RACGP

Vision for general practice and a sustainable healthcare system

September 2015

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Disclaimer

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

Icon acknowledgement

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

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- Aboriginal Health Council of South Australia
- Australian Association of Practice Management
- Australian College of Emergency Medicine
- Australian College of Nursing
- Australian Medical Association
- Australian Primary Health Care Nurses Association
- Consumer Health Forum
- Greater Metro South Brisbane Medicare Local
- The Pharmaceutical Society of Australia
- The Royal Australasian College of Physicians
- The Society of Hospital Pharmacists of Australia

This collective effort has resulted in the finalisation of the Vision, a robust document outlining the RACGP's position on the changes needed to better support the delivery of general practice patient care as the foundation for a sustainable and efficient healthcare system.

Contents

Executive summary

The Royal Australian College of General Practitioners (RACGP) is the peak professional body for general practice in Australia, representing more than 30,000 members working in or towards a career in general practice.

We recognise the numerous challenges the healthcare system faces. The population is ageing, chronic diseases are becoming more prevalent, the cost of healthcare continues to increase, patient expectations have changed and an uneven health workforce distribution prevents equitable access to healthcare.

As a result, the delivery of patient services in Australia is under constant strain. Health funding arrangements are failing to address current needs and will fail to meet the future needs of our population. If we do nothing, health outcome disparities will persist and overall healthcare expenditure will continue to rise.

The solution is a healthcare system oriented towards primary healthcare. Well-supported primary healthcare, with the patient at the centre, is the key to an efficient and effective healthcare system. With improved support in key areas, general practice can play an advanced role in improving the health outcomes of Australians and help governments tackle growing healthcare costs.

Led by a general practitioner (GP) taskforce, and informed by grassroots GPs, patients and stakeholders, the RACGP has developed the *Vision for general practice and a sustainable healthcare system* (the Vision). The model aims to better support the delivery of efficient healthcare in Australia by strategically reorienting how general practice services are funded and incentivised. The Vision is based on the patient-centred medical home model, informed by the RACGP's definition of quality general practice.

Scope of the Vision

General practice is the first point of contact for the healthcare system, with nearly 85% of Australians seeing a GP each year.[1] Ensuring access and quality of care in this sector is vital to the overall quality and sustainability of Australia's healthcare system. The Vision focuses on the strategic investments that can improve and enhance the delivery of general practice patient services, the foundation of an effective and efficient healthcare system.

The RACGP firmly believes that a well-supported general practice sector will result in efficiencies for primary and secondary care, and the broader healthcare system. We acknowledge there is much to be done to improve patient care while achieving efficiencies within the broader healthcare system. The RACGP would welcome and fully participate in efforts to pursue broader healthcare system reform in partnership with others seeking to improve patient satisfaction and health outcomes.

Fee-for-service funding underpins a flexible, accessible and responsive general practice sector, and the Vision seeks to complement the foundation it provides for quality patient care. While the fee-for-service model has served Australia well, remains stable and should continue to be the cornerstone for general practice funding, it does not fully support the delivery of a range of quality patient services, including chronic disease management and integration or coordination of care. The Vision seeks to maintain the fee-for-service model while reinforcing and introducing key initiatives that support an efficient general practice sector.

While the RACGP recognises flaws and inefficiencies in the current Medicare Benefits Schedule (MBS), it is not the focus of the Vision. To redress the issues within the MBS, the RACGP is actively participating in a range of consultations and forums through the Federal Government's Medicare and primary healthcare reviews.

Aboriginal Community Controlled Health Organisations (ACCHOs) are an integral part of the Australian healthcare system and are a key means of reducing health inequalities between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians. The RACGP is committed to working with ACCHOs and their national representative body, the National Aboriginal Community Controlled Health Organisation (NACCHO), to ensure they are not disadvantaged by recommended changes to funding arrangements.

The funding available to support ACCHOs and the way it is delivered is not included in the Vision. Conversations regarding the appropriate funding options for ACCHOs, recognising their unique features and service mix, are needed.

Addressing multiple issues

The Vision seeks to address a range of issues. Table 1 provides a high-level overview of these issues, which are described in more detail in Section 1.

Table 1. The issues facing general practice and the Australian healthcare system	
	**Patient needs are changing as a result of:** • chronic and complex diseases becoming more prevalent • an ageing population
	**Health costs are increasing for system funders and for patients accessing services. Future growth in health costs will be driven by greater:** • capacity and preference to consume more, higher quality health services • health workforce labour costs • rates of chronic and complex disease • technological change
	**Poor equity of access is resulting in poor health outcomes for:** • people living in rural and remote areas • Aboriginal and Torres Strait Islander peoples • older people • culturally and linguistically diverse peoples
	**Barriers that prevent GPs and their teams from achieving improved health outcomes include:** • the continued freeze on indexation • inadequate support for continuity of care • inadequate support for preventive health activities • inadequate recognition of varying levels of practice and service complexity • uncertain and poorly targeted funding • growing specialisation of the medical workforce

Underpinning principles

The RACGP has identified the following core principles for achieving an equitable and sustainable healthcare system:

- Ensuring all patients have access to timely and affordable quality healthcare.
- Recognising the value of patients having a continuing relationship with a general practice (and a usual GP) as their medical home.
- Promoting patient-centred care through involving and engaging patients in planning and delivery of care.
- Actively supporting continuity of care.
- Placing a genuine priority on prevention and early intervention activities.
- Committing to evidence-based, effective and coordinated chronic disease management.
- Promoting research, ongoing education and comprehensive training.
- Supporting a culture of quality and safety improvement.
- Committing to effective and efficient use of health resources.
- Orienting health policy, including systems and workforce, toward primary healthcare services.
- Reducing wasteful or inefficient practices and processes across the healthcare system.

The patient-centred medical home

Informed by these principles and responding to the issues identified, the Vision aims to reorient the healthcare system toward a GP-led primary healthcare system, underpinned by the patient-centred medical home model (the medical home) (Figure 1).

