patients.

Broader patient enrolment funding should recognise both the practice's role in supporting a GP to provide a broad range of services to the community as well as the GPs role in providing ongoing care.

In addition, any model for patient enrolment needs to be carefully evaluated for part-time GPs.

3.2.3 Differential rebates for enrolled patients

The Committee recommends several aspects of care (flexible access, chronic disease management) be linked to patient enrolment. It is unclear from the report what the implications would be for non-enrolled patients (eg if it is intended there would be differential rebates).

The value of the service provided by the GP as to whether the patient is enrolled for non acute care is the same (eg suturing a patient). There may be additional value to the patient for being enrolled for certain conditions. When the actual or potential benefit is described the practitioner who provides the additional value should be remunerated. A differential rebate is one method for recognising and rewarding the additional value.

Both enrolled and unenrolled patients should continue to receive rebates via fee-for-service as currently administered through the MBS. However, the RACGP recommends that modelling be undertaken to estimate the effect and value of differential rebates for care provided to enrolled patients, versus non-enrolled patients. Increasing funding to provide care for enrolled patients, would provide a further incentive for patients to access the majority of their care from their regular GP or practice.

Differential rebates would benefit patients with higher health needs, such Aboriginal and Torres Strait Islander patients, and patients with complex and chronic disease. Failure to recognise the high health needs of patients could result in lower enrolment rates for these groups.

3.2.1 Voluntary patient enrolment

The RACGP supports *voluntary* enrolment that sees a patient identify a preferred GP at their practice, while also being able to access care from other GPs within or outside of the practice as needed. Under a voluntary system, patients are able to choose whether to enrol with a practice, and GPs and practices can choose whether they wish to offer a patient enrolment.

A voluntary enrolment system must support patients who:

- present with emergency concerns at another practice
- wish to change their nominated GP or practice
- are geographically mobile (consideration of whether payments can be shared between practices in such circumstances is needed)
- are unable to visit their usual practice and need to seek care at another practice (eg practice closure or no appointments available).

3.3 Recommendation 3 – flexible access to care through non face-to-face services

The RACGP supports the facilitation of existing GP-patient relationships by encouraging care to be delivered flexibly (including the use of non-face to face care) by the patient's usual GP. The best option for achieving this is for removal of the MBS rules that stipulate that MBS consultation items can only be claimed when a patient is present face to face.

3.3.1 Preventing abuse of flexible systems

A model supporting flexible access for patients needs to consider mechanisms that prevent the establishment of digital-only health clinics, who enrol patients to receive remote services online. Face-to-face services should not be discouraged in the process of increasing access to non-face-to-face services. Physical examination is still a vital part of clinical care and cannot be replaced by digital technology.

In chronic care an ongoing relationship with the patient is vital to releasing the value inherent in the GP having a holistic knowledge of the patient's medical and social context. This can only be developed through regular face-to-face and non face-to-face clinical visits. Digital only models are akin to episodic fragmented care of the patient and are unlikely to deliver the demonstrated benefits that this paper proposes.

3.3.2 Protecting GP wellbeing

Safeguards need to be put in place to ensure that GP wellbeing is protected with the introduction of increased service accessibility and flexibility.

Safe working hours for GPs must be maintained. GPs who work 40 hours or more a week have a less positive perception of their work-life balance than those working fewer than 40 hours.[1] Without appropriate restrictions in place for flexible access, there is room for patients to overload GPs with requests (eg an expectation they can email and get a response at any time), which may lead to work dissatisfaction and burnout. Patient and provider education will be required to ensure that flexible access to care does not have adverse effects for GPs.

The decision for the use of non-face-to-face types of consulting should rest with the patient's GP, as they bear the medico-legal responsibility for ensuring that appropriate, safe care is provided.

3.4 Recommendations 4, 5 and 6 – Chronic Disease Management items

3.4.1 Combining General Practice Management Plans and Team Care Arrangement items and redistributing rebates between plans and reviews

While some redistribution of funding between plan and review may be appropriate (eg disincentivising the preparation of a management plan only, and providing more support for reviews), the RACGP does not support a net reduction in Chronic Disease Management funding, which is likely to occur under the recommendations as proposed by the Committee.

