RACGP

Royal Australian College *of* General Practitioners

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RACGP submission

Primary Health Care 10-Year Plan

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1. Introduction

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to provide a submission to the Department of Health on the draft Primary Health Care 10-Year Plan (the 'Plan').

The RACGP is Australia's largest professional general practice organisation, representing over 41,000 members working in or toward a specialty 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.

2. General comments

Australia's healthcare system is considered one of the best in the world.[1] However, rising rates of chronic disease, an ageing population, the COVID-19 pandemic, delayed preventive care due to the pandemic, and a looming mental health crisis, are putting increasing pressure on the system. This is resulting in poorer outcomes and long hospital wait times. Unless there is significant investment and reform, the system will fail.

General practice is the foundation of the Australian healthcare system. Australians see GPs more than any other health professional. In 2020-21, GPs and their teams provided over 171 million services, with almost nine in ten people consulting a GP.[2]

General practice is the most efficient and cost-effective part of the health system.[3,4] Despite this, the sector is in a state of crisis. Funding has stagnated, there are critical gaps in workforce supply, and the high-quality care GPs provide is at risk.

The RACGP outlined these challenges, as well as critical real-world solutions, in the initial RACGP submission to the Primary Health Reform Steering Group (the 'Steering Group') in July 2021. While some of the recommendations in this submission were adopted in the draft Plan, there remain several gaps that the Plan must address. These include:

- Investment in general practice to support GPs to spend more time with their patients. This includes higher rebates for Level C and D standard consultations, as well as the introduction of a Medicare Benefits Schedule (MBS) item for Level E consultations (over 60 minutes)
- A permanent and equitable telehealth scheme that improves access to services for those with greatest need, including Indigenous peoples, people with disability, and elderly, by incorporating rebates for longer phone consultations
- A fit-for-purpose model of Voluntary Patient Enrolment (VPE) that supports high-quality, continuous care to support increased funding for quality general practice care not supported by Medicare
- Practical measures to increase the attractiveness of general practice as a career and provide greater support for rural GPs
- Designating GPs as key stakeholders in joint planning and commissioning, and the development of mechanisms to involve local general practices in service design and delivery.

The RACGP calls for greater alignment between the Plan and the RACGP *Vision for general practice and a sustainable healthcare system* (the Vision), which describes a sustainable model of high-quality, cost-effective and patient-centred care that aims to address many of Australia's healthcare challenges.

Specific feedback in response to the consultation questions is provided overleaf.

3. Responses to consultation questions

1. Do you consent to being named as having provided a submission to this consultation process?	
Yes	
2. Do you consent to your submission being published on the consultation hub?	
Yes	
3. Please provide your response to the listed actions under reform stream 1: Future-focused health care - Action area A: Support safe, quality telehealth and virtual health care. (300 word limit)	

The RACGP supports this action area in-principle.

The *RACGP Vision for general practice and a sustainable healthcare system* (https://www.racgp.org.au/advocacy/advocacy-resources/the-vision-for-general-practice) describes RACGP support for Voluntary Patient Enrolment (VPE) as a means to identify and strengthen GP–patient links. However, the RACGP will only support VPE if it is combined with significant additional investment in general practice and is balanced with a commitment to fee-for-service remaining the primary funding mechanism for general practice. Any VPE model must target continuity of high-quality care, rather than limiting expenditure. Requirements for VPE are discussed further in the response to question 15.

The RACGP has strongly advocated for the ongoing use of telehealth to enhance patient management and care, as outlined in our previous submission. The introduction of Medicare rebates for telehealth consultations have been critical to ensuring access to general practice care during the COVID-19 pandemic. Our position remains that telehealth should be available to patients with an ongoing relationship with their GP, and we are supportive of linking a sustainable, ongoing telehealth scheme to VPE in Australia.

RACGP members have consistently raised concerns about how the removal of rebates for longer phone consultations increase access issues and health gaps for specific groups, including Aboriginal and Torres Strait Islander people, elderly people, people with disability, and rural populations. The RACGP urges the federal government to include rebates for longer telephone consultations in a permanent telehealth model.

