RACGP pre-election statement

10 May 2013

The Royal Australian College of General Practitioners
1. Get real about investment in GP services for patients – rebates need to keep pace with inflation

- Care delivered through primary healthcare is the most efficient way to deliver healthcare, and as such, needs to be funded accordingly.
- Although bulk-billing rates for GP services are at a record high, with 82% of GP services bulk billed in the December quarter, this is not an accurate reflection of the “appropriateness” of patient rebates.1
- Affordability of healthcare is poor. Australia has the 5th highest out-of-pocket healthcare costs in the world, with the average Australian paying $1075 per year in out-of-pocket expenses2
- Patients are increasingly delaying seeing their GP/a GP due to financial reasons. Around 8% of persons that needed to see a GP in the previous 12 months had delayed seeing or had not seen one because of the cost.3
- MBS fees have not kept pace with inflation in the past 20 years, and as such, need to be reviewed to address this.

2. Genuinely commit to preventive health and invest in the future

- General practitioners play a crucial role in preventing and/or managing chronic diseases by identifying and monitoring biological and behavioural risk factors, providing clinical advice, counselling, prescriptions, and referrals to other health professionals.
- Improvements in general practice will, in turn, lead to cost-savings associated with reduced reliance on secondary and tertiary healthcare; reduced physical, psychological and social disabilities.
- Yet, dedicated expenditure on prevention in general practice represents less than 2% of MBS expenditure.4
- Properly supported preventive health will benefit patients (through targeted preventive health advice, lifestyle advice, and earlier detection of issues/potential issues and treatment)
- Preventive health will also achieve long term savings to the health budget
- Expand health checks to include health checks for people at key stages throughout their life, including adolescents and young adults.

3. Strengthen chronic disease management and coordination of care

- General practice needs real investment (funding and support) in chronic disease management – not shifting of funding – if it is to assume an expanding role and absorb the additional work required in the management of the majority of chronic disease conditions within the community setting.
- By investing in general practice chronic disease management and coordination, real savings “downstream” in the health system can be achieved.
- Strengthening funding for chronic disease management will facilitate partnership between individual patients, their personal GP, and extended healthcare team, allowing for better targeted and effective coordination of clinical resources to meet patient needs.
- There are identifiable and measurable benefits associated with chronic disease management and coordination of patient care delivered in GP led teams, including:
  - Improved continuity of patient care5
  - Improved quality and cost effectiveness of care for patients with a chronic disease, achieved through reduced hospital presentations (32-40% drop), hospital admissions (16-24% drop), and length of hospital stay (36% drop)6,7,8
• Reduced disparities in access to for traditionally difficult to reach groups

• Improved overall population health\lower overall healthcare spending.

4. Improve health outcomes for Aboriginal and Torres Strait Islander Peoples

• Shape the direction of future reform to close the gap:
  • More collaborative COAG dialogue and a commitment to stronger future collaborative reform - there needs to be stronger collaboration between primary care (including Medicare Locals) and Aboriginal Community Controlled Health Services (ACCHSs) to ensure that Aboriginal and Torres Strait Islander health service planning and delivery and the overall health advancement of the community is a high priority.
  • Build sector capacity through stronger investment in ACCHSs – invest in ACCHSs as they deliver best practice chronic disease management and preventive care and are a proven model of success.
  • Address cost barriers (pharmaceutical) through the expansion of proven strategies – a commitment is needed for recurrent and ongoing delivery of closing the gap PBS co-payment relief scheme. This will ensure a reduction in cost barriers for patients and enable gains to continue be made in prevention and chronic disease management.
  • Invest in a strategy that closes the MBS inequity gap – there is a need for the development of an investment strategy that closes the MBS inequity gap. “Overall [in 201—2011], per person expenditure for MBS services was lower for Indigenous Australians ($493) than for non-Indigenous Australians ($737)” An increase in spending on MBS and PBS is required, taking into account the greater health needs of Aboriginal and Torres Strait islander people and access issues. Except for remote and very remote areas, PBS expenditure per person was lower for Indigenous Australians. Services need to be more accessible, and incentives could be offered to encourage this.