Recommendation 4 does not account for the full suite of Chronic Disease Management items available to a patient each year. In one year, a patient can currently claim one General Practice Management Plan (721), one Team Care Arrangement plan (723) and three reviews for each of those plans (six 732s). Bulk billing incentives are also applicable to some patients for each of these services.

Equalising the value of rebates across the plan and reviews incentivises use of the full Chronic Disease Management Suite (2x plan and 6x reviews) -however, many patients do not receive or require the full Chronic Disease Management suite. In such cases, Recommendation 4 will devalue the patient's plan.

3.4.2 Setting a minimum of 40 minutes for General Practice Management Plan

The RACGP does not support a minimum 40 minute timeframe for the completion of a General Practice Management Plan. A General Practice Management Plan can be fully developed in under 40 minutes especially where the patient is well known to the GP.

Where there is adequate auditing measures and compliance consequences for those creating sub-standard care plans, there should be no need for an arbitrary time measurement.

An alternative to time based chronic disease management items is to tier rebates based on patient complexity. This would align more closely to the Department of Veteran Affairs model, which the RACGP supports.

3.4.3 Linking allied health services to General Practice Management Plans

Recommendation 5 includes changes to allied health descriptors (10950-10970 and 81100-81125), removing references to the patient's Team Care Arrangement and clarifying that allied health services will be instead linked to the creation of a General Practice Management Plan.

The RACGP agrees that this change will increase efficiency; however, the additional requirements in communicating with other team members (ie phone calls, letters) must be considered when reviewing the rebate value of a General Practice Management Plan, and result in an overall increase in funding.

3.5 Recommendation 7 – Care facilitation

The RACGP strongly supports the introduction of coordination payments to support care facilitation – however, the best way to achieve requires careful consideration and rigorous consultation. This care facilitation must relate to patients with chronic and complex care needs.

Of the options presented by the Committee, our members indicated a preference for:

- "block funding for care facilitation, outside the MBS", and
- "new fee-for-service funding for care facilitation under the current set of items available for allied health appointments, for patients with a GPMP"

Members noted that either of these approaches could improve GP funding, but come with specific advantages and disadvantages.

Providing block funding for practices to provide care facilitation (potentially for their enrolled patients) would allow flexibility in providing care facilitation to patients as needed. While fee for service funding would create a clearer record of activity and ensure payment goes to the person doing the facilitation work in the practice, although with decreased flexibility for practice

The RACGP does not support the option of PHNs providing care facilitation services using funding outside of the MBS. Many PHNs do not have the skills or resources available to implement effective care facilitation strategies. Experience has also shown that the further funding is removed from patient care, the less likely it will actually benefit patients. The role of care coordination should therefore occur within general practice, as close to the patient as possible.

If funding for care facilitation falls outside of the MBS (for example, block payments), this could have an effect on a patient's Medicare Safety Net threshold. If this is the option put forward, the Committee must also recommend that the Medicare Safety Net threshold be reduced accordingly.

3.6 Recommendation 8 and 9 – patient engagement

3.6.1 Engaging patients in their own care planning

The RACGP supports patient involvement as partners in their care planning, but would like more information on how such advice and support mechanisms will be developed and implemented. Our members report that they already engage patients in their own care planning, where appropriate.

3.6.2 Patient attendance at case conferences

The RACGP supports the inclusion of patients in case conferences and shared decision making; however, patient attendance should ultimately be at the discretion of the practitioner and not determined by the item descriptor. There will be circumstances where a patient's delegate would be a more appropriate person to attend case conferencing eg patients with dementia and some (few) mental conditions. The emphasis should be include the patient where appropriate.

Case conferences are often used for the health practitioners' benefit and the presence of the patient can sometimes be a barrier to open discussion. These include multidisciplinary care team meetings where complex patient presentations are discussed by clinicians (with patient consent) with a goal to determine the best treatment options, referral pathways, and so on.

Cases where patient presence may be problematic include palliative care, mental health and alcohol and other drugs. In other instances, family meetings with care teams, discharge planning, and treatment planning case conferences are ideal to have patient and family or carers present. In some of these cases, it is appropriate to have a family member or carer present without the patient. These circumstances should also be supported through the MBS.

Implementing this recommendation as currently proposed by the Committee could:

- add logistical complexity in requiring a patient to attend a case conference
- increase the duration of case conferences due to time required for practitioners to explain concepts to the patient in layman's terms.