The RACGP is supportive of Practice Incentives Program eHealth Incentive (ePIP) reform. Elements encouraging participation in My Health Record (MHR) should remain, with the focus broadened to include interoperability (eg embedded medication lists) and uptake of electronic prescribing. Any new ePIP outcome measures must be aligned to safe and high-quality healthcare, rather than arbitrary numbers and/or percentages.

4. Please provide your response to the listed actions under reform stream 1: Future-focused health care - Action area B: Improve quality and value through data-driven insights and digital integration (300 word limit)

Again, the RACGP supports action area B in principle. However, several issues previously raised by the RACGP regarding digital integration in general practice remain unaddressed, including:

- lack of GP time to familiarise themselves with new digital systems
- lack of interoperability of digital systems
- excessive compliance and regulatory burden
- lack of funding to support time needed for accurate records
- lack of meaningful clinical information available through digital systems
- lack of a forum or funding mechanism for GPs to interact with public hospitals. Enhanced digital linkages require meaningful, ongoing relationships between GPs and hospitals.

GPs must be supported to be involved in interpreting, understanding, and responding to data trends and patterns. The lack of a recurrent funding model for these types of activities is a serious omission. The RACGP would support a firm commitment to new funding for this type of activity, continued funding for the PIP Quality Improvement Incentive (PIP-QI) and investigating future focus areas for the PIP-QI with GPs individually – who must be engaged to achieve the desired goal.

The RACGP would welcome the opportunity to provide further insights about data limitations, improvements in data infrastructure, and linkages to broader health system data. Other key stakeholders, including universities, professional organisations and consumer organisations, should also be involved.

The RACGP believes that a clinically usable and integrated MHR system should be a short- or medium-term action, rather than 'future state'. Any measures to enhance MHR coding or usage need to be formally trialled, ideally through peer-reviewed research.

Unique challenges around digital health may be faced in rural and remote areas, where there may be limited access to infrastructure (i.e. a stable internet connection) and greater need for digital communication to support continuous care (e.g. due to long distances to health services). This may need to be addressed through broader efforts to improve infrastructure, as well as targeted support for general practices providing services in these areas.

5. Please provide your response to the listed actions under reform stream 1: Future-focused health care - Action area C: Harness advances in health care technologies and precision medicine (300 word limit)

The RACGP supports action area C in-principle.

The RACGP welcomes the specific action to engage peak organisations, professional colleges and bodies, and educational institutions in developing resources for service providers. While advances in genomics and precision medicine may have significant future value in mainstream medicine, currently their use remains relatively limited by a lack of robust general practice evidence. It is recommended the focus of the Plan be shifted more towards building the evidence base for these technologies in general practice, including through greater support for research in general practice.

While we acknowledge the potential future value of healthcare technologies and precision medicine, the RACGP also notes the capacity and workload of GPs remains a barrier to their adoption in general practice. This must be addressed through broader reform and greater investment in general practice to ensure GPs are able to spend time learning and adopting new technologies without compromising patient demand for care. GPs require additional support for their involvement in genomics and precision medicine.

A number of RACGP resources already exist in this area, for example the *RACGP Clinical Guideline on Genomics in General Practice* which is currently under review (https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/genomics).

6. Please provide your response to the listed actions under reform stream 2: Person-centred primary health care, supported by funding reform – Action area A: Incentivise person-centred care through funding reform, using VPR as a platform (300 word limit)

The RACGP supports this action area in-principle. It is positive to see the draft Plan incorporate additional funding for mental health and aged care, as was recommended in the RACGP submission to the Steering Group.

The RACGP has consistently raised the issue of funding structures and investment in general practice not adequately supporting comprehensive care, including chronic disease management and preventive care. The RACGP is cautiously supportive of the introduction of blended payment models on top of fee-for-service to address this issue. However, the RACGP does not support any attempts to redirect fee-for-service funding into block payments and re-badge this as 'new funding'. Nor does the RACGP support any funding model that is primarily based on block or capitation payments linked solely to quality and outcome measures. These models:

- do not align with the flexibility required in general practice

- are not likely to measure and improve health outcomes, instead they could potentially worsen health inequalities by providing less funding for practices in lower socioeconomic areas
- do not account for concerns around data quality and linkage.

