RACGP submission to *Unleashing the Potential of our Health Workforce Review* (Scope of Practice Review)

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Executive Summary

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to provide a submission to the Department of Health and Aged Care's (DoHAC) independent Scope of Practice Review, led by Professor Mark Cormack.

The RACGP's position on the Scope of Practice Review is that the Review must be about more than role or task substitution. The RACGP has previously called on the Government to ensure:

- maintaining the quality and safety of patient care is the primary consideration of any change to scope of practice for all health professionals
- changes in scope of practice are being considered in the context of enabling best practice multidisciplinary care teams (MDCTs) focussed on delivering coordinated, continuous and whole of person care
- the review is underpinned by the quadruple aim we all strive for in health care – improved patient and population outcomes and experience, and improved care team worker experience, for lower overall cost.
- GPs are also facilitated to work at top of scope.

The RACGP defines "full scope of practice" for general practitioners (GPs) as the breadth of competencies attained upon completion of medical and general practice specialty training. "Top of scope" is defined as the value that GPs add over and above what other health professionals in the general practice team can do. This can be restricted by MBS or regulatory barriers.

Enabling general practice

In developing this submission, the RACGP consulted widely with members.

The overwhelming majority of GPs believed they could increase their scope of practice for the benefit of their patients.

Limitations of GPs' scope of practice result from:

- GPs not being allowed to provide certain services for which they have the clinical competencies, training and skills to provide safely, effectively and economically. Eg interpret electrocardiograms (ECGs).
- In the case of some other services, GPs are allowed to provide them but find it difficult to do so because third-party funders of care (such as Medicare, other government agencies, private health insurers and compensation authorities) do not provide any subsidy to patients or funding for GPs to do this. Eg iron infusions and joint injections/aspirates.

  For some services, those third-party funders do provide subsidies or alternate funding to patients when other (non-GP) health professionals provide those services. Eg Patients needing diagnosis and management of dementia must see a geriatrician due to GPs having limited MBS access to amyloid PET scan or functional MRI (for diagnosis) and PBS prescription of cholinesterase inhibitors (for management).
- Increasingly, state health services and hospital specialist teams provide primary care services. This has the effect of de-skilling general practice teams and increasing demand for hospital services. Eg palliative care outreach service, type 2 diabetes clinic, complex wound clinic.

Barriers

The **reported barriers** to GPs working to their "full scope of practice" broadly fall under the following themes:

1. Lack of financial support from third party funders of care, including government, through patient subsidy or other mechanisms.
   - Especially, relative to increased complexity and inherent legal risks of skills being utilized (particularly for some procedures, mental health and women's health services).
2. Restrictions imposed that unnecessarily curtail scope.

- For example, through (MBS) item descriptors and Pharmaceutical Benefits Scheme (PBS) restrictions.

3. Red tape and Medicare complexity.
    - Fear that non-compliance will result in punitive penalties.
    - Onerous administrative requirements that make practicing in an area unattractive or unaffordable or that are inconvenient to the patient (such as providing certain sick certificates or the assignment of benefit requirements for bulk billed telehealth consultations).
4. Lack of funding and system support for interdisciplinary and multidisciplinary care in general practice.
    - Medicare benefits payable only when services are provided personally by or under the direct supervision of the GP, inhibiting delegation of tasks to the broader practice team.
5. Lack of access to local community health data (eg antibiotic resistance and infectious disease data) and other disease information and evidence to assist GPs in tailoring care to their local communities.
6. Costs associated with additional training and education and sometimes difficulties accessing this education and training.
7. Inadequate recognition and respect of the role of the GP and their skills by other professional groups and government agencies.

Facilitators

The **reported facilitators** for improving access to general practice and increasing the capacity of the health system included:

- Greater utility of MDCT within general practices (in-building or in "well-planned virtual buildings" in remote areas) by sharing or devolving tasks to other health professionals in their teams.
- Being able to initiate and/or continue medications which currently require a non-GP specialist or other (such as stimulant medication for attention deficit hyperactivity disorder [ADHD], oral isotretinoin for acne, cholinesterase inhibitors for dementia, antiviral medications for human immunodeficiency virus [HIV], gender affirming hormone therapy and adrenaline autoinjectors for anaphylaxis).
- Being recognised as specialists with agencies like Centrelink, workers compensation bodies, the Department of Veteran Affairs (DVA) and National Disability Insurance Agency (NDIA).
- Facilitation of access for GPs as visiting medical officers or employees within hospitals (admitting rights, access to day surgery units or local hospital lists to maintain surgical and other sub-specialty skills such as colposcopies and endoscopies), with recognition that GPs can play valuable roles in hospital care, including liaison roles between hospital and primary care as well as direct clinical care.
- Non-disease specific MBS items that reward management of complex and time-intensive health care needs (such as: chronic disease, multimorbidity, mental health, women's health, trauma, substance use), and adverse social determinants of health such as poor quality or overcrowded housing and lack of access to other health services, either through cost or long wait times in the public hospital system.
- Medicare benefits being payable for investigations such as magnetic resonance imaging requested by GPs. Currently Medicare benefits are payable for some investigations only when they have been requested by a non-GP medical specialist, even by a specialist who has no expertise in the patient's health problem.
- Reducing or removing requirements to maintain credentialing for delivering particular care, such as for opioid agonist therapy.
- Increased blended funding to support training and ongoing professional development, in addition to being subsidised or funded for the provision of additional services and tasks devolved to the broader multidisciplinary general practice team.

Fragmentation of care reduces healthcare efficiencies and drives up costs.

By enabling GPs and their teams to work to the top of their scope, more patient care could be provided in the community in line with the principle of the right care, delivered in the right place, at the right time.