3.7 Recommendation 10 and 11 – Health assessments

3.7.1 Evidence-based health assessments

The Committee recommends that processes be set up to gather evidence on the effectiveness of Health Assessments with a focus on at-risk populations, including using data at a Primary Health Network (PHN) level.

The RACGP supports the intent of this recommendation – to collect evidence to understand the effectiveness of Health Assessments. However, our members have indicated a preference to avoid PHN involvement. Many PHNs do not have adequate access to data to undertake an effectiveness study and do not have the necessary skills or resources to undertake this type of work.

It is vital for any health service to be evidence-based and have benefits that outweigh potential harm. Evidence reviews should be undertaken by existing GP research networks and any data used must remain de-identified. The RACGP recommends that the Committee also identify what other evidence reviews are required, such as for pharmacy health checks and interventions.

3.7.2 Deletion of health assessments lasting less than 30 minutes (item 701)

The RACGP does not support the removal of health assessments lasting less than 30 minutes. We understand that the deletion of item 701 is based on an increase in longer health assessments and fewer short assessments being claimed.

The Committee has suggested that services currently considered as health assessments under 30 minutes can be 'more appropriately billed as a general consultation. The RACGP does not agree that reduced use of item 701 is an indication of its clinical need.

A more likely scenario is that the rebate value for a 30 minute 701 is too low, and as a result GPs bill a general consult item as an alternative – potentially impacting the accuracy of data and any analysis on their use. Rather than removing the item, the RACGP recommends increasing the rebate to accurately reflect the cost of providing the service.

It appears premature to remove these health assessments before the evidence for them has been evaluated (as identified in recommendation 10 of the report – see section 3.7.1 of submission). More information about the rationale for deleting item 701 is needed in order for the RACGP to comment further.

3.7.3 Expanding eligibility to new at-risk populations and modifying existing populations to better align with clinical and service needs

The RACGP supports expanding eligibility for health assessments to new at-risk populations (including newly added groups such as children in out-of-home care, and prisoners on discharge) and reflecting the *Guidelines for preventive activities in general practice* 9th edition (Red Book) and the *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people* (National Guide).

People who have been incarcerated have high health and social support needs related to the social determinants of health. It is an ethical and public health priority that these patients receive the medical attention they need both in prison and on leaving prison. Furthermore many of these health problems contribute to re-incarceration which creates a substantial cost burden.

The proposed GP health assessment item for patients after release from prison will allow GPs to provide holistic healthcare to this high needs population at a crucial healthcare transition point. GPs can support patients leaving prison by:

- working with the patient to maintain the health gains achieved in prison, such as ensuring psychiatric medications are continued and patients are linked to community healthcare and support networks
- ensuring treatments commenced in prison are completed, such as Hepatitis C treatments
- following up with healthcare management plans commenced in prison. This is particularly valuable for those who were in prison for relatively short sentences, where screening and investigations may have commenced but substantial follow up is required.

The RACGP recommends this health assessment be available to any person incarcerated, rather than just for those with a six months sentence.

This health assessment item has potential to enhance care for Aboriginal and/or Torres Strait Islander people who are disproportionately represented in prison populations. However, there needs to be consideration of the rebate amount in comparison to the Aboriginal health assessment (715) and whether both can be claimed within a given timeframe.

3.8 Recommendation 12 – Medication management reviews

The RACGP does not support a reduction in the rebate for Domiciliary Medication Management Reviews and Residential Medication Management Review items. Medication errors are a common cause of hospitalisation and devaluing these items may reduce general practice uptake of these measures (eg it may not be financially viable to provide a medication review). Investing in patient safety interventions to prevent adverse medication events and preventable hospitalisations may be cost-effective or even cost saving.

A current requirement for Domiciliary Medication Management Review is that a reviewing pharmacist provide a written report as well as discussing findings with the GP (face-to-face or by phone). Our members have highlighted that many Domiciliary Medication Management Reviews are completed by locum pharmacists who can be difficult to contact due to the transient nature of their work.

