



RACGP

Royal Australian College of General Practitioners

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# *RACGP submission*

# *A new National Disability Strategy beyond 2020*

November 2020

## 1. Introduction

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to provide a submission to the Department of Social Services on the development of a new National Disability Strategy (the Strategy) beyond 2020.

The RACGP is Australia's largest professional general practice organisation, representing over 40,000 members working in or toward a career in general practice. The RACGP is responsible for:

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

### 1.1. Specific Interests Groups

The RACGP recognises that many GPs develop an interest in specific areas of general practice throughout their career. It values these specific skills and experience through the endorsed groups of the RACGP's Faculty of Specific Interests.

Two of these Specific Interests Groups – Disability and Child and Young Person's Health – share an interest in developing best practice primary healthcare for people living with disability. The groups advise the RACGP on primary healthcare policy, GP education and other disability issues as they relate to general practice.

## 2. General comments

The RACGP welcomes the inclusion of health and wellbeing as one of six outcome areas proposed for the Strategy. We agree that any outcomes for people living with disability should be measured and reported on.

We also support the proposed guiding principles that could be used to guide the development of policy and design of programs by government and non-government organisations.

This submission provides feedback on some of the issues with health outcomes for people with disability from the perspective of GPs, and outlines solutions to addressing these in general practice. It proposes reforms to the health system that would facilitate access to healthcare for people living with disability in accordance with the guiding principles.

GPs are most often a patient's first point of contact in the health system and they provide ongoing care for their patients. Even when other health professionals are providing support to a person with disability, many people with disability have other health issues which require care from GPs and their teams. GPs are therefore intrinsically involved in disability work and often have a strong and ongoing relationship with people living with disability.

## 3. Recommendations

The RACGP recommends the Strategy:

- acknowledge the central role of GPs in supporting and improving health outcomes for people with disability
- link to information about the roles of key workers involved in the National Disability Insurance Scheme (NDIS) (eg planners and Local Area Coordinators), and highlight the need for GP input into the planning process to ensure participant needs are met
- prioritise meeting the health needs of people with cognitive disability.

Specific actions that could be taken to improve health outcomes for people with disability include:

- expanding the role of GPs in the NDIS planning process
- recognising the time spent by GPs preparing reports and completing other documentation to support NDIS applications, including consideration of how GPs can be reimbursed for work completed when patients are not present
- consulting with key stakeholders around the development of a voluntary patient enrolment model
- making Medicare Benefits Schedule (MBS) telehealth items permanent beyond 31 March 2021

- increasing Medicare rebates for GP consultations to reflect the real cost of providing ongoing comprehensive, patient-centred care to people with disability
- promoting uptake of existing MBS health assessment items.

#### 4. Strengthening accountability – National Disability Insurance Scheme

It is proposed that the Strategy include information about the roles and responsibilities of various levels of government in disability policy and service delivery. This includes the role of the NDIS.

While the RACGP is supportive of the NDIS, the quality and suitability of NDIS plans would be enhanced with input from the patient's GP. This has the potential to improve the efficiency of the planning process, better target supports and empower patients to have greater ability to recognise and achieve their goals. Greater involvement of GPs would better integrate health and disability services with tangible benefits for patients, more efficient use of resources and stronger accountability.

The RACGP has repeatedly called for GPs to be included in NDIS plan development. Our [submission](#) to the Joint Standing Committee on the National Disability Insurance Scheme's inquiry into NDIS planning recommended that:

- GPs have the opportunity to view and discuss a draft of a patient's NDIS plan with the patient, and provide feedback and advice to NDIS planners for consideration when finalising the plan
- GPs automatically receive a copy of a patient's NDIS plan (with patient consent) to allow them to keep a complete record of their patients' health and social journey (supporting continuity of care)
- notifications be sent to a patient's usual GP to update them on the patient's NDIS status and provide information relevant for the provision of ongoing, holistic care by the GP
- GPs be able to make direct contact with NDIS planners (with patient consent) to advise of issues being experienced by a patient or the need to amend their plan.

The Strategy should link to information about the roles of key workers involved in the NDIS (eg planners and Local Area Coordinators), and highlight the need for GP input into the planning process to ensure participant needs are met.

##### 4.1. Lack of funding for NDIS work performed by GPs

The Department of Health has confirmed that patients can access MBS rebates for consultations with their GP when the GP is assisting them to apply for the NDIS. However, MBS items for GP consultations can only be billed if the patient is in attendance at a face-to-face or telehealth appointment.