The medical home is an approach to providing quality patient care whereby each patient has a stable and ongoing relationship with a general practice that provides continuous and comprehensive care throughout all life stages.

The medical home facilitates a partnership between individual patients, their usual treating GP and extended healthcare team, allowing for better-targeted and effective coordination of clinical resources to meet patient needs.

The full value of general practice patient services is achieved when GPs and practices are supported to deliver broad-ranging preventive, chronic disease management and acute primary healthcare services in diverse practice settings.

These activities, supported by workforce and infrastructure, will facilitate the provision of acute, preventive and chronic disease care, ultimately supporting quality healthcare and healthcare system efficiency.

The elements of the Vision are set out in Figure 2. Additional detail on each element is provided in Section 2.

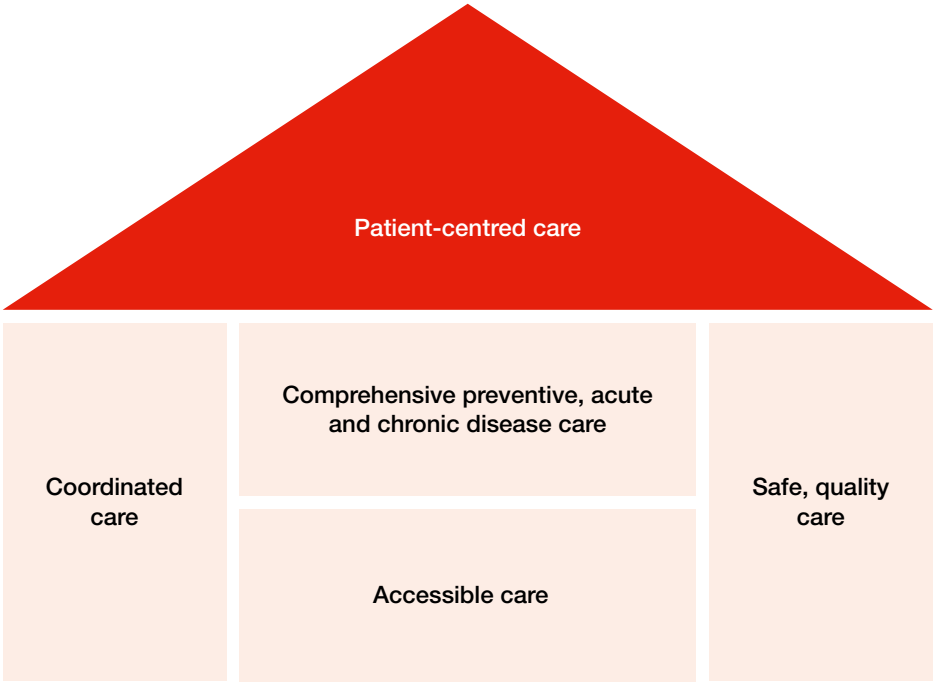

Figure 1. The key elements of the medical home (more detail on the medical home is provided in Section 1.3)

Elements of the Vison

A key feature introduced in Figure 2 is the clear delineation between payments for individual GPs and general practices, recognising the role of each in delivering or coordinating different elements of the Vision. Further detail on payment delineation is provided in Section 2.

	Payments	Separation of payment		Purpose	Benefit
		GP	Practice		
	Fee for service	✓	%	Support patient access to care regardless of need, location or practice	Maintain flexibility and responsiveness
	Patient enrolment	✓	%	Formalise relationship between patients and their GP	Care is patient-centred, continuing, coordinated and comprehensive
	Complexity loading	✓	✓	Respond to socioeconomic and Aboriginal and Torres Strait Islander status, rurality and age profile of local community	Reduce health inequalities
	Comprehensiveness	%	✓	Recognise GPs and practices for the range of services they provide	Patients can access a comprehensive range of primary care services from their general practice
	Coordination	✓	✓	Improve continuity of care between healthcare providers and sectors	Improve patient outcomes through better coordination
	Research	✓	✓	Support innovation and improvement led by GPs and general practices	Innovation and quality becomes an integral part of practice culture
	Practice nursing	✗	✓	Continue to support team-based care	Patients receive services from a practice team, improving access and care
	Teaching	✓	✓	Train the next generation of doctors	Workforce and training sustainability
	IT and infrastructure	✗	✓	Expand service capacity and information management capacity	Greater use of practice information for innovation and improvement with space to expand
	Indexation of payments			Maintain value of payments over time	Align payments with the increasing cost of providing health services

Figure 2. Activities and infrastructure required to achieve healthcare sustainability

1. Understanding the challenges the Australian healthcare system faces

This section provides an overview of the Australian healthcare system and the interface between general practice, broader primary healthcare, and the secondary healthcare sector. It describes issues the Australian healthcare system faces and how primary healthcare can address these challenges, ensuring sustainability and improved patient health outcomes.

1.1 The Australian healthcare system

The Australian Institute of Health and Welfare (AIHW) provides a succinct description of Australia's healthcare system in *Australia's Health 2014*:[2]

> *Australia's health-care system is a multi-faceted web of public and private providers, settings, participants and supporting mechanisms. Health providers include medical practitioners, nurses, allied and other health professionals, hospitals, clinics and government and non government agencies. These providers deliver a plethora of services across many levels, from public health and preventive services in the community, to primary health care, emergency health services, hospital-based treatment, and rehabilitation and palliative care.*

Figure 3 provides a high-level overview of the interrelationships between the elements of the current Australian healthcare system.