3.9 Recommendation 13 – Increasing rebate for hospital, institution or home visits for enrolled patients with a General Practice Management Plan

The RACGP recommends that the increased schedule rebates for hospital, institution and home visits be applied for all patients, not just enrolled patients with an existing General Practice Management Plan. Often patients require care at a hospital, institution or home before they are able to arrange a visit to their practice for a General Practice Management Plan. Also, home visits are not always related to chronic disease management – more commonly, they are for acute issues.

Our members report that these visits, along with those to residential aged care facilities, can take significant time and result in additional loss of practice consulting time (ie due to travel time and distance, administration arrangements, inconvenience, lack of access to necessary technology, etc). As such, increased funding for these services needs to factor in such hidden costs to the GP.

If the Committee decides to put forward the recommendation as it stands, it should be explicit that rebates should not be tied to the single GP who wrote the patient's General Practice Management Plan given that:

- some practices (including Aboriginal Medical Services) utilise team arrangements, in which it is common for different GPs from the practice to see a patient
- GPs who share patients will be unfairly penalised, as will GPs who cover for a patient's usual GP when they are unable to attend (eg holiday cover)
- there is potential for a GP who is not the patient's usual GP to create the General Practice Management Plan, allowing the patient to access a higher rebate only when seen by them, not their usual GP.

3.10 Recommendation 14 – Minimum of 6 minutes for a Level B consultation

The Committee has recommended changing the descriptors for level B consultations (items 23, 5020 and 5023) to state that the consultation length should be a minimum of 6 minutes.

The RACGP does not support this recommendation. Setting a minimum time for level B consultations would have unintended consequences on patient care.

Level B consultations are currently time and content based. In most circumstances, a consultation that meets the requirement of the Level B descriptor will be more than 6 minutes in length. However, there are circumstances where the requirements for a level B consultation are met in less than 6 minutes.

For example, an experienced GP can efficiently and effectively see a patient with a viral upper respiratory tract infection – examine their ear, nose and throat, measure their blood pressure and discuss preventive health – in under six minutes.

Enforcing a minimum time will act as a disincentive for efficient practice and patients receiving efficient services will effectively have their patient rebate cut.

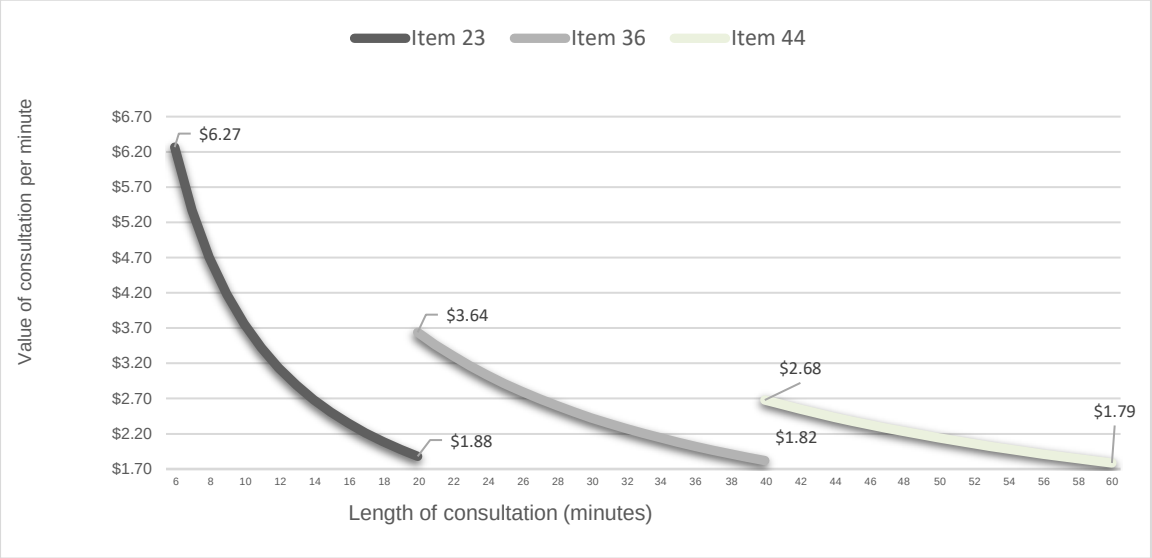
The RACGP recommends that rather than reduce funding for brief consultations, priority should be given to increasing the funding for longer consultations and reducing the incentive within the current system which reward rapid care.