The RACGP recommends that consideration be given to how GPs can be reimbursed for time spent preparing reports and other relevant documentation to support NDIS applications when patients are not present. One option could be to consult with key stakeholders around the development of a voluntary patient enrolment model. Under this model, a fixed amount would be paid to the GP/practice to support the delivery of additional and more comprehensive services, including care coordination activities between consultations.

#### 5. Enabling flexible access to healthcare for people with disability

Another of the proposed guiding principles for the new Strategy is *Design universally*. The specific measures outlined below would enable flexible access to healthcare for people with disability, ensuring their disability does not prevent them from accessing care when they need it.

##### 5.1. Telehealth

The introduction of temporary COVID-19 MBS telehealth items in general practice was a critically important development. Telehealth offers numerous benefits and has demonstrated that care can be effectively delivered remotely.

The RACGP welcomed the government's recent decision to extend telehealth until 31 March 2021. However, we would like to see telehealth retained permanently. While not a substitute for face-to-face care, telehealth provides greater flexibility for patients, is useful in connecting with hard-to-reach groups, and will be key to addressing the long-term health impacts of COVID-19.

Telehealth provides considerable financial savings to practices when patients require support staff to attend the practice with them. For those patients who struggle to attend face-to-face consultations due to behavioural or physical problems, telehealth offers another means of access. This model of care has also enabled people with disability to access care from a number of different health professionals, including psychologists, social workers and occupational therapists.

In the absence of a COVID-19 vaccine, the continuation of telehealth could form part of an ongoing strategy to reduce the risk of infection in the community. This ensures vulnerable populations, including people with disability, continue to have access to essential services.

## 6. Addressing the health needs of at risk groups – People with cognitive disability

One of the guiding principles identified in the position paper is *Address barriers faced by priority populations*. Feedback from our members indicates that the Strategy needs to address the unmet health needs of people with cognitive disability as a priority. The life expectancy of people with cognitive disability is 10–20 years less than the general population.<sup>1</sup>

The RACGP [submission](#) to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability discussed healthcare for people with cognitive disability. The submission makes a number of recommendations to improve access to healthcare for this group, and prevent cases of violence, abuse, neglect or exploitation.

People with cognitive disability face a number of barriers to accessing healthcare, including communication issues, limited access to skilled patient advocates, poor health awareness and financial barriers.

### 6.1. Inadequate funding limits the ability of GPs to provide comprehensive care

RACGP members report the Medicare system is inflexible and does not appreciate the complexity of care patients with cognitive disability require. There is a financial disincentive to provide long or prolonged consultations which is a barrier to GPs' ability to provide healthcare to large numbers of patients living with disability.

Many people with cognitive disability reside in supported residential accommodation. The use of medication charts is commonplace in these settings. Residents with cognitive disability have a higher burden of chronic disease and are at increased risk of poor health outcomes due to polypharmacy, which can be widespread. These patients require frequent medication review and repeat prescriptions. However, Medicare does not remunerate time not spent face-to-face with a patient, this can place financial strain on a GP responding to staff requests to update medication charts and write repeat prescriptions without seeing a patient for a consultation.

The RACGP recommends that Medicare rebates for GP consultations be increased to reflect the real cost of providing ongoing comprehensive, patient-centred care to people with disability. Our [Vision for general practice and a sustainable healthcare system](#) notes that comprehensive care is a core feature of high-performing general practice. Practices equipped to provide timely, holistic and comprehensive care can reduce the need for more expensive care provided in hospitals or by other medical specialists.

As above, a voluntary patient enrolment model could also address this funding shortfall.

### 6.2. GP health assessments

The RACGP supports the [recommendation](#) from the Roundtable on the Health of People with Intellectual Disability that MBS health assessment items be better promoted to encourage greater uptake. People with intellectual disability are one of the target groups eligible for an annual health assessment, however only a small percentage of this cohort receive these assessments. This may be due to a lack of awareness among GPs that they can claim these item numbers.

## 7. Conclusion

The RACGP looks forward to contributing to further discussions around the new National Disability Strategy. Please contact Ms Emma Stonham, Manager – RACGP Specific Interests, on (03) 8699 0350 or at [emma.stonham@racgp.org.au](mailto:emma.stonham@racgp.org.au) if you have any questions or comments regarding this submission.

## 8. References

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<sup>1</sup> O'Leary L, Cooper S, Hughes-McCormack L. Early death and causes of death of people with intellectual disabilities: a systematic review. *J Appl Res Intellect Disabil* 2018;31(3):325–42.