A blended funding model with the following features is required to best support high-quality general practice care:

- fee-for-service continuing to provide the majority of general practice funding
- transparent reinvestment of any savings generated through VPE into general practice
- increased patient rebates for longer GP consultations (Level C and D), as well as the introduction of an appropriately funded Level E standard consultation (>60 minutes)
- deprivation payments based on patient demographics or practice location
- service coordination payments to support comprehensive care
- no requirement to bulk bill services.

Funding reform is discussed further in the response to Question 15.

The RACGP is supportive of measures to enable efficient and appropriate accreditation arrangements.

7. Please provide your response to the listed actions under reform stream 2: Person-centred primary health care, supported by funding reform – Action area B: Boost multidisciplinary team-based care (300 word limit)

The RACGP supports this action area in-principle.

The RACGP welcomes measures that enable an integrated, multidisciplinary team care environment. Team-based care is particularly important for groups that may have complex care needs, including those with chronic conditions and Aboriginal and Torres Strait Islander peoples.

Multidisciplinary teams must exist within or in close communication with local general practices. When situated at the centre of their patients' care, GPs provide continuity of care, reducing fragmentation and duplication of services. This can lower rates of hospitalisation and emergency department attendances, as well as lower mortality rates.[5] Without strong links back to general practice, this action area could increase disjointed care and fragmentation in the health system.

As addressed in the previous RACGP submission, high-functioning multidisciplinary teams require appropriate funding and staffing. While the RACGP strongly supports increasing funding for the Workforce Incentive Program, we note the boost to this program should incorporate both the Doctor stream and Practices stream. The RACGP would further support investigating how flexible pooled funding for team care arrangements could fund clinician time with patients, as well as care coordination activities.

As outlined in the response to Question 6, the RACGP does not support funding models that are based on block or capitation payments linked solely to quality and outcome measures, for example team-based care indicators. Indicators of this type often do not necessarily reflect the delivery of high-quality care, do not align with the flexibility required in general practice, and can needlessly restrict funding for general practices that are delivering high-quality health services.

8. Please provide your response to the listed actions under reform stream 2: Person-centred primary health care, supported by funding reform – Action area C: Close the Gap through a stronger community controlled sector (300 word limit)

The RACGP supports action area C.

The RACGP welcomes the commitment to support Aboriginal Community Controlled Health Organisations (ACCHOs) and improve health outcomes for Aboriginal and Torres Strait Islander people. We strongly support the ACCHO model of comprehensive primary healthcare as well as efforts to develop and support the Aboriginal and Torres Strait Islander health workforce.

Increasing the number of health checks is reasonable if they are useful to Aboriginal and Torres Strait Islander people and result in appropriate follow-up care for issues identified. We look forward to continuing support from the Department for the partnership work between the RACGP and National Aboriginal Community Controlled Health Organisation (NACCHO) to implement this.

Regarding the action on educating primary care providers, the RACGP is unaware of what resource the Plan is referring to as the 'RACGP standards for general practice on cultural safety'. Resources of this type should be developed by Aboriginal and Torres Strait Islander organisations to ensure they are culturally safe. Furthermore, education on existing resources may not be sufficient to change health systems and must be accompanied by practical actions supporting change.

The RACGP notes this action area will need to be underpinned by substantial additional resources to effectively improve health outcomes for Aboriginal and Torres Strait Islander people and must have input from Aboriginal and Torres Strait Islander people and ACCHO representatives. There is a need for specific investment for the Indigenous Australians' Health Program and the National Aboriginal and Torres Strait Islander Health Plan.

There should also be specific consideration of Indigenous Data Sovereignty and best-practice data governance principles under this action area, as well as the Plan more broadly.