3.11 Recommendation 15 – Introducing Level E consultation for 60 minutes or more

The RACGP supports Recommendation 15. However, introduction of a Level E consultation alone will not address the underlying issue of MBS time tiers and lack of support for longer consultations.

The RACGP agrees with the Committee that improved patient outcomes are associated with longer, comprehensive consultations for patients who have complex health concerns. However, the rebate values for consultation levels A–D currently drop in value every minute (Table 1), disadvantaging patients who require more time with their GP. This is due to both poor weighting of rebate values, and overly long time intervals.

Table 1. Value per minute of general practice consultations



Introducing a level E rebate alone, without reconsideration of rebate values or intervals, will only exacerbate the current issues with time tiered consultations.

3.12 Recommendation 16 – Residential aged care facility visits

GPs spend significant time performing unremunerated work related to residential aged care facilities attendances. Some of our members report unremunerated factors contributing to up to half their time when visiting patients in residential aged care facilities. These factors include:

- traveling to and from a residential aged care facility
- trying to locate the patient when onsite
- liaising with a patient's family and carers
- liaising with nursing and support staff, hospital staff, allied health staff, and other specialists
- gathering information on the patient's medical history
- follow-up phone calls post-consultation
- writing progress notes at the residential aged care facility and at their practice
- discussion with pharmacists and providing repeat prescriptions (especially providing Schedule 8 drugs for palliative care patients)
- completing paperwork requested by the residential aged care facility (eg adjustments to medication charts, reports on health status).

The Committee recommends changing the structure of rebates for residential aged care facility attendances (items 20, 35, 43, 51, 92, 93, 95 and 96) to reflect an initial flag fall rebate and a stable rebate for each consultation completed during the residential aged care facility visit.

The RACGP notes that in the 2018-19 MYEFO, the federal government committed to investing $98 million over four years from 2018-19 towards MBS rebates for these services by introducing a flag fall fee to the value of $55. The new flag fall fee was introduced on 1 March 2019, alongside new base rebates to replace the existing items.

The RACGP has previously advocated for this change as the current diminishing Medicare rebate per patient seen is a barrier for GPs supporting their patients in residential aged care facilities. It also prevents GPs from being able to raise a bill to cover the additional costs of providing care in this setting.

The changes for introduction in March, in particular the flag fall, goes some way to recognising the costs of attending a residential aged care facility. However, the changes have resulted in a reduction in funding for GPs providing more than 17 services at an aged care facility. This is not acceptable, and must be rectified as a priority. GPs, regardless of the number of services provided, must be supported to provide aged care services.

The RACGP calls for the Committee to recommend an increase to the rebate value of new item numbers for residential aged care visits (items (90020, 90035, 90043, 90051) – this will ensure that GPs seeing many patients in one visit are not disadvantaged by the change.

There already is some concerns regarding the new RACF items numbers. For example, it is not clear whether the non face-to-face time can occur away from the nursing home. For many patients within a RACF who have significant dementia (for example) the patient's presence may not add to the services being provided for the practitioner. The RACGP strongly recommends reviewing the details regarding the recent changes to RACF resident rebates.

3.12.1 Additional investment in aged care

The RACGP recommends further aged care investment, in addition to an added flag fall. Schedule rebates for services at residential aged care facilities should be increased, in line with Recommendation 13 to increase the schedule rebate for services at a hospital, institution or home (and, in turn, a flag fall should be implemented for those services).

While the RACGP is supportive of the additional (albeit limited) funding, which goes some way to recognise the costs of attending a residential aged care facility, we note that there is currently no alternative solution to replace the removal of the General Practitioner Aged Care Access Incentive. The removal of this incentive from May 2019 will result in a $3000 to $5000 yearly loss for GPs providing care to patients in residential aged care facilities. Increasing the scheduled rebate for patients in residential aged care facilities is needed to support these services in the absence of the General Practitioner Aged Care Access Incentive.

3.13 Recommendation 17 – Changing terminology that MBS uses to describe registered and enrolled nurses

The Committee recommended that the terminology currently used in the MBS to describe registered and enrolled nurses and their role be modernised to reflect the role of these health professionals as members of the practice team. This recommendation specially focussed on the use of the term 'practice nurse' (which was said to conflate the distinct groups of enrolled and registered nurses) and the language of 'for and on behalf of' (which does not appropriately reflect the role of nurses).