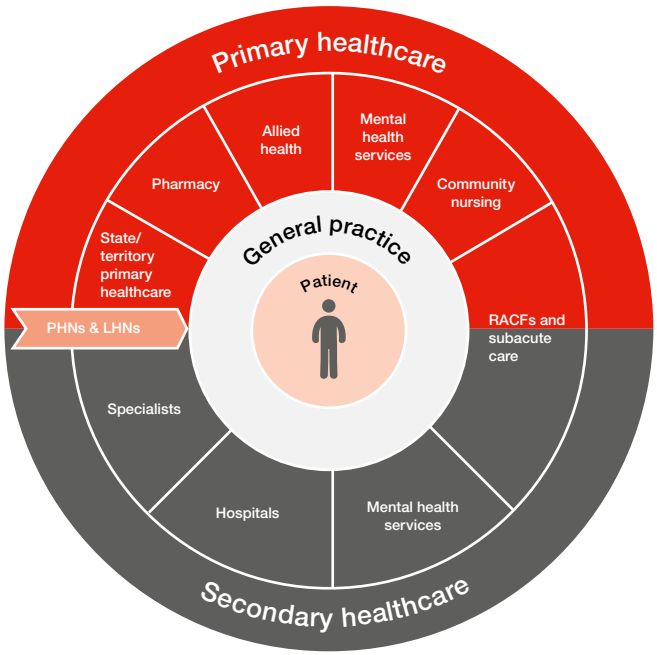

Figure 3. The current Australian healthcare system

LHNs, Local Hospital Networks; PHNs, Primary Health Networks; RACFs, residential aged care facilities

Primary healthcare

The primary healthcare sector, consisting of general practice, allied health, dental, pharmacy, community health and nursing services, is typically the first point of contact for patients seeking to access healthcare services.

Responsibility for funding primary health services is shared between federal and state or territory jurisdictions, which can result in duplication and overlap in service provision.

Commissioning agencies, such as the Primary Health Networks (PHNs), can add value to the sector if they support primary healthcare services to provide quality services to the community through coordinating and integrating services while strengthening relationships.

General practice

General practice is the cornerstone of the Australian primary healthcare sector.

General practices are evolving in response to patient needs, competition pressures and limited resources. There are a wide range of practice styles, governance structures, areas of specialisation and working arrangements. Establishment of large corporate practices and co-location of a broader range of primary healthcare professionals within a general practice is occurring more frequently.

The clinical general practice team also continues to evolve. Practice teams are often multidisciplinary, made up of GPs, general practice nurses, allied health professionals and, occasionally, nurse practitioners, pharmacists and/or pathology collection professionals. A key feature of these teams is that they are often not under the same roof. Commonly, only nursing professionals are physically co-located with GPs. When providing services on referral from GPs, allied health and nurse practitioners play key roles within the GP-led team.

The interface between general practice and state or territory-funded primary health services is complex and evolving as population needs and service mix change. General practices assist their patients to navigate the private and public primary healthcare systems to access the care they need external to that provided by the practice. GPs also play a role in assisting patients to navigate social and welfare services, recognising the impact of social determinants on health status and their capacity to precipitate and exacerbate health issues. Similarly, Local Hospital Networks (LHNs) and GPs need to work collaboratively to ensure smooth patient transition between healthcare providers.

Secondary healthcare

The secondary healthcare sector provides care to patients who are referred by GPs or who present to hospital emergency departments. Hospitals, other medical specialists and sub-acute services support patients by assessing, diagnosing and managing acute and chronic health issues.

Responsibility for funding and providing services in the secondary healthcare sector is shared between federal and state or territory jurisdictions, private health insurers and private providers. Coordination and strategic planning occurs at state or territory and LHN levels.

1.2 Challenges facing the healthcare system

Patient needs are changing

One in every three Australians has a chronic disease and two in three have at least three or more risk factors for heart disease, diabetes or chronic kidney disease.[2,3] Multimorbidity, the presence of multiple chronic conditions in a single individual, is increasingly the most common presentation in general practice patients.[4]

The population is also ageing. Currently, one in seven people is aged older than 65. By 2060, this will increase to one in four people, leading to increased health service demand.[5,6]

Additionally, information about health, illness and possible treatments is more readily available than ever before. As a result, many patients approach healthcare as informed consumers.

Unnecessary hospitalisations occur

There are a growing number of patients with complex health needs who experience unnecessarily poor health outcomes. Inadequate linkages between general practice, state or territory-funded services, other medical specialists and health professionals fragments care, negatively impacting patients' health.

In 2013–14, the AIHW reported that 6.2% of hospital separations (slightly more than 600,000 patient separations) were classified as preventable.[7] According to the AIHW, preventable hospitalisations are conditions where hospitalisation could have been avoided if timely and adequate non-hospital care had been provided.

Health costs are increasing

The cost of healthcare in Australia continues to rise. Patients face dual increases as funders of the system via taxation and through gap payments when accessing services. One in 20 people surveyed by the Australian Bureau of Statistics (ABS) indicated that when they needed to see a GP, they either delayed their visit or did not go due to concerns about cost.[8] Individual contributions at the point of service increased by 4.9% per year between 2002–03 and 2012–13.[9]

All levels of government express concern regarding increases in healthcare expenditure and the resulting impact on their current and future budgets.

Healthcare providers report that the cost of providing care is increasing as the cost of consumables continues to rise, advancements in technology require adoption of newer, more expensive instruments, and tests and staff labour costs continue to increase.

Table 2. Increases in health expenditure between 2002–03 to 2012–13[9]

▲12.7%	▲40%	▲104%
Gross domestic product (GDP) spending on health	Recurrent expenditure per person	Out-of-pocket costs for GP service

The Federal Government's *2015 Intergenerational report* highlights the drivers for future growth in health spending per person, including:[10]

- greater capacity and preference to consume more, higher quality health services as incomes rise
- health workforce labour costs
- rising rates of chronic and complex disease
- rapid technological change.

In the coming years, population ageing is projected to account for approximately 10% of the increase in real health expenditure per person. While projected to slow slightly, population growth will also contribute to increasing health expenditure.[10] Health costs escalate in the final years of life, peaking in the final year.[11] Population ageing is likely to lead to a large increase in health costs as a result of greater demand for better quality end-of-life care.