9. Please provide your response to the listed actions under reform stream 2: Person-centred primary health care, supported by funding reform – Action area D: Improve access to primary health care in rural areas (300 word limit)

The RACGP supports the intent of action area D. However, we do not support the implementation of the proposed model of Rural Area Community Controlled Health Organisations (RACCHOs), as these risk fragmenting and duplicating care. This model is likely to be administratively burdensome, more expensive to maintain than general practice and may also increase system complexity. The model does not address recruitment and retention issues and may further drive out interest and attractiveness of rural general practice. The model does not seem to add value to the existing situation while increasing cost and complexity. Rural Australians would be better served by strengthening rural general practice.

The RACGP welcomes the action to increase GP training places, particularly in rural areas. While the current GP workforce can meet demand – albeit with a need for redistribution – future workforce supply is in jeopardy. Key gaps in this action area include measures to increase the attractiveness of general practice as a career, given fewer medical students are choosing general practice as their specialty each year, and mechanisms to provide practical support for rural GPs such as greater incentives, rebates, and scholarships.

Adequate remuneration for general practice remains a critical issue. The decline in general practice funding via Medicare, through both the Medicare rebate freeze and the ongoing failure to appropriately index MBS patient rebates, has impacted the viability of rural general practices and the attractiveness of general practice more broadly. This must be addressed through increased investment in general practice.

The RACGP also supports the use of telehealth, electronic communications, and virtual models of care in rural and remote areas as part of an integrated health system. A permanent model of telehealth that incorporates longer phone consultations will help to support access in rural areas, particularly those with limited videoconferencing infrastructure and digital access issues.

10. Please provide your response to the listed actions under reform stream 2: Person-centred primary health care, supported by funding reform – Action area E: Improve access to appropriate care for people at risk of poorer outcomes (300 word limit)

The RACGP supports action area E in-principle.

People living in disadvantage should have to access to appropriate health services to reduce risk of poorer outcomes. GPs are often the first, and sometimes only, contact within the health system and must be supported to spend

sufficient time with their patients to address preventive, complex care issues (e.g. chronic disease, co-occurring physical health issues for those with mental illness, Aboriginal and Torres Strait Islander peoples).

While shorter consultations provide support for everyday issues, evidence shows that longer consultations with a GP have significant advantages. These include increased patient education, identification and management of complex issues (including coordination of interpreter services), early intervention, immunisation adherence, counselling, patient satisfaction and participation, and better use of medications.[6,7] Longer consultations are crucial to enhancing access to care and increasing the capacity of GPs to deliver high-quality preventive care for those at risk of poorer outcomes. Funding for longer consultations also supports GPs to spend time coordinating care across team members, disciplines and interfacing with hospitals.

The draft Plan must be amended to support GPs to spend more time with their patients. This funding could be through higher rebates for Level C and D standard consultations, as well as the introduction of an MBS item for Level E consultations (over 60 minutes).

Access to care through telehealth is also a key issue. Restricting longer telehealth consultations to video limits access for people lacking the infrastructure and digital skills for videoconferencing. The permanent telehealth model must incorporate rebates for longer telephone consultations.

11. Please provide your response to the listed actions under reform stream 2: Person-centred primary health care, supported by funding reform – Action area F: Empower people to stay healthy and manage their own health care (300 word limit)

The RACGP supports action area F and welcomes the reference to supporting the update and implementation of the *RACGP Guidelines for preventative activities in general practice*. This resource is currently under review by the RACGP, and we would welcome support for this resource moving forward.

It is important funding systems incentivise high-quality, continuous care that improves patient outcomes, and reduces hospitalisations and emergency department attendances.[8] The RACGP supports investment in general practice to enhance care for the 2,000 days after birth and for people with complex chronic conditions. However, the RACGP urges caution in linking any payments to quality and outcomes measures. These models:

- do not align with the flexibility required in general practice
- are not likely to measure and improve health outcomes but could potentially worsen health inequalities by providing less funding for practices in lower socioeconomic areas
- do not account for ongoing concerns around data quality and linkage.