The RACGP supports this recommendation with the proviso that any changes to terminology should not influence a registered or enrolled nurse's scope of practice, which is based on the skills and experience of the relevant nurse.

3.14 Recommendation 18 – Telehealth

The RACGP supports the modernisation of consultative medicine via greater access to non-face to face services, such as telehealth. The RACGP sees the best option to achieving this is through the removal of rules in the MBS that stipulate that consultations must be provided face to face.

To prevent misuse of non-face to face care, it is important for these services to be provided:

- by the patient's usual GP or practice wherever possible, or that care is coordinated with the usual GP or practice
- via acceptable and secure telehealth platforms
- to patients who also physically attend their usual practice.

The RACGP's position on on-demand telehealth services is available on our website.

4. Additional feedback and recommendations

The RACGP has considered additional recommendations for general practice (some the RACGP has previously called on the MBS Review to implement), which have not been included in the GPPCCC Report. These recommendations are outlined below.

4.1 More general practice investment through Medicare

The RACGP strongly recommends that the Committee provide further recommendations to address funding shortfalls of the current general practice model.

4.1.1 Current funding for general practice consultations is unsustainable

MBS patient rebates have failed to keep pace with inflation and do not reflect the cost of delivering high quality general practice services. Patient out-of-pocket costs continue to increase each year, as government funding fails to offset the growing cost of services. While patient rebates have never accurately reflected the cost of providing care, this underfunding has been exacerbated by funding freezes introduced by successive governments, and using the Wage Cost Index 5 (WCI5) as a method of indexation, which is considerably lower than both the consumer price index (CPI) and health inflation.

Costs to provide care have continued to increase year on year, but the government has failed to match these increases in the patient rebate.[2] As a result, the government's contribution to patient care now only covers around 50% of total cost to the patient for privately billed care.[3]

General practices are facing mounting costs for staff and consumables and many cannot afford to offer care at the rate that government is willing to pay for it.

Some recommendations from the Committee will result in a net loss of funding for general practice. Rather than reducing GP funding through these recommendations (such as placing a 6 minute limit on level B consultations and removing shorter health assessments), the MBS Review needs to increase funding for high quality care (such as level C and D consultations, and for regular chronic disease management).

4.1.2 Investing in general practice will bring benefits for patients, health providers and health funders

Given the majority of patient care in Australia is provided by GPs, it is essential that patient visits to their GP are appropriately funded.

Despite being the most accessed form of healthcare, general practice services represent only 7.4% of total government (including federal, state and territory, and local) health expenditure.[4]

In the past year, almost 90% of Australians received care from GPs and their teams. Over 80% of patients have a usual GP and 90% a usual practice.[5] However, care is fragmented with no formal system for practice enrolment – patients frequently attend multiple general practices.[6]

Local and international evidence shows that better support for and use of general practice is associated with:

- lower emergency department presentations and hospital use[7,8,9,10]
- decreased hospital re-admission rates[11]
- health benefits for Aboriginal and Torres Strait Islander communities[12,13]
- achieve significant savings for the healthcare system[14]

The effect of fragmented care and inadequate support for general practice in Australia is costing the country billions of dollars each year. In 2016–17, 6% of all hospital admissions were the result of 22 preventable conditions that could have been appropriately managed by general practices. These conditions resulted in more than 2.8 million bed days nationwide.[15] If general practice was appropriately supported to manage these conditions in the community, it would have saved the government a conservatively estimated $3 billion AUD.*[16]

Mental Health Services]

The RACGP recommends the addition of longer mental health consultations that align with the funding for Level D and E items.

The current items for mental health visits of 20 minutes fails to support patients with significant mental illness especially during the acute phases of their illness. Patients with complex medical conditions have access to Level D and soon Level E consultations. Patients with mental health illnesses should be afforded the same level of access as patients presenting with physical medical concerns.

4.1.3 Funding to support implementation of recommendations from the MBS Review

While the many recommendations from the MBS Review will bring long term financial savings for Australia, most will require initial investment. It is essential that the implementation of recommendations from the MBS Review does not result in an increased cost burden for general practices.