Introduction

*"There are **four main features of "good" primary care services**:*
first-contact access for each need;
long-term person (not disease) focused care;
comprehensive care for most health needs; and
coordinated care when it must be sought elsewhere.

Primary care is assessed as "good" according to how well these four features are fulfilled. For some purposes, an orientation toward family and community is included as well."

Barbara Starfield, Liyu Shi and James Macinko

Professor Barbara Starfield is internationally known for her work in primary care and her books and research are widely recognised as seminal works in the field. Her work has defined the key features of "good" primary care services.

In Australia, primary care has been viewed as "care that happens in the community". However, **primary care is about more than just the setting or being an access point for the system**. Primary care offered by general practice is both wholistic and holistic in its approach. General practice embodies all the features for "good" primary care. It is comprehensive, coordinated and continuous across a person's lifespan. It includes health promotion, prevention and screening, early intervention, treatment and management.

Unfortunately, with increasing rates of chronic disease and an ageing population, government subsidy and funding of Medicare for primary care has not kept pace with patient needs. **The fee-for-service Medicare Benefits Schedule (MBS) funding mechanisms incentivise volume-based care over integrated, team-based and longitudinal care models**.[1] General practice needs a system that supports coordinated, continuous and often complex care.

State, territory and federal governments are focused on addressing health workforce shortages and maldistribution to improve patient access to primary health care and to ease the burden on secondary and tertiary care. However, workforce shortages are being experienced across many sectors including nursing, pharmacy and allied health. Reviewing barriers and incentives for working to full scope of practice and empowering coordinated multidisciplinary teams to optimise the health workforce will improve overall access and equity to healthcare, ***provided* the solutions embody all the features of "good" primary care**. Nurse-led clinics and independent pharmacist prescribing are among some proposed "solutions" to address patient access challenges. However, **these models are flawed** as they do not incorporate all four of the main features of primary care services. It is essential that all the parts of primary care will work efficiently and safely together and that any provider of primary care services should be assessed for and meet these measures. Fragmented healthcare has been shown to be less safe and more expensive than models that facilitate continuity of care. Therefore, reform based on only the prioritisation of access at the expense of longitudinal, comprehensive and coordinated care doesn't work.

General practice is a specialty

The RACGP is Australia's largest professional general practice organisation, representing over 46,000 members working in or toward a specialty career in general practice including four out of five GPs in rural Australia.

The RACGP sets and maintains the standards for high-quality general practice care in Australia and advocates on behalf of the general practice discipline and our patients. As a national peak body, our core commitment is to support GPs and their broader healthcare teams to address the primary healthcare needs of the Australian population.

General practitioners undertake the same first eight (8) years of medical training as other specialists like cardiologists, dermatologist, psychiatrists, and others. This training includes six (6) years of medical school and two (2) years as an intern, before then entering the community to undertake a further three to four years of specialist general practice training. The speciality is selected, not a default training pathway for unsuccessful applicants of other medical specialties.

To achieve Fellowship and as generalist specialists, GPs have been assessed against the RACGP curriculum and syllabus at the level of Fellowship as detailed in the "Capability profile of the general practitioner". In the curriculum and syllabus, the scope and range of GP skills is detailed in the 'guiding topics and areas' and the 'competencies and learning outcomes' sections within each unit. In the profile, the "Statement of fellowship outcomes" details the specific competencies of a GP at fellowship.

Ongoing continuing professional development (CPD) is about maintaining Fellowship, but some GPs wish to extend their skills beyond that, within the scope of general practice and the community setting. Some of these extended skills are currently being defined by the RACGP's 37 specific interest groups. There may be additional education and training to attain these extended skills but they are building on foundational skills GPs have already achieved in attaining Fellowship. In many urban areas GPs with a Specific Interest (GPSIs) work to the top of their scope of practice or, following additional hospital-based training, expand their scope in a certain area to provide care within hospital teams.

In some instances, GPs may expand their scope of practice into obstetrics, anaesthesia, emergency medicine, palliative care and surgery, particularly in regional, rural and remote locations. GPs undertake additional training, developed in partnership with the relevant College (such as the Royal Australian and New Zealand College of Obstetricians and Gynaecologists in the case of obstetrics training).

"Generalism" is at the core of all general practice. GPs continually maintain their breadth of knowledge and skills ("full scope of practice") and may even deepen or extend their foundational training to match the needs of their community as well as for personal development. GPs are experts in undifferentiated illnesses, chronic disease management, complex multi-morbidity and judicious and coordinated use of finite medical resources.

The role of general practice in a coordinated, sustainable, accessible and affordable health system.

*Extracted from the RACGP's Vision for general practice and a sustainable health system

A key role of general practice is to guide patients through the complexities of the healthcare system while preventing unnecessary screening, testing and treatment and guiding patients to seek appropriate care.

Every touch point in in the provision of general practice care affords an opportunity to improve on multiple health outcomes. A visit to a GP is not just about 'getting a prescription for a medicine'. **An analysis of over 1.5 million GP-patient encounters in Australia confirmed that the majority of GP appointments made specifically to request medication resulted in additional healthcare needs being addressed during the same visit.**[2]

Multiple health professionals working in isolation and offering or purporting to offer the same service reduces opportunities for comprehensive care, adds to health system complexity, duplicates and/or fragments care, creates patient confusion around role delineation[3] and directs patients away from the essential coordinated medical care provided by their general practice. **Fragmented healthcare has been shown to be less safe and more expensive than models that facilitate continuity of care**. **Local and international evidence shows better support for, and use of, general practice is**

associated with lower emergency department presentations and hospital admissions[4,5,6,7,8,] decreased hospital readmission rates[9], and significant savings for the healthcare system[10,11, 12].

Effective and efficient long-term management of complex, chronic diseases is one of the greatest health-related challenges facing government, citizens and health professionals. In 2018-2019, the disease groups that caused the most burden on the health system were cancer, musculoskeletal conditions, cardiovascular diseases, mental ill-health and substance use disorders. These conditions accounted for 35% ($47 billion) of total national health expenditure ($133.9 billion).[13] Lumos[14] data in NSW demonstrates the benefits of GP access to reduce hospital readmissions and in the management of chronic diseases. The data showed that a GP visit within the first week of hospital discharge was followed by 7% fewer readmissions within 28 days, while a visit in the first four weeks resulted in 13% fewer readmissions over the following 1–3 months. Unplanned readmissions are estimated to cost Australia in the order of $1.5 billion annually. Reducing avoidable hospital readmissions supports better health outcomes, improves patient safety and leads to greater efficiency in the health system.[15]

Consideration should be taken to ensure that any new mechanisms introduced to facilitate scope changes do not result in increased fragmentation and siloed health care provision. Patient safety is paramount and best protected where multidisciplinary teams, which include their GP, are working together to provide coordinated, collaborative and continuous care.

To achieve this, significantly increased funding is required for general practices to employ, coordinate and provide oversight to a team of qualified health professionals, including nurses, nurse practitioners and pharmacists. This could be facilitated through the Workforce Incentive Program (WIP) and other blended funding.

The RACGP supports the WIP Practice Stream as it recognises the additional time required for GPs to effectively lead patient care across the MDCT and encourages more general practices to employ nurses as part of a general practice based MDCT allowing clinicians to work to top of scope. It could be expanded to included dedicated funding for general practice-based pharmacists.

RACGP's response to the consultation questions

General

Q1. Which of the following best describes your interest in the Scope of Practice Review? (Select from list)

Medical - GP

Q2. What is your postcode?

N/A – National organisation

Benefits of expanded scope of practice

Q3. Who can benefit from health professionals working to their full scope of practice? (Select from list)

Consumers, Funders, Health Practitioners, Government/s, Other - Insurers

Q4. How can these groups benefit? Please provide references and links to any literature or other evidence.

Enabling GPs to work to their full scope benefits consumers (timely access to care in the community, closer to home), health funders (care provided by primary care is the less expensive part of our healthcare system) and it creates improved job satisfaction which has expected workforce flow-on effects such as GP attraction and retention, and increased hours for part-timers. When other team members in general practices are added and enabled to work to their full scope of practice, GPs will be able to delegate more within the coordinated practice team, freeing up more time for complex or urgent care. This will result in improved access to general practice.

Benefits for consumers

Consumers benefit when they can access the care they need, provided by the most appropriate health professional in a coordinated and timely manner, whilst considering their care in the context of their individual needs. They also benefit when they can access care close to home and have most of their care met in that setting. Where referral onward is needed, it is coordinated.

Key benefits include:

- better outcomes for people who can access culturally safe care
- improved equity of access through increased range and number of services delivered.

When GPs and their general practice team are appropriately supported to deliver evidence-based preventive care and high-quality acute and chronic disease management, patients also benefit from a reduction in future out-of-pocket costs and the costs associated with unnecessary investigations. There are significant risks with over-investigation including patient harm, so GPs working to their full scope of practice benefit patients. Australians are experiencing financial strain and therefore will benefit from any reduction to expenditure for unnecessary investigations.

Evidence-based preventive care and high-quality acute and chronic disease management provided through general practice will:

- ✓ help people to live healthier lives and age well in the community
- ✓ reduce disease complications and prevalence of preventable hospital presentations and admissions
- ✓ reduce healthcare expenditure for government
- ✓ reduce future out-of-pocket costs for patients
- ✓ address health disparities and inequities experienced by some population groups
- ✓ increase the overall economic productivity of society.

GPs and their teams already provide preventive care to their patients. However, there is opportunity for patients to be further supported to access preventive care routinely through their general practice.

*Extracted from the RACGP's Vision for general practice and a sustainable health system

Preventative care and long-term management of chronic disease is particularly important for rural and remote communities. The rate of potentially preventable hospitalisations and potentially avoidable deaths increase with remoteness.[16] Having adequate access to coordinated care that includes screening, early disease management, and supportive care interventions through primary and community care are imperative to closing gaps in health equity for rural and remote patients and reduces the need to travel for hospitals and acute care services.

Benefits for Government(s) and Funders

More care provided by general practice teams equals better long-term outcomes and lower costs. Primary healthcare system reform around the world has largely been guided by the 'Quadruple aim of primary healthcare' and Australia's Government has also adopted this approach to reform. Importantly, these aims can only be achieved by encompassing the four main features of primary care described earlier in this submission.

The Quadruple aims are:

- Improve the health of the population.
- Improve the patient experience of care.
- Reduce healthcare costs.
- Improve the work life of health providers.

Following these principles, first released in 2015 and then revised in October 2019, the RACGP published its *Vision for general practice and a sustainable healthcare system* (the Vision), outlining a model of care that aims to address many of Australia's longstanding healthcare challenges.

Australia's health system needs modernising to better suit the needs of an ageing population requiring care for complex chronic conditions.[1] It is important to prioritise affordable, accessible, coordinated, continuous and high-quality general practice services supported and coordinated in a team environment. This in turn will support GPs working to the top of

their scope, allowing patients to talk to their GP, not only when they are sick but also about how to stay healthy and active in the community.[1]

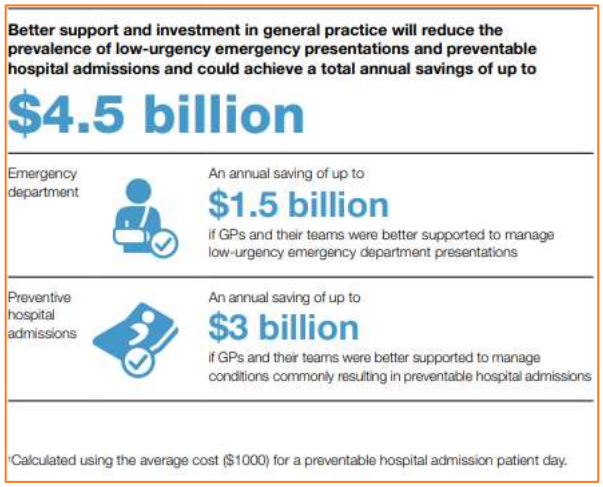
The RACGP Vision is underpinned by six core features of high-performing general practice (patient-centred, continuous, comprehensive, coordinated, high-quality and accessible) and was developed by specialist GPs through extensive consultation with stakeholders including members, consumer groups and peak health bodies.[1] The Vision emphasises the critical role GPs play in the overall health system. **By adopting a patient-focused model of care, it supports GPs working to their full scope of practice to provide continuous and coordinated care to patients of all ages, genders and cultural backgrounds.**

The Vision aims to ensure the sustainability of the healthcare system, identifying opportunities for reform centred on better use and support of general practice, the most efficient part of the healthcare system.

The Price Waterhouse Coopers (PwC) report, commissioned by the RACGP - *Economic benefits of the RACGP's Vision for general practice and a sustainable healthcare system* estimated (conservative) direct benefits of implementing the Vision to be in the order of $1.0 billion in 2021 and $5.6 billion over the following five years at a minimum[7]. The report also acknowledged many non-monetary benefits from the implementation of the Vision, including improved access to general practice, improved health and social outcomes for vulnerable groups, improved patient satisfaction with care and improved health provider satisfaction[7].

Calculated in 2021, the estimated benefits of the Vision included:

- $152 million of savings in preventable hospital admissions,
- $552 million of savings in emergency department presentations and
- $69 million of savings in unplanned hospital readmissions[7].



*Extracted from the RACGP's Vision for general practice and a sustainable health system

In addition, it was expected to generate $250 million of savings in workforce productivity and a gain of 98,000 Quality-adjusted life years (QALYs)[7].

There are significant cost implications with over-investigation and GPs are trained in rational test ordering which provides economic benefit to government(s) and funders (RACGP - We live in testing times – teaching rational test ordering in general practice). There is evidence that established GPs order less tests per consultation and problem than trainees (Pathology test-ordering behaviour of Australian general practice trainees: a cross-sectional analysis - PubMed [nih.gov]).

A US study[17] of nurse practitioners [NPs] working in an emergency department showed that compared to physicians, NPs incur greater resource costs to treat patients yet achieve worse patient outcomes.

GPs working to their full scope of practice enables a greater focus on health promotion and preventive care, which alongside reducing expenditure for governments, will address health disparities between population groups, help people live and age well in the community, reduce disease complications and prevalence of preventable hospital presentations and admissions, and increase the overall economic productivity of Australian society[1]. It would also improve health system capacity with each health workforce providing the widest range of services they can deliver safely, and improve health system productivity and efficiency, with care directed to the profession with the most appropriate skills to meet the person's healthcare needs.

Benefits for health practitioners

In addition to the benefits for patients and funders, ensuring full scope of practice for practicing GPs is expected to increase career satisfaction, contributing to the attractiveness of general practice as a medical specialty and improving retention.

As a part of a general practice MDCT that includes GPs, other health professionals can, and do, deliver safe and high-quality care to patients.

It is important that new initiatives foster collaboration and coordinated multidisciplinary care and not create more fragmentation (see Q5).

Risks and challenges

Q5. What are the risks and other impacts of health practitioners working to their full scope or expanded scope of practice? Please give examples of your own experience.

1) Role and task substitution across settings will not address the issues associated with workforce shortages

While there is a need to enhance the health workforce, task and role substitution (through increasing scope of practice) in a non-coordinated, non-collaborative way does not appear to have resolved international workforce crises. Policy makers need to consider the unintended consequences from well-intended policy that sounds sensible, but actually ends up working in the opposite direction.

There is limited economic evidence for role substitution in primary care; more economic evaluations are needed.[18]

A US study[19] of nurse practitioners [NPs] working in an emergency department showed that compared to physicians, NPs incur greater resource costs to treat patients and resulted in worse patient outcomes. Additionally, evidence[20] showed that seeing a nurse at a nurse-led clinic in the Australian Capital Territory costs four times as much as seeing a GP and increases accident and emergency visits which is not cost effective. **The average cost to taxpayers per service delivered by a nurse-led clinic was $162.21 compared to $38.20 for a 'standard' MBS item 23 Level B GP consultation.**

Dependent on experience, nurses rely on decision-making algorithms in their practise, which may result in high levels of referrals to specialists, high rates of diagnostic testing and prescribing.[21, 22]

A Cochrane review of non-medical prescribing for acute and chronic disease management in primary and secondary care found that non-medical prescribers prescribed more drugs, at higher drug doses and used a greater variety of drugs compared to 'usual care' medical prescribers.[23] This becomes a very expensive model of care. An analysis of a Cochrane Review with positive findings for non-medical prescribing found that non-medical prescribers frequently had medical support available to facilitate a collaborative practice.[24]

Healthcare in rural and remote locations is nuanced and favours flexible arrangements over rigid policy. Whilst pharmacists, nurses and NPs can play an important role in areas of need, working in partnership with other healthcare providers, health professionals working independently is not a long-term workforce solution. All patients should have access to a GP who can coordinate their care, whilst also providing high-quality, safe medical diagnoses and management for all presentations in the community context.

The United Kingdom, Canada and the United States are all reporting GP workforce crises despite a decade of access to nurse and pharmacist prescribing. Alberta (where pharmacists have the broadest scope of practice) is experiencing a doctor shortage which is sparking concerns about patient care and safety.[25,26]

Medical workforce shortages in general practice are better addressed by:

- improving support for medical training in general practice
- improving MBS and WIP funding for existing service providers/prescribers
- cutting red tape preventing overseas trained doctors from working in Australia (whilst considering concerns raised in RACGP's submission to the Kruk report)
- providing incentives to encourage medical practitioners to work in rural/remote areas and underserved populations

- improving access and pipeline by encouraging junior doctors to complete GP rotations as part of their hospital training
- ensuring non-GP and GP workforces are being best utilised within their existing scope of practice.

2) Prioritising access over continuity of care by using multiple providers who offer similar services, across different settings increases cost and unnecessary fragmentation

In delivering a high-performance health system, it is necessary to allocate resources carefully and effectively and assess the cost-effectiveness of services.

Local and international evidence shows that better support for, and use of, general practice is associated with lower numbers of emergency department presentations and hospital use[27,28,,29,30], decreased hospital readmission rates[31], health benefits for Aboriginal and Torres Strait Islander communities[32,33] and significant overall savings for the healthcare system.[34,35,36]

The Commonwealth Fund's *Mirror, Mirror 2021: Reflecting Poorly – Health Care in the US Compared to Other High-Income Countries* report[37] **ranked Australia with Norway and the Netherlands as the top-performing countries overall**, outperforming the United Kingdom, New Zealand, Canada and the United States**.**

All patients should have access to general practice-based primary healthcare that meets their health needs. Current challenges should not deter Australia from striving for equity of access. **The RACGP continues to be concerned about task substitution as a solution to workforce shortages and the prioritisation of rapid access to primary care through various health professionals without focusing enough on the patient needs and the core model of 'continuity of general practice-based care'.**

Figure 1 (below) shows the associations between continuity measures as years with the same regular general practitioner (RGP) and odds for use of out-of-hours (OOH) services, acute hospital admissions and mortality in a 2018 Norwegian study.[38] This demonstrates that the length of the patient-RGP relationship is significantly associated with lower use of all of these service types and lower mortality. "The presence of a dose-response relationship between continuity and these outcomes indicates that the associations are causal".[38]

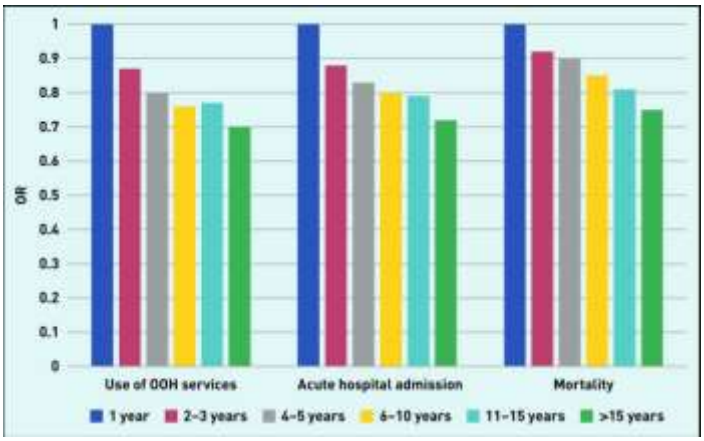


Figure 1:

Length of patient-regular doctor relationship is associated with lower use of out-of-hours services, fewer acute hospital admissions and lower mortality.

Episodic and independent care from multiple providers risks undermining the quality and efficiency of the Australian healthcare system, is expensive and results in poorer patient outcomes.[39] This results from factors such as a lack of consistency and unified medical records, ineffective clinical handover, missed opportunities for patient follow-up, learning from patient interactions, the provision of contradictory clinical advice, missed opportunities to detect contra-indications and to initiate a range of opportunistic health promotion activities, and diminished clinical governance and accountability. Losing this important opportunity for holistic, comprehensive and integrated care is detrimental for patients.

Fragmenting healthcare has been shown to be less safe and more expensive than models that facilitate continuity of care. Whilst integrated MDCT's broaden the range of care offered to patients by building capacity and streamlined healthcare within a given setting. Task substitution offers the same range of care, provided by different health professionals, losing the opportunity for comprehensive, safe and integrated care.

Teamwork and cooperation are also critical. In October 2022, the United Kingdom House of Commons Health and Social Care Committee *Future of General Practice* report showed there was a high level of consensus about the potential benefits of 'an array of professionals working in general practice' and identified that there needs to be better funding for these roles **in** general practice to allow GP supervision and flexibility in the type of staff recruited to meet community need. It also stated that 'there can sometimes be a trade-off between access and continuity, and…the balance has shifted too far towards access at the expense of continuity'. There is substantial evidence to show that continuity of care improves health outcomes.

Ireland's Health Service Executive 'Enhanced Community Care' initiative also promotes primary care MDCT's, noting they are '**ideally based in a building where accommodation is appropriate and available to enhance multidisciplinary work**'. In rural and remote Australia, there is scope for "virtual buildings". However, the same patient record must be accessed on all occasions, by all members of the care team, to create a comprehensive record that drives patient safety and allows whole-of-patient review. **My Health Record is not an adequate communication tool for use in collaborative care. It is not comprehensive or established.**

The RACGP fully supports multidisciplinary team-based primary care settings which include a GP, such as general practices and Aboriginal and Community Controlled Health Services. These settings allow health professionals to work collaboratively with GPs.

Research in 6,287 general practices in England between 2015 and 2019 found that the highest quality of care was seen in teams with more GPs. It was only slightly more expensive to employ GPs than non-GPs. Higher numbers of pharmacists within the general practice team increased the quality of prescribing and lowered prescribing costs. Teams that were predominantly GPs and nurses were associated with lower accident and emergency attendances than teams which had higher numbers of other clinicians.[40]

Patient safety is paramount and best protected where health service providers are working together respectfully and appropriately, communicating fulsomely, with instruments such as Medicare-subsidised GP Management Plans and Team Care Arrangements. Using skills, expertise and established scopes of practice in complimentary rather than competitive ways will best serve patients and create efficiencies for the health system.

GP accessibility is regularly cited as the reason for expanding scope of practice of non-medical professionals. There are many professions that have already cited their own challenges, which expansion of scope won't fix. The pharmacists have publicised they are under strain and experiencing workforce shortages and burnout. The Pharmaceutical Society of Australia has spoken out about the labour shortages affecting pharmacies, and persistent challenges in recruiting and retaining pharmacists across all settings. The Australian Nursing and Midwifery Federation has said Australia is facing a severe shortage of nurses. The Australian Primary Health Care Nurses Association (APNA) has also spoken out about the shortage of nurses – their survey found 1-in-4 primary health care nurses plan to leave nursing in the next 2 to 5 years. The Kruk Review[41] highlighted these shortages and allied health workforce shortages, noting that clients in the National Disability Insurance Scheme (NDIS) are waiting up to six months to see allied health professionals. Shifting tasks from one workforce to another experiencing shortages is not a solution.

Expanding scope of practice of healthcare professionals without the same level of training as GPs can lead to fragmented and inefficient care, mis- or delayed diagnoses[42], inappropriate or delayed treatment – including pharmacological treatment, inappropriate referrals and interventions and/or adverse events resulting in physical or psychological harm to patient.

Expanding scope of professions without sufficient consideration could lead to a two-tiered system, where patients who cannot access GP services (for example, due to cost or geographic location) receive care from another professional without the same level of qualification as a GP. This has the potential to reduce equity of access to high-quality healthcare, increase health disparities, drive down efficiencies and increase costs.

3) Patient confusion around role delineation

Patients are often confused about the qualifications of different health professionals. They do not understand the difference in skill sets between health professionals. When non-medical professionals practice tasks that have historically been underpinned by medical training (eg diagnostic skills), the patient may not recognise that they are receiving care from a health professional who has not been trained as a medical practitioner.

The setting in which care is delivered and the integration of health professionals within the patient's MDCT can also have an impact on health outcomes. Information must be shared with patients on the differences in the levels of care that will be provided in each setting and by which health professional so they are empowered to make informed decisions about where to access their healthcare and from whom.

Any radical reforms to scope of practice must include a consumer awareness campaign including extensive communication, education and advertising about the changes. This advertising to consumers should require healthcare providers to state their level of training, education and licensing.

4) GP workforce pressure with additional workload from new tasks and/or time spent in a supervisory role whilst upskilling other health professionals

GP delegation to a multidisciplinary team is an important enabler of expanded scope of practice and would require initial supervision and training by GPs. If a non-GP workforce was being trained to undertake GP tasks independently, the level of supervision and time required would be like that required of supervisors training registrars which is known to be significant. Adding extra supervisory requirements for independently practising non-GP workforce would be an additional burden that takes time away from direct patient care. However, training members of a general practice based MDCT to take on tasks collaboratively and within the same setting as the GP(s), would require less training and is managed more easily.

5) Increased burden of redesign and maintaining governance requirements for education and training to suit new learners

Role and task substitution from GPs to other health professionals with inappropriate qualifications is not a solution to an undersized general practice workforce and unmet need for GPs.

The costs of developing, promoting, delivering and maintaining education and training is significant and will potentially be duplicated by more than one profession. Additional costs need to be considered for quality assurance activities such as audits for compliance and quality health care, currency and competency.

As the number of professionals with increased scope rises, so will demand on the health workforce and services to monitor and maintain professional standards. Governance, monitoring and maintenance activities include, and are not limited to, health professional registration, education level, qualifications, credentialling, supervision, mentoring, policy and procedures, education program accreditation and review, education material, ongoing training requirements, equipment, auditing, record keeping, and continuous quality improvement. This increased demand will be at a national, jurisdictional and local level, as well as in the public and private settings. The implications of, and capacity for, this demand will need to be considered in decisions regarding increased scope.[43,44]

6) Reduced training opportunities and skill decay

Skill acquisition and retention is crucial for medical practitioners. It requires a healthy environment that is not focussed on high turnover (MBS needs to reward quality not quantity) and access to training and upskilling opportunities. Overseas trained doctors and international medical graduates in particular need support from a team around them.

Any expansion of scope of practice should consider the costs of achieving the expanded skills, which potentially includes a reduced capacity for existing medical training.

When multiple health professionals are training to undertake overlapping tasks, it reduces overall training opportunities and potentially reduces frequency of presentations which will present difficulty in maintaining proficiency and competency

of skills. An example is a rural GP who needs access to hospital lists to maintain their surgical skills, especially those who provide endoscopy, colposcopy or anaesthetic services.

7) Medical and professional indemnity insurance may limit scope and increased premiums could become prohibitive.

Scope of practice is traditionally defined by professional standards, codes of ethics and professional conduct, and includes skills that a health practitioner is authorised, educated, competent and confident to perform.

The cost of medical indemnity insurance can differ between companies, but generally premiums are calculated based on historical claims data, underwriting trends, actuarial information, individual claims and risk factors associated with the specific doctor or sub-specialty they practice.

Strict requirements are set out around who can be insured and the scope of practice that can be insured. A range of important discretions around coverage offered are also provided, including in relation to ensuring appropriate professional practice.

"I recently worked a weekend locum as a GP Obstetrician. Increasing my indemnity to the appropriate level I discovered that the medical indemnity provider only sold insurance in blocks of 3 months. The weekend ended up costing me more money than I earned. Thankfully it was offset by another locum within that 3-month insurance block."

GP, Mackay

Examples of risks for expanded scope pilots

1. **Antimicrobial resistance is one of humanity's greatest health challenge:** **R**educing antibiotic use is a national and international priority. Multiple prescribers create more risk for the patient and can contribute to overprescribing of antibiotics.

   There is a body of evidence that shows community pharmacists do not have the knowledge and training (even with post-graduate prescribing qualifications) to prescribe antibiotics and support appropriate antimicrobial stewardship.[23,45,46,47,48,49,50,51,,52,53,54] Studies and data also show that retail pharmacists do not adhere to protocols and have a lower threshold before recommending medicines to patients.[55,56,54,57]

   It is not only the medical community that has expressed concerns. The New South Wales Antimicrobial Stewardship Pharmacists Network highlighted in their 2019 submission to the Therapeutic Goods Administration (TGA) that antimicrobial resistance is a significant concern with down-scheduling of antibiotics.[58] The submission also highlighted that because pharmacists are not mandated to report antibiotic prescribing to a patient's GP or other doctors, it creates suboptimal standards for follow-up and review as well as fragmentation.

2. **Proper policy process and compliance monitoring are crucial:** The TGA has established processes that provide for formal consultation and assessment of evidence prior to the scheduling of medicines. Allowing jurisdictions to duplicate this process or potentially implement a process that does not have the same rigour, oversight and open consultation, creates confusion and multi-tiered scheduling systems which risk patient safety. There are already established processes in place that allow for continued dispensing of medicines by pharmacists. The jurisdictional pharmacy pilots have shown a disregard for Commonwealth medicines policy, advice from the medical community and recommendations from the TGA by establishing protocols outside regulatory processes. They effectively down-schedule medicines and bypass safety mechanisms and external independent regulatory oversight processes. Political decisions (election promises) are influencing policy process.

   This risk is compounded by the lack of compliance auditing. The Professional Services Review (PSR) has raised compliance and regulatory concerns with pharmacist prescribing, given there are no mechanisms in place to permit external independent evaluation of inappropriate practice in relation to prescribing.[59]

   It is unclear how this will impact Professional Indemnity insurance for all involved in the event of a serious adverse patient health outcome.

3. **Pharmacists do not have the medical training to diagnose and prescribe:** People present to a retail pharmacy with symptoms, not a diagnosis. Adding on a 2.5hr module (in the case of the UTI pharmacy pilot) or the equivalent

of a post-graduate certificate with only three weeks practical training (expanded scope of practice pilot), will never be equivalent to the clinical competency underpinned by almost 12 years of training undertaken by a GP.

The RACGP remains concerned about approaching prescribing as a task that can be independently delegated. There is a conflation of diagnosing and prescribing skills and the role of diagnosis in prescribing is being diminished. All prescribers need extensive training and knowledge to manage the complexities of multimorbidity, polypharmacy and non-routine aspects of individual patients. This knowledge comes from the years of comprehensive training. For medical students, training for 5-6 years results in an intern who only prescribes under close supervision.

The Prescribing Skills Assessment, adapted to Australia from the British Pharmacological Society, is the skills/knowledge-based assessment required by an increasing number of medical schools. Prescribing in settings that do not encompass all the features of good primary care services, will have diminished impact.

There is a large risk that there will be decreased attractiveness of GP training and risk to the GP training pipeline if it is perceived that the many years of medical training required by GPs are deemed unnecessary by non-medical health professionals taking on corresponding tasks outside their scope of practice.

4. **Conflict of pecuniary interests:** One of the great strengths of medication prescribing in Australia is the high degree of separation of pecuniary interest between the prescriber and the dispenser. The separation of commercial interests and dispensing roles helps safeguard patient safety. Otherwise, there is a risk that prescribing is not evidence-based and is influenced by financial factors. The model of GPs prescribing and pharmacies dispensing provides clear separation from this financial conflict of interest for prescription-only medicines.

   GP training includes a unit on Integrative Medicine in the curriculum and the focus of this is the rational evidence base for the use of complimentary medicines, understanding of their risks, benefits and interactions and discussion of these with patients including cost considerations. Retail pharmacy is clearly conflicted.

5. **The importance of appropriate health settings:** The retail pharmacy environment is busy and this is not a suitable environment for sensitive health conversations. A solo pharmacist cannot step away into a consulting room. Despite the availability of consultation rooms in some pharmacies, evidence shows these are not well-utilised and sensitive conversations are often happening at the counter. [60,61,62,63] Comprehensive, high-quality diagnosis and prescribing equivalent to medical care is not able to be provided over the counter or where there are multiple distractions, both for the patient and the prescriber. Retail pharmacies lack the appropriate systems for follow-up of abnormal results or to institute appropriate recalls and reminders that are an essential part of general practice.

Case example: Diagnosis of urinary tract infections (UTIs) by retail pharmacists (Queensland pilot)

- People do not present to pharmacy with a diagnosis of a UTI (or other condition). They present with symptoms which *might* be a UTI for which there is a large differential diagnosis (including pregnancy, STIs, cancer, genital infections and undiagnosed diabetes to name a few). **A diagnosis, which requires medical training, is required to determine if a UTI is present.** Queensland doctors have already encountered patients with much more significant health concerns who had treatment delayed because they were incorrectly prescribed antibiotics by pharmacists on the presumption of a UTI during the *Urinary Tract Infection Pharmacy Pilot – Queensland (UTIPP-Q)*.
- The Australian Medical Association Queensland (AMAQ) survey reported 240 patient complications as a result of the UTIPP-Q pilot. Another AMAQ survey highlighted 73 apparent cases where chlamydia, herpes, gonorrhoea, and an ectopic pregnancy were allegedly mistakenly categorised as UTIs in the UTIPP-Q.
- In their 2023 submission to the South Australian Select Committee on Access to Urinary Tract Infection Treatment, the Royal Australasian College of Surgeons and the Urological Society of Australia and New Zealand stated:

  "The presentation of a classic urinary tract infection (UTI) is not uniform. The symptoms may NOT be present in some cases – in patients with diabetes, there may be no burning or stinging during urination; in patients with a neurological condition or the elderly, the only symptom may be change in behaviour or cognition. There is also the very real possibility that the symptoms of a classic UTI may NOT be due to an infection. Frequency and burning on urination can be seen in cases of kidney stones, bladder cancers, interstitial cystitis, cancers in the pelvis, fistulae (connection between bladder or urethra and vagina or bowel) or foreign body reaction (eg eroded mesh). Therefore, this condition, so easily diagnosed when there is no knowledge to exclude other diagnoses, can result in significant harm if poorly or inadequately assessed."

Q6. Please give any evidence (literature references and links) you are aware of that support your views.

Above (Q5) statements are referenced. Please refer to specific references.

Real life examples

Q7. Can you identify best practice examples of health practitioners working to their full or expanded scope of practice in multidisciplinary teams in primary care? (Select yes or no).

Yes

Q8. Please give examples, and any evidence (literature references and links) you have to support your example. Please provide references and links to any literature or other evidence.

Team-based care is widely recognised as best practice in the delivery of primary healthcare services. Team-based care models, such as the patient-centred medical home (PCMH), are characterised MDCTs working together to provide coordinated, collaborative and continuous patient care. There is evidence that team-based care contributes to reduced hospital readmission rates and emergency department presentations.[64]

There is also a substantial body of literature that demonstrates the benefits of care continuity with respect to patient satisfaction, reduced mortality, reduced emergency department presentations and reduced avoidable hospital admissions, particularly for the heaviest users of healthcare.[65, 66, 67]

The RACGP's support for a team-based approach to providing healthcare is reflected in the:

- *Vision for general practice and a sustainable healthcare system*
- *Standards for general practices* (5th edition)

- Curriculum for Australian General Practice (Specifically, core competency 2.3 within the core competency framework of the curriculum which relates to the ability to collaborate and coordinate care.
- Position statement on the role of specialist GPs.

The Australian Government has recognised general practice as the most appropriate setting in which to provide person-centred, continuous, and coordinated care to the community.[68] General practices must remain the clear first point of contact for patients within the healthcare system.

Below are some examples of existing models for MDCT's where skills at top of scope or expanded scope are utilised.

Teams of GPs with Extended Skills

"When I was on Thursday Island, we had a team of GPs, who between them also did surgery, anaesthetics, obstetrics, public health and medical education.

There was a complementary skill mix of extended scope GPs."

Outer metropolitan NSW GP

1. Rural generalists

Rural generalists are recognised through the Rural Generalist Fellowship (which is an additional year of training in addition to the RACGP Fellowship). The focus is on developing the extra skills required to deliver high quality healthcare to meet rural, remote and very remote community needs. They can be the only health practitioner or part of a small team delivering primary care services, emergency medicine and additional skills like obstetrics, anaesthetics, mental health and surgical services in hospital and community settings to provide access to a broader range of specialist medical care in rural and remote areas.

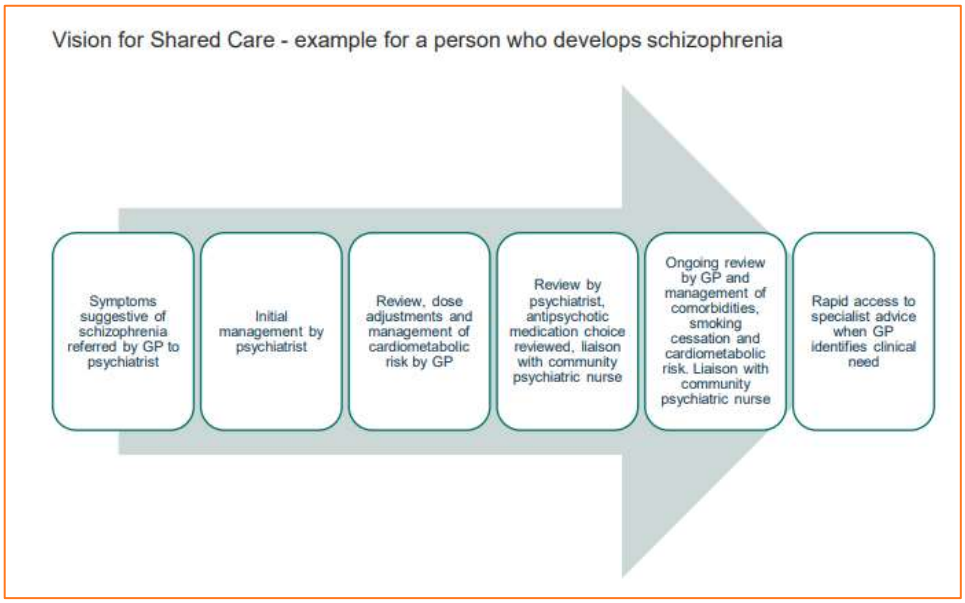
2. Shared care models

Patients are increasingly living with multiple chronic diseases. When patients are referred for specialist care there can sometimes be a disconnect from the GP. The Shared Care Model aims to ensure that the management of co-morbidities and preventive activities remain prioritised. It also allows patients to benefit from interim review scheduled between specialist visits. Shared care already happens in some settings, and for some conditions, but is not yet normalised in the management of serious or complex conditions.

This model refers to situations where there is joint responsibility for planned care that is agreed between healthcare providers, the patient and any carers they would like to engage.[69] It provides improved quality and continuity between services by clearly delineating roles and responsibilities