The RACGP appreciates the importance of supporting individual health literacy and agency. Evidence shows that longer consultations with a GP have significant advantages, including for enabling individual health literacy.[9,10] As such, the Plan must be amended to support GPs to spend more time with their patients. Funding through higher rebates for Level C and D standard consultations, as well as the introduction of an MBS item for Level E consultations (over 60 minutes) is urgently required.

12. Please provide your response to the listed actions under reform stream 3: Integrated care, locally delivered – Action area A: Joint planning and collaborative commissioning (300 word limit)

The RACGP supports this action area in-principle. However, if not well-implemented jurisdiction-based planning will increase health system complexity and entrench disadvantage that is now evident for some patients facing a 'postcode lottery' when accessing services.

International experience supports better integrated and supported primary care to improve health outcomes and reduce pressure on hospitals.[11] The RACGP strongly supports measures to establish an integrated health system that promotes GP-led multidisciplinary care and seamless patient navigation.

While there have been some reported improvements throughout COVID-19, general practice engagement with Primary Health Networks (PHNs), local hospitals and other planning bodies is extremely varied. This is partially due to

the lack of a funding mechanism for GP engagement with these bodies. Local health districts and hospital services need to have clear linkages and accountability to general practice if an integrated health system is to be achieved.

State health departments need to require engagement between public hospitals and general practice, with clear indicators for integrated care. The RACGP supports a new funding mechanism which promotes innovative models of GPs and hospitals working together to reduce emergency presentations and preventable hospital readmissions.

The Plan should designate GPs as key stakeholders in joint planning and commissioning and endorse mechanisms to involve local general practices in service design and delivery. The Plan should encourage state health departments to:

- consult their RACGP State Faculty on the planning, design and evaluation of trials/initiatives involving general practice
- include and fund GPs representation on any relevant steering committees
- include dedicated funding for innovative models that improve integration between GPs and public hospitals
- distribute final reports on any projects involving general practice.

The Plan should also specify that any care model evaluations or trials are made publicly available.

13. Please provide your response to the listed actions under reform stream 3: Integrated care, locally delivered – Action area B: Research and evaluation to scale up what works (300 word limit)

The RACGP supports this action area in-principle. The RACGP supports the development of an institute for primary healthcare translational research, noting this should be progressed with input from relevant medical colleges, universities and the Australasian Association for Academic Primary Care.

Key gaps in this action area are increasing academic workforce capacity and support for nation-wide practice-based research networks (PBRNs). Producing evidence to underpin clinical practice in primary care requires a thorough understanding of the general practice context. The active participation of GPs and their practice teams is therefore essential for successful research and research translation in the primary care setting. Research funds need to flow to general practice to train future generations of researchers with the experience and understanding to design and interpret applied research in primary care.

Workforce strategies in the Plan need to include measures to support and grow the GP research and academic workforce. This is important not only for undertaking research and contributing to the evidence base, but also for developing, supporting and providing role models for the pipeline of medical students into general practice. As part of supporting the role of GPs in research and academia, mechanisms must also be put in place to embed general practitioner researchers in grant review panels and better support the key role of PBRNs in developing research capacity.

The RACGP notes that the percentage of National Health and Medical Research Council and Medical Research Future Fund funding dedicated to general practice remains unacceptably low and inadequate to support general practice research capacity. The Plan should incorporate a significant increase to identify and answer the important research questions in general practice, with additional targeted funding to build the research workforce (for example, dedicated academic chair positions in general practice).

14. Please provide your response to the listed actions under reform stream 3: Integrated care, locally delivered – Action area C: Cross-sectoral leadership (300 word limit)

The RACGP supports the intent of action area C, including measures to build understanding and support for the reform agenda. However, the RACGP would recommend the action area be simplified according to the actions included in the original Steering Group Discussion Paper. This should include a focus on the following:

- supporting GP leadership
- governance arrangements that empower clinicians and consumers, carers and families to work together
- reforming the system to better align business profitability and sustainability with high-quality patient outcomes.

As highlighted in our earlier submission to the Steering Group, the RACGP recommends an action be added around supporting GPs to be leaders. The upskilling of GPs and development of health leadership roles is essential to ensure general practice is built into the design and management of health system reform, as well as providing supplementary career pathways for GPs. The time and contribution of GP leaders should be appropriately valued.

The RACGP supports creating a more streamlined approach to general practice accreditation. The RACGP sees synergies between gaining accreditation against the *Standards for general practices* and the *Standards for general practice training*. Where profession-led and specific standards for accreditation are available, the Plan needs to work with experts to design processes that adapt to advances in models of care. The RACGP has recently commenced a review into the *Definition of a general practice for the purpose of accreditation* (against the *Standards for general practices*) which seeks to incorporate the innovative models of care being provided by GPs in the Australian community.

15. Please provide any additional comments you have on the draft plan (1000 word limit)

General practice is the backbone of the primary care system, with almost nine in 10 Australians visiting their GP each year.[12] Evidence both nationally and internationally shows that a well-supported general practice sector will result in efficiencies for primary and secondary care, and the broader healthcare system.[13] Failure to invest adequately in general practice will result in continued increases in overall healthcare costs.

The health system is currently under stress, dealing with the added demands of the COVID-19 pandemic and vaccination rollout and reduced ability to recruit doctors internationally. In addition to placing practices under strain, there are several broader health system implications. Lack of resourcing in general practice results in increased pressures on hospital emergency departments, with many regions reaching crisis point in recent months.

While the Primary Health Care 10-Year Plan presents a significant opportunity for reform, it must be targeted towards supporting general practices to deliver high-quality, comprehensive care. The RACGP has provided further comments on two key elements of this reform, voluntary patient enrolment (VPE) and funding models, below.

Voluntary Patient Enrolment

Strengthening links between patients and GPs via VPE could produce meaningful benefits for patients, health system funders and providers of comprehensive holistic general practice care.[14] However, it is critical VPE is appropriately adapted to the Australian health system and model of general practice. For the RACGP to support VPE, it must incorporate:

- a firm commitment to enrolment remaining voluntary for both general practices and patients
- continued access for patients to seek care for standard consultations from other general practices if desired
- funding for general practice implementation until the process is normalised, including software, technology and practice resources to enrol patients and support their care via an integrated health system
- additional and significant investment in both practices (including practice teams) and GPs individually to provide high-quality, comprehensive and coordinated care for enrolled patients
- retention of fee-for-service as the core of general practice funding
- transparent oversight of any additional investment or reinvestment of any savings generated by VPE into general practice
- an electronic registration system that seamlessly integrates with current processes and practice software
- governance of any model to reflect the critical role of GPs in primary care
- a commitment to adapting the model based on GP feedback
- a process to review and evaluate the impact of the model on patient care and practice viability.

Access to telehealth and certain MBS items for enrolled patients requires a transition period of two years where GPs not participating in VPE are still able to bill these MBS items. Further, enrolment eligibility should require two face-to-face services in the last 24 months and one face-to-face service in the previous 12 months for patients of ACCHOs and MMM6/MMM7 practices. Thereafter, one face-to-face service every 24 months should be required to maintain enrolment.

Funding models and reform

As outlined in the previous RACGP submission, reform cannot be implemented without significant investment in general practice. Reform around VPE cannot result in an overall reduction in funding that supports patients to access their GP or negatively impact the viability of general practice. The RACGP firmly cautions against using VPE to focus on reducing funding or restricting access to care for practices and patients who are not participating in the model.

It is critical that GPs are equal partners in the design of any new payment models. The COVID-19 pandemic has shown the ability of general practice to adapt to new ways of working (such as the introduction of MBS-funded telehealth and operating vaccination clinics) and that incentive designed care can rapidly reduce practice viability.[15] Changes to funding models require careful consideration to reduce risk around access to appropriate care, poorer outcomes for Australians and general practice business viability.

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