The RACGP notes that in its 2018-19 Mid-Year Economic and Fiscal Outlook (MYEFO), the federal government committed to funding $17.5 million over four years from 2018-19 for chronic disease management (CDM). The MYEFO provided no further detail regarding this funding.

The RACGP would like further information on how this funding will affect the implementation of recommendations in the GPPCCC Report (including recommendations 1–6).

* Calculated using the average cost ($1000) for a preventable hospital admission patient day.

4.1.4 Reinvestment of savings from MBS Review

The federal government has committed to reinvesting MBS Review savings back into Medicare. The RACGP calls on the Committee and Taskforce to provide more transparency into reinvestment by detailing what savings will be made, and the additional spending is required, across the Committee's recommendations. The RACGP would also like to see, in detail, how the MBS Review savings have been (or will be) reinvested into the health system, particularly into general practice.

4.2 Recognising GPs as specialists

Calculations show that scheduled patient rebates for GP services are consistently undervalued when compared to those for other medical specialist consultations, even after adjusting for years in training between specialisations. The RACGP reiterates its call for a loading of at least 18.5% to be applied to all GP consultation scheduled rebates to bring them to the level of other specialist consultation items.

In addition, the RACGP recommends that the Committee support recognition of specialist GP skills and experience within the MBS. Unlike most other industries, more experienced GPs do not financially benefit from the skills and experience they gain over time. This can limit:

- general practice as a desirable vocation
- engagement with chronic or complex patients
- practice leadership and ownership.

4.3 Shared medical appointments

There is currently no MBS support for patients who attend a shared medical appointment facilitated by their usual GP. The RACGP recommends that the Committee support introducing MBS rebates for patients who attend shared medical appointments.

Many GPs run group sessions for their patients (eg in suicide prevention or following disasters). Shared medical appointments can help to reduce demand and improve efficiency in general practice. They can also empower patients with tools for self-care.

Shared medical appointments:

- increase clinical and cost-efficiency
- improve clinical teamwork (eg GPs can work alongside other members of their team during a shared appointment to share knowledge and increase patient literacy)
- increase patient/provider satisfaction (eg patients feeling they have had more face-time with their GP, even if one-on-one time within the group is brief)
- reduce repetitious workloads (eg GPs can provide the same relevant information to multiple patients at the same time)
- make clinical practice more engaging (eg patients are engaged with other patients and can learn from shared communications between their GP and a range of individuals).

4.4 Support for patient requiring interpreters

The RACGP recommends that the Committee consider how the MBS can support patients that require an interpreter. While medical practitioners have access to fee-free interpreting via the Translating and Interpreting Service, the low take-up rate has been attributed by many to insufficient financial remuneration for practice costs and additional consultation time required.

A recent study reported that 5% of all private practice consultations involved communicating in a language other than English, yet only 1% of these included use of a trained interpreter.[17]

While GPs can claim a longer rebate to reflect the longer consultation, many are hesitant to do so out of fear of inadvertently breaching Medicare compliance. The MBS must be explicit that the additional time required in a consultation as a result of using an interpreter can be considered as part of the overall consultation time, and the complexity of the consultation.

In addition, the current poor weighting of rebate values (explained in detail in Section 3.11) means that patients who require interpreters, and therefore longer consultations, are disadvantaged in terms of rebate per minute. Adding further rationale to the need to address the current diminishing rebate per minute of general practice consultations.

4.5 My Health Record

The success of My Health Record will directly relate to the level of medical note curation by GPs. GPs are ideally placed to ensure that the contents of My Health Record are up to date and relevant to the patient. The RACGP recommends that an item number be introduced to support GPs in undertaking these activities.

The RACGP supports the idea of a national electronic health record and notes that several of the Committee's recommendations include the addition of a nominated GP being responsible for maintaining their patient's My Health Record.

General practice teams generate a large amount of data for My Health Record, including authorship of Shared Health Summaries. In addition to creating clinical content for documents such as Shared Health Summaries, participating in My Health Record also involves ensuring the necessary practice policies and processes are established and maintained to meet technological and regulatory requirements. As a key contributor to My Health Record through the creation of Shared Health Summaries and other forms of health data, general practice should be financially supported to participate through an appropriate incentive scheme.