Inequitable access results in poor patient outcomes

While needs will continue to evolve, little change has been seen in some areas of need and intractable health disparities remain. Unequal access to care and unequal health outcomes persist for people living in rural and remote areas, and people in lower socioeconomic groups. The latest Closing the Gap report on life expectancy shows the gap in life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians as 10.6 years for males and 9.5 years for females.[12]

Older patients and patients from a culturally and linguistically diverse background also experience poorer health outcomes.

A major contributor to inequitable access to healthcare is workforce maldistribution, with continued and long-standing shortages in many rural, remote and lower socioeconomic areas.[13]

1.3 Primary healthcare is key to addressing these challenges and ensuring sustainability

The evidence for general practice and primary healthcare is clear

A high-performing and well-resourced general practice and primary healthcare sector will address many of the challenges facing Australians and the healthcare system in the decades to come.[14] Compared to expensive hospital services, primary healthcare is the most cost-effective way to support Australians to live healthy and productive lives.

GPs contribute to a functional healthcare system by managing and triaging undifferentiated symptoms, matching patient needs with healthcare resources and providing care at a lower cost outside of hospitals.[15]

The international and Australian evidence is undeniable. Healthcare systems focusing on primary healthcare have lower use of hospitals and better health outcomes when compared to systems that focus on specialist care.[16–21]

Ensuring access to GPs in healthcare systems is associated with lower hospital demand

Patients of primary healthcare providers incur lower costs compared to patients of specialists when receiving care for conditions that can be managed in the general practice setting.[22] Greater supply of GPs and patient access to a preferred GP are associated with lower emergency department presentations and hospital use by patients across a range of acute and chronic conditions.[22–40] Readmission risks also decrease when patients can readily access primary healthcare on discharge from hospital.[15,41,42]

Researchers in Australia agree that a lack of access to primary healthcare can lead to unnecessary hospitalisation for patients with acute and chronic conditions.[43] An analysis of primary healthcare-based coronary heart disease programs demonstrated that existing primary healthcare based approaches to disease management are highly cost-effective.[44] Primary healthcare in remote Aboriginal and Torres Strait Islander communities has also been associated with health benefits to individual patients and cost savings to public hospitals.[45]

An example of GP-led primary care demonstrating these effects.

The Team Health Care Trial (the trial) was conducted between 2003 and 2005 in Brisbane general practices as part of the Department of Health and Ageing-funded Coordinated Care Trials. The trial focused on improving coordination of primary care and coordination of care between primary, hospital and residential aged care services.

The trial found the cost of care for the intervention group was trending downwards by the end of the trial when compared to the control group as a result of slower growth in inpatient costs. Service use substitution occurred, whereby inpatient services were substituted for MBS and Pharmaceutical Benefits Scheme (PBS) services at lower cost, indicating improvements in both care and healthcare system efficiencies.[46]

The medical home

The medical home model underpins the Vision.

The medical home features five key attributes that closely align with the role of general practice in the Australian healthcare system:

- Comprehensive care that meets the majority of a patient's needs.
- Patient-centred care that prioritises the development of relationships between patients and providers.
- Coordinated care where care is planned and coordinated across healthcare settings to maximise positive outcomes.
- Accessible care, available to patients easily, when it is needed and in responsive settings.
- Safe, quality care, where GPs and general practice systems aim for continuous quality improvement.[47]

Medical home models have been associated with:

- increased access to appropriate care[48]
- decreased use of inappropriate services (particularly emergency departments)[49,50]
- increased provision of preventive services (eg cancer screening)[51]
- improved care experiences for patients and staff[49,52]
- cost savings to payers.[53]

Continuity of care is a key characteristic of medical homes. Continuity of care, specifically seeing the same heath professional consistently, has been shown to reduce emergency department use and preventable hospital admissions.[19,33,54,55] Research also shows that continuity of care contributes to an overall lowering of costs, increased patient satisfaction and greater efficiency.[40,56,57]

1.4 Current barriers preventing general practice from improving outcomes and achieving healthcare system sustainability

There is clear evidence for the role of general practice and primary healthcare in achieving healthcare system sustainability through reduced hospital presentation and admission. Despite this, numerous barriers make it difficult for GPs and their teams to provide the support required for patients, particularly those with chronic or complex conditions.

Freezing indexation impedes access to care and threatens practice viability

Despite the increasing out-of-pocket costs to patients, patient rebates have been frozen until July 2018.

The indexation freeze on rebates will continue to increase out-of-pocket costs and ultimately affect general practice viability, resulting in reduced patient access.

Varying levels of practice and service complexity are not adequately recognised, hindering comprehensiveness

There is significant value for communities if their local general practice offers a range of health and medical services, including aged care in the community, residential aged care, prevention, palliative care, immunisation, women's health, men's health, children's health, after-hours services, home care, and hospital-in-the-home.

Comprehensiveness is even more important in rural, remote and socially disadvantaged areas, where patients may have reduced access to other healthcare services. If patients are able to access these services in the community, their healthcare needs will be better met, minimising the need to present to hospitals or specialists for more expensive care.

However, there is currently:

- no support for practices offering a broad range of services
- no recognition of the increased resources required for GPs and general practices providing a comprehensive range of services
- no support for practices operating in socially disadvantaged areas
- limited support for practices operating in rural and remote areas.

As a result, there are often limited services for those most in need.

Inadequate support for continuity required to improve outcomes for patients with complex and/or multiple conditions and comorbidities

Current Medicare rebates recognise episodic, acute and sub-acute care, supporting the delivery of healthcare when the patient is physically present with the GP. While this works well for many presentations, patient rebates do not adequately support healthcare delivery for patients with chronic and complex disease.

Chronic and complex care management requires significant time to coordinate patient care, regardless of whether the patient is physically present. Activities include liaising with other healthcare providers, carers and family, following up test results and appointments, and preparing letters, reports and summaries.

Consultations with patients who have chronic and complex disease(s) takes longer, with much of the work undertaken outside the consultation time. Medicare does not recognise or value this work.

Inadequate support for preventive health activities

Preventive care leads to cost savings associated with reduced reliance on secondary and tertiary healthcare, including reduced physical, psychological and social disabilities,[2] yet dedicated MBS expenditure on prevention in general practice is minimal.

The lack of support for preventive health (ie targeted preventive health advice, lifestyle advice, earlier detection of potential issues, and treatment and screening) significantly limits the ability of GPs and practices to deliver crucial healthcare activities.

Current incentive programs are misaligned

Some Practice Incentive Payments (PIPs) are achieving their objectives and should continue as planned, with regular review to ensure they continue to meet patient needs (ie the Practice Nurse Incentive Program [PNIP] and PIP teaching payment). However, others require redirection to better suit patient needs, and to support practices to flexibly and appropriately respond to the needs of their communities. Rather than focusing on patient-centred care, some of the current PIPs and Service Incentive Payments (SIPs) are either disease-specific, or focus on the priorities of the current (or past) governments.

PIP operates as an umbrella program used to deliver individual initiatives with little or no interrelation with other initiatives.[58] The result is a misalignment between payments and the strengths of primary healthcare.

While the majority of funding is directed to the practice, many of the activities are undertaken by individual GPs. There is often a mismatch between the work undertaken by individual GPs and the funding end point. General practice owners are increasingly contributing to the healthcare system, sometimes with little understanding of that system.

Inadequate support for general practice research undermining commitment to quality and safety

There are 134 million general practice patient services delivered every year, providing a rich data source that could potentially be used for research purposes.[59] However, research in primary healthcare is limited due to a lack of coordinated support.

Research is essential to improving the quality of care for Australian patients, ensuring there is ongoing identification of opportunities for improvement. General practice and primary healthcare are significant components of the healthcare system. It is vitally important that research is undertaken in primary care, where a large proportion of prevention, chronic disease management and acute care takes place.

Yet, GPs face significant barriers to research participation due to a lack of time, limited training in research methods, lack of clinical research career pathways, underdeveloped infrastructure and inadequate project funding.[60]

Practice viability is difficult to establish and maintain

General practice in Australia is dominated by a private, small business model. This allows flexibility, competition and greater responsiveness to local needs. However, it is crucial that established practices remain viable so they can contribute to a strong primary healthcare sector. If general practices are not viable, patient access will be reduced.

Increasing specialisation of the medical workforce

The ratio of GPs to other specialist medical practitioners points to an unnecessary specialisation of the Australian medical workforce. Between 2008 and 2012, specialist numbers increased by 35%, while the number of GPs increased by only 8%. This has resulted in supply of one GP for every 1.14 specialists.[61]

Increased specialisation leads to more fragmented, disease-focused care, rather than patient-focused, comprehensive, coordinated care. ‘Procedural medicine’ rather than ‘cognitive medicine’ is prioritised and rewarded. Care becomes very costly when specialists provide services that could be delivered by GPs within the general practice setting.

2. *A vision designed to underpin a sustainable and efficient healthcare system*

This section of the Vision describes the RACGP's recommendations for investing in, and reorienting funding for, general practice in order to support improvements to patient health outcomes and healthcare system sustainability.

The following provides a description of the elements forming the Vision. In line with the RACGP's proposed approach to implementing the Vision provided in Section 4, Appendix 1 outlines the RACGP's proposed models for voluntary patient enrolment (VPE) and health service coordination.

Fee for service

Maintaining flexibility for practices and access for patients

What is it?

The fee-for-service model supports GPs and their practice teams to provide care to their patients regardless of practice size, structure, infrastructure, geographic location or any other limiting factors. It is, and should remain, the primary means of supporting patients accessing Australian general practice services.

Benefits

- **Supports a range of presentations:** The fee-for-service model allows general practices to flexibly meet the healthcare needs of individuals with a wide variety of clincal presentations and needs, from general consultations, to acute care and minor procedures.

How is it best supported?

GPs should be able to determine a fair and equitable fee for their service. The fee-for-service model is best supported by the continuation of appropriatley indexed patient rebates administered through the MBS.

Voluntary patient enrolment

Formalising the relationships between patients and their GP

What is it?

VPE creates a formal link between a patient and a general practice, making it a key enabler of health service coordination and continuity of care, particularly for preventive activities and chronic disease management. The model involves a patient enrolling with a specific practice and identifying a preferred GP, while being able to access care from other GPs within or outside of the practice as needed.

Patient enrolment must be voluntary for both the patient, and the general practice and GP (ie patients may choose whether or not to enrol, and GPs and practices may choose to participate in the program).

Benefits

- **Better-defined practice population:** Practices with a better understanding of their practice population can tailor services to the needs of their community.
- **Better relationships between GPs and patients:** VPE can lead to the establishment of stable and enduring relationships between a GP and a patient, shown to have a positive impact on patient health outcomes.[62]
- **Alignment of chronic disease management items with enrolment to a patient's medical home:** Linking chronic disease management MBS item numbers to a patient's medical home will ensure funding for chronic disease management is directed efficiently and effectively, promoting better coordination of care and improved patient health outcomes.

How is it best supported?

A single nominal enrolment payment to the GP would best support the establishment of VPE.

Payment to the GP would support them to:

- establish stable and enduring relationships with their patients
- create or strengthen the patient's record, including family history, collation of medication history and collation of test results from other healthcare providers (eg computed tomography [CT] scans from a local hospital).

As part of the VPE model, the RACGP proposes establishment of a continuity of care payment supporting practices to maintain continuity of care and to develop strong relationships with their patients.

Greater detail about the RACGP's proposed model for VPE is provided in Appendix 1.

Complexity loading

Responding to health inequalities

What is it?

A complexity loading for GP and general practice payments would support the delivery of patient services in areas of community need and recognise practices providing services to more complex patients.

Benefits

- **Address workforce distribution disparities:** The loading would remove disincentives for GPs to practice and operate in areas of community need.
- **Support delivery of health services to 'hard to reach' patients:** GPs who provide care to patients with high clinical needs and those who are hardest to reach will be supported to provide patient services, reducing long-standing health inequalities.

How is it best supported?

Based on the enrolled practice population, complexity loading could be calculated according but not limited to:

- socioeconomic status of the community in which the practice operates
- rurality of the practice
- patients who identify as an Aboriginal and/or Torres Strait Islander person
- age of individual patients.

Dedicated funding is required to support practices when providing care to communities in need.

Comprehensiveness of service

Recognising GPs for the range of services they provide

What is it?

GPs and general practices that provide a comprehensive range of services can respond to the needs of the community they serve. Enhancing the comprehensiveness of services provided in the primary health sector will reduce demand for more complex and expensive services in the secondary and tertiary health sectors.

Benefits

- **Better community-based healthcare delivery:** The more services available within the community, the less patients will need to rely on more expensive secondary and tertiary hospital care.
- **Increased access to health services:** A broader range of available services in the primary healthcare sector will provide increased opportunities for patients to access the care they need, when they need it.
- **Patient-centred orientation and continuity of care:** Practices that provide a range of services are well placed to respond to their patient's needs over the patient's life, supporting continuity of care.

How is it best supported?

A comprehensiveness payment made to a practice would recognise the GPs and general practices that provide a broad range of services to the community, supporting efficiency and the delivery of quality primary healthcare services.

The payment to a practice would be based on an agreed range of measures for comprehensive service provision. This would include undertaking work such as:

- routine undifferentiated care
- acute care
- preventive healthcare
- after-hours care
- immunisation
- home visits
- women's health
- men's health
- child health
- minor procedures (eg fractures, lacerations and abscesses)
- Aboriginal and Torres Strait Islander health services
- structured care for chronic disease management and mental health care
- aged and palliative care.

The payment to the practice recognises the practice's role in supporting a GP to provide a broad range of services to the community. It would be paramount that provisions are in place for a percentage of the payment to be apportioned to the GPs directly providing the services.

Health service coordination

Improving coordination between the community and hospitals

What is it?

Health service coordination requires comprehensive needs assessment, collaborative planning, and regular follow-up and review. Improving patient transitions between healthcare providers and sectors (eg community to hospital) will help them stay in the community for longer, and reduce the length of hospital stays and readmission rates. Both GPs and general practices play a role in supporting a system for coordinating and integrating care.

Benefits

- **Chronic disease services targeted to those most in need:** Better targeting of health resources to patients who would benefit most from services will result in better health outcomes
- **Reduced waste and inefficiencies:** Supporting a single point of coordination and integration will reduce the duplication of effort across sectors.
- **Reduced hospital-bed days:** Supporting coordination of care will reduce readmission rates and facilitate early discharge, freeing hospital beds for patients who require hospital admission.
- **Care delivered within the community:** Better support for transition from hospitals to community-based care allows patients to leave hospitals safely and sooner.

How is it best supported?

Payments to practices that bridge the gap between hospitals and the primary healthcare sector will support specific activities with proven patient benefit, including:

- coordination of care
- early discharge from hospital
- discharge review
- supporting hospital-in-the-home programs
- patient handover between sectors
- communication between and across sectors.

It would be paramount that provisions are in place to ensure that part of the payment is apportioned to the GPs directly providing the services.

Greater detail about the RACGP's proposed model for better supporting health service coordination is provided in Appendix 1.

Quality, safety and research

Supporting innovation and quality

What is it?

Better support is needed for GPs and practices to undertake quality, safety and research initiatives, facilitating practice systems and teams to analyse data and monitor and improve the quality and safety of patient care.

Quality, safety and research activities include patient feedback, clinical governance activities and/or research in general practice and primary healthcare. The goal is to support GPs and practices to deliver health interventions that will have a positive impact on health outcomes, expenditure, quality of life and burden of care.

Benefits

- **Improved services:** Research, quality and safety initiatives all aim to improve safety, quality and efficiency, improving the experience and outcomes for patients.
- **Adoption of best practices:** Clinical governance, quality improvement, and safety initiatives allow practices to review the delivery of care and identify where improvements can be made, improving safety and quality of service delivery.
- **Cost savings:** Reducing inefficiencies or unsafe practices results in less waste within the healthcare sector.

How is it best supported?

Payments to practices would recognise the role they play in undertaking and supporting quality improvement, and include recognition of the clinical leadership role GPs assume in leading quality and safety improvements and research. Dedicated funding is required to support practices in implementing quality, safety and research initiatives.

General practice nursing

Promoting team-based care

What is it?

General practice nurses are valuable members of the general practice team. They provide assistance to GPs in providing preventive care for patients with acute health problems, as well as chronic disease management, health promotion and service coordination.

Benefits

- **Increased access to timely and appropriate care:** General practice nurses play a key role in triaging patients in the general practice setting. Triaging patients ensures they have access to timely and appropriate care.
- **Enhanced team-based approaches to care:** General practice nurses, in partnership with GPs, play a key role in assisting patients to manage chronic disease.
- **Reduced service fragmentation:** General practice nurses play a valuable role in service coordination and system integration.

How is it best supported?

The PNIP provides practices with payments to support the employment of general practice nurses as part of the practice team. PNIP allows some flexibility to practices to employ Aboriginal health workers in addition to, or instead of, general practice nurses and even allied health professionals in urban areas of workforce shortage. The continuation of this support is crucial to the RACGP's Vision.

Teaching

Training the next generation of GPs

What is it?

Medical students require placement in general practices to provide them with exposure to the specialty of general practice as part of their broader medical training. Support for medical students in general practice must be maintained and strengthened.

Benefits

- **Student exposure to general practice:** Medical students have exposure to other medical specialties via the hospital system, but cannot secure exposure to general practice unless individual practices provide a placement. It is vital that practices are supported to provide medical students, regardless of their ultimate career choice, with a quality general practice learning experience.

How is it best supported?

Teaching requires commitment and significant time and input on behalf of the practice and the GP leading the training. Suitable payments to practices would support coordination, infrastructure and administrative duties related to placing students within general practice. The PIP Teaching Payment provides support for this work.

Payments to GPs supervising medical students recognises the additional work involved in teaching or training and the opportunity cost of undertaking training. Creating a mechanism to support individual GPs who provide teaching and supervision will ensure that funding is directed to those undertaking teaching activities. The continuation of this support is crucial to the Vision.

IT and infrastructure

Using technology to improve efficiency

What is it?

IT, eHealth and physical infrastructure all play a pivotal role in creating capacity in primary healthcare.

IT and eHealth have the capacity and potential to support improved management of patient information and efficiency, reducing the administrative burden on the practice team, vastly improving service integration and continuity of care. Physical infrastructure is often required for a practice, particularly in an area of need, in order to expand to provide much needed services to the community.

Benefits

- **Increased capacity to provide services:** With greater physical space, a broader range of services can be provided within the practice setting (eg more acute services, group programs, additional nursing or allied health support).
- **Improved efficiency:** Improved IT and eHealth capabilities will improve practice efficiency, information security and management, and help reduce health spending wastage.

How is it best supported?

Ongoing funding for general practices to adopt new technologies and increase physical infrastructure is required. Dedicated funding has previously been highly effective in increasing general practice IT and physical infrastructure, resulting in increased capacity and the adoption of eHealth technologies. These programs should be continued and adequately funded.

Payments to practices that support adoption of new technologies and expansion of capacity, similar to current arrangements via the PIP and previous general practice infrastructure programs, would support improved IT capacity and integration.

Indexation

Maintaining the value of patient rebates and support payments

What is it?

Federal governments have traditionally indexed the MBS fees at a modest rate, providing small increases to patient rebates at a lower rate than the consumer price index (CPI). Medicare indexation has never kept pace with the costs associated with providing quality health services, and PIPs and SIPs have never been indexed.

The problem with freezing indexation

The sustainability of many general practices is threatened by the ongoing freeze on MBS fee indexation. The cost of delivering healthcare will continue to rise and absorption of the rebate freeze will become increasingly difficult. General practices will be under increasing pressure to pass additional costs onto patients.

The cumulative effect of the indexation freeze is that even children and concession card holders will inevitably face an increase in out-of-pocket costs when practices are forced to increase fees to cover the cost of delivering care. Patients who already pay gap fees will experience increasing fees over time.

The RACGP proposes that full indexation of MBS patient rebates be implemented

- **Create true sustainability for general practice patient services:** General practices are generally small businesses with little capacity to reduce the impact of rebate cuts on their patients over a long period of time. Suitable indexation of patient rebates and support payments will create genuine sustainability for general practice patient service delivery.
- **Minimise costs barriers to accessing care:** Access to high-quality primary healthcare is associated with better health outcomes and lower cost to the Federal Government. Further cost barriers that increase over time will negatively impact access to healthcare.

3. How the Vision could be funded

Implementing and maintaining the medical home will require additional investment in primary healthcare. However, any investment in general practice will result in cost savings overall, as efficiencies in the system are achieved.

3.1 Reducing costs in the hospital sector

Evidence from Australia and other countries indicates significant savings can be achieved through greater investment in general practice, reducing both emergency department presentations and preventable hospital admissions.[48,49]

Emergency department presentations

GPs would be able to manage most (if not all) emergency department presentations triaged as non-urgent or semi-urgent. These types of presentations include minor:

- wounds
- symptoms of existing stable illnesses
- limb trauma
- head injuries with no loss of consciousness.[63,64]

Most emergency presentations occur between 8.00 am and 8.00 pm, when general practices are most accessible.[63,64] However, most practices also have arrangements in place to support patient access to appropriate general practice care outside of these hours.

The RACGP estimates that GPs could manage nearly one-third of all emergency department presentations. General practice-type emergency department presentations cost $1.4 billion a year.[63]

If these presentations were reduced by 10%, savings of $140 million could be achieved. Savings of $423 million could be achieved through a 30% reduction.

Preventable hospitalisations

Preventable hospitalisations are those which could have been avoided if timely and suitable care had been provided (ie if primary care was utilised, if vaccination was provided and chronic conditions appropriately managed). These types of hospitalisations cost $2.5 billion a year.[63,65]

Greater investment in general practice to improve management of these types of conditions could achieve a 30% reduction in preventable hospitalisations, saving $700 million a year in hospital costs.[63,65]

Outpatient services

There were nearly half a million general practice or primary healthcare-type services delivered in hospital outpatient clinics in 2011–12. If these services were redirected into general practices, up to $108 million could be saved each year in the hospital sector.[63,65]

Table 3. Efficiencies to be found and savings to be redirected to better support GPs and their teams		
Emergency departments		One-third of emergency department presentations could be managed by GPs = **$1.4 billion every year**
Hospitalisations		6% of hospitalisations are preventable = **$2.5 billion every year**
Outpatient services		More than 400,000 general practice/primary care services are provided in outpatient clinics = **$108 million every year**

Redirecting savings into general practice

Better support and investment in general practice to reduce avoidable hospital presentations and admissions, combined with assuming responsibility for care provided in hospital outpatient clinics, would achieve savings of up to $1.2 billion.

Achieving savings through reducing preventable hospital presentations and admissions is only possible by investing in the rebuilding of Australian general practice.

3.2 Realigning PIP and SIP funding

The RACGP proposes that elements of the current PIP scheme be replaced by GP- and general practice-support payments. Through increased investment, and retargeting and reorienting the way in which PIP and SIP funding is distributed, significant overall improvements to the healthcare system can be achieved.

The RACGP advocates for the retention of the PNIP and PIP Teaching Payments with a broadened eHealth PIP to include infrastructure capacity. Retaining these payments should be contingent on regular review of these programs in order to ensure they remain appropriately targeted, and utilised by practices, with minimal red tape.

Better focused and better oriented payments will support practices and GPs in delivering quality, efficient, patient-focused care, benefiting individuals, families, communities and the Federal Government as health funders

4. *Implementing the Vision*

The RACGP recognises the need for a considered and comprehensive approach to implementing change within general practice and the health sector more broadly. GPs are time-poor and want to focus on providing high-quality care to patients, practices are balancing the increasing costs of providing care with meeting the needs of patients and change takes time.

Therefore, we recommend adopting a staged approach to implementation, with VPE being the first element to come into effect. Further detail regarding our suggested model of VPE is discussed in Appendix 1.

However, staged implementation does not mean partial implementation. All elements of the Vision are designed to complement each other and to, once fully implemented, support the delivery of general practice patient services through a patient-centred medical home model.

5. *Delivering community benefits*

In summary, the implementation of the RACGP's *Vision for general practice and a sustainable healthcare system* will see a range of benefits for patients, healthcare providers and Governments.

Figure 4. The benefits to patients, healthcare providers and governments

Appendix 1

Understanding voluntary patient enrolment

The RACGP has developed a model to support GPs and patients to develop and formalise long-term relationships through the mechanism of VPE. Our model for enrolment seeks to support general practices and GPs to undertake an enrolment process with patients, while minimising red tape, and supporting efficient and appropriate use of health spending.

The RACGP does not intend for VPE to change the way patient access to services is supported. Under our model, patients would still receive support via the fee-for-service funding approach as currently administered through the MBS.

Table 1. The RACGP's proposed model for VPE

Model	Enrolment would be driven by GPs, who would enrol a patient during a consultation The model does not include formal clinical assessment of need as part of the enrolment process
Eligibility	All patients would be eligible to enrol with a general practice and to nominate a preferred GP This model does not preclude patients from seeking care from a different GP or practice
Funding VPE	The RACGP recommends that a standard nominal fee is charged for patient enrolment, which would cover administrative time when enrolling a patient The enrolment fee would be paid directly to the GP, in addition to claiming a MBS patient rebate for the clinically relevant consultation for when the patient is enrolled (similar in concept to a bulk-billing incentive, which is paid in addition to the patient rebate)
Funding continuity of care	As part of the VPE model, the RACGP proposes establishment of a continuity of care payment A continuity of care payment would take the form of a quarterly or annual payment, paid per enrolled patient, if the enrolled patient accesses a defined proportion of medical services from their enrolled practice (determined by MBS claims history). This will: • incentivise practices to maintain continuity of care and to develop strong relationships with their patients • reduce the likelihood that practices will enrol patients without enhancing the continuity of care offered to enrolled patients, including arrangements for after-hours care
Roles and responsibilities	**GP's role** • Enrols patient during a consultation, collecting or updating patient information • Assumes majority of responsibility for enrolled patient (within defined parameters) • Provides ongoing care for enrolled patient using appropriate MBS item numbers **Practice's role** • Provides enrolled patients with information about: – the practice – access, including after-hours arrangements – vaccination (maintaining a vaccination register) • Institutes or maintains a recall and reminder system • Commits to be responsible for, and understand the needs of, their patient population, including compiling information on patient demographics and clinical data • Commits to provide swift access to enrolled patients who require urgent care
Implementation	A phased implementation over a three to five year period would allow patients, GPs and practices to adjust to an enrolment system Systems for recognising patient enrolment would be required to prevent patients from enrolling at multiple practices, and to determine eligibility for enrolment-linked MBS item numbers and continuity loading

The RACGP's recommended model for the coordination of care measure

The RACGP's proposed model for the coordination of care measure seeks to redesign the chronic disease management (CDM) MBS item numbers – General Practice Management Plans (GPMPs) – to better target services to patients most in need.

The RACGP's proposed model is based on the Department of Veterans' Affairs' (DVA) Coordinated Veterans' Care (CVC) program.

Table 2. The RACGP's proposed model for chronic disease management

Model	The RACGP proposes a three-tier system for managing enrolled patients with chronic disease			
		CDM A	**CDM B**	**CDM C**
	Target population	Enrolled patient who has a chronic disease requiring little or no structured care	Enrolled patient who has a chronic disease requiring multidisciplinary team care	Enrolled patient who has a chronic disease and is at high risk of hospitalisation, or an enrolled patient who requires palliative care
	GPMP prepared or updated	If clinically indicated (exclusion criteria would apply)	Yes	Yes
	Team care arrangements (TCA)	No	Part of GPMP	Part of GPMP
	Allied health visits	Up to three	Up to five	Five plus five (extra five after additional GP review, if required)
	Model	Current practice for GPMP	Current practice for GPMP, incorporating simplified TCA	Modelled on DVA's CVC program
Eligibility	Patients with chronic and complex health needs that require a degree of coordination of care, and who are enrolled with a practice would be eligible to access CDM MBS item numbers GPs should determine which of their (or their practice's) enrolled patients require the range and level of services provided under each of the CDM tiers, in accordance with guidelines agreed upon with the Department of Health			
Payment schedule	Proposed payment schedule across three tiers of CDM items			
		CDM A	**CDM B**	**CDM C**
	MBS rebates for ongoing care provided by GP	Yes	Yes	Yes
	MBS rebate for preparation of GPMP by GP	Yes	Yes	Yes
	Support payments for coordination of care by GP or delegate	No	No	Yes
Roles and responsibilities	**GP's role** • Determination of eligibility for CDM item and suitable tier • Preparation of GPMP • Review of GPMP • Review of allied health service provision and determination of need for additional appointments (CDM C only) **Practice's role** • Employment and support for general practice nurse to undertake coordination and integration activities			
Implementation	This measure would be contingent on the introduction of VPE			

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