• Support GPs to provide healthcare for Aboriginal and Torres Strait Islander patients:
  • Recognise that Australian general practices need support to improve practices and processes concerning the identification of Aboriginal and Torres Strait Islander people in their patient population groups. The National Indigenous Reform (Closing the Gap) Agreement expects that “all jurisdictions will improve procedures for collecting Indigenous status information in health and education by training staff in key data collections positions about how and why to ask the Indigenous status questions and raise awareness about its importance.”
  • Invest in an effective communication campaign, targeted to all GPs and their practice staff, to educate general practice about the range of GP-mediated interventions available for their Aboriginal and Torres Strait Islander patients. For example a telephone hotline for GPs providing care to Aboriginal and Torres Strait Islander patients could be funded.
5. Secure the rural and remote workforce we need through better planning, stronger investments in and rewarding of rural skills

- Work towards a more equitable system through 3 key action areas:
  
  i. Shift to a patient centred approach to health needs analysis – lead and invest in a national system of health needs analysis to ensure resources are prioritised and directed to the areas of most need
  
  ii. Fix the rural classification system – commit to fixing the current anomalies in the Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) classification scheme to a system that moves beyond the current locational aspects towards analysis based on local need and context to ensure a fairer share for rural communities
  
  iii. Build capacity to sustain rural skills - commit to a centralised workforce planning approach to accurately map and fund training requirements, with priority for rural training positions, providing certainty across the full medical education and training pipeline, including significantly increasing GP training positions.

- Secure a future general practice workforce through stronger investments in rural skills and training:
  
  - skills and support:
    
    i. Reward rural skills to ensure an appropriately trained and resilient rural and remote health workforce that is able to respond to the challenge of managing growing demand in rural and remote communities. Maintain the Rural Procedural Grants Program ($80.0M) and introduce an Advanced Skills Grants Program ($80.0M)
    
    ii. Provide additional investments in rural skills and supports including the development of Clinical Skills Maintenance Workshops ($0.7M), the expansion of the Rural Locum Education Program ($1.0M), and support for GPs undertaking FARGP ($2.0M)
    
    iii. Support IMGs through education programs, and recurrent funding for mentoring and support.
  
  - training integration:
    
    i. Integrate medical school, hospital-based post-graduate years, and vocational training to provide a practice-based training ‘pipeline’ to support rural general practice workforce recruitment and retention aims helping to address maldistribution and overcome policy inconsistencies
    
    ii. Expand clinical training capacity to meet demand, including further investment in and expansion of training capacity in rural general practice in order to meet increasing demand for medical training in the clinical general practice setting ($52.0M for Rural Teaching PIP increase, and 10% increase in Practice Subsidies).

6. Reverse current trends to specialisation and sub-specialisation by investing in GP training and encouraging junior doctors to choose general practice as their career of choice

- Quality patient care delivered via general practitioners, in collaboration with other medical specialists, is the most efficient and cost effective way to successfully manage the healthcare
of an ageing population with increasing numbers of patients with complex multi-system conditions.

• Medical Undergraduate training places were originally increased to redress the rural and outer metropolitan community's access to general practice services.

• The most recent Medical Workforce 2011 report released by the Australian Institute of Health and Welfare (AIHW) showed a decline in the supply of GPs despite recent increases to GP vocational training, whereas other specialty areas demonstrated overall growth. 13

• To reverse the trend, further increases are required.

• Increase GP training numbers to 1700 per annum.

• Increase prevocational training numbers to 1500 per annum to expose junior doctors to general practice early.

• Double the teaching PIP from $100 to $200 for each three hour teaching session to support GP supervisors.

7. Greater investment is needed to ensure that general practitioners are able to meet professional development requirements

• There needs to be greater investment in ongoing professional development and quality improvement activities for Australian general practice.

• General practitioners should not be deterred from participating in quality professional development activities (including clinical audit, peer-review, conference attendance, and online learning) to address their individual learning needs (maintain or improve their existing knowledge base and skill set), due to financial constraints.

• Ensuring such ‘accessibility’ supports a safe and high quality primary health care delivered to our communities is maintained.

• The $2000 cap on tax deductions self-education expenses for general practitioners falls well below many basic course costs and needs to be addressed.

8. Improve patient access to healthcare through videoconferencing and e-health

• Telehealth services are beneficial for many groups patients, particularly those with chronic disease(s) who have difficulties accessing their GP due to transport, mobility, and distance issues (including those living in remote areas). 14

• Introduce GP to patient videoconferencing in general practice as part of the MBS.

• Introduction of videoconferencing services will be cost neutral, as services will be used as an alternative to face-to-face services – not in addition to.

• RACGP can work with government to ensure that the system benefits patients who are most in need.
References


10. Australian Institute of Health and Welfare (AIHW) 2013, Expenditure on health for Aboriginal and Torres Strait islander people 2010-2011, p.11.