The RACGP does not support the current Practice Incentive Payment – eHealth Initiative (ePIP), under which benefits are paid solely to the practice, and which uses arbitrary upload targets as a criterion for eligibility.

In addition to the current lack of an incentive model to support improvements in data quality in general practice, there are currently no agreed requirements to ensure information uploaded to My Health Record is fit for sharing. The RACGP supports the development of initiatives that would drive data quality in the sector, which would in turn support the quality of information that is uploaded to My Health Record.

The RACGP's position on My Health Record is available on our website.

4.5 Ongoing support for the MBS Review

The RACGP notes the recent decision for the MBS Review to conclude by mid-2019, despite commitment to fund the review until at least 2020 in the 2017–18 Federal Budget.

The RACGP recommends an ongoing review of the MBS to ensure that all items remain relevant and effective.

5. Conclusion

The RACGP looks forward to hearing about the final recommendations and outcomes from the Committee, and further participation in future MBS Review consultations.

If you have any questions or comments regarding this submission, please contact Ms Susan Wall, Program Manager – Funding and Health System Reform, on (03) 8699 0574 or at susan.wall@racgp.org.au

6. References

[1] Royal Australian College of General Practitioners. Health of the Nation 2018. East Melbourne, RACGP, 2018.

[2] Australian Institute of Health and Welfare. Health expenditure Australia 2016–17. Cat. no. HWE 74. Canberra: AIHW, 2018. Available at www.aihw.gov.au/reports/hwe/073-1/health-expenditure-australia-2016-17/contents/table-of-contents [Accessed 12 February 2019].

[3] Department of Health. Annual Medicare statistics – Financial years 1984–85 to 2017–18. Canberra: DoH, 2018. Available at www.health.gov.au/internet/main/publishing.nsf/Content/Annual-Medicare-Statistics [Accessed 12 February 2019].

[4] Productivity Commission. Report on government services. Canberra: Productivity Commission, 2019. Available at www.pc.gov.au/research/ongoing/report-on-government-services [Accessed 12 February 2019].

[5] Australian Institute of Health and Welfare. Australia's health 2018. Canberra: AIHW, 2018.

[6] Wright M, Hall J, van Gool K, Haas M. How common is multiple general practice attendance? Aust J Gen Pract 2018;47(5):289–96.

[7] Pereira Gray DJ, Sidaway-Lee K, White E, Thorne A, Evans PH. Continuity of care with doctors – A matter of life and death? A systematic review of continuity of care and mortality. BMJ Open 2018;8(6):e021161-e.

[8] Barker I, Steventon A, Deeny SR. Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: Cross sectional study of routinely collected, person level data. BMJ (Clinical Research Ed) 2017;356:j84-j.

[9] Nagree Y, Camarda VJ, Fatovich DM, et al. Quantifying the proportion of general practice and low-acuity patients in the emergency department. Med J Aust 2013;198(11):612–15.

[10] Steering Committee for the Review of Government Service Provision. Report on Government Services. Canberra: Productivity Commission, 2018.

[11] Shen E, Koyama SY, Huynh DN, et al. Association of a dedicated post-hospital discharge follow-up visit and 30-day readmission risk in a Medicare advantage population. JAMA Intern Med 2017;177(1):132–35.

[12] Zhao Y, Thomas SL, Guthridge SL, Wakerman J. Better health outcomes at lower costs: The benefits of primary care utilisation for chronic disease management in remote Indigenous communities in Australia's Northern Territory. BMC Health Serv Res 2014;14:463.

[13] Dalton APA, Lal A, Mohebbi M, Carter PR. Economic evaluation of the Indigenous Australians' Health Programme Phase I. Burwood, VIC: Deakin University, 2018.

[14] Baird B, Reeve H, Ross S, et al. Innovative models of general practice. London: The King's Fund, 2018.

[15] Australian Institute of Health and Welfare. Potentially preventable hospitalisations in Australia by small geographic areas. Canberra: AIHW 2019.

[16] National Health Performance Authority. Hospital performance: Costs of acute admitted patients in public hospitals in 2011–12. Sydney: NHPA, 2015.

[17] Bayram C, Ryan R, Harrison C, Gardiner J, Bailes MJ, Obeyesekere N, Miller G, Britt H. Consultations conducted in languages other than English in Australian general practice. Aust Fam Physician. 2016;45(1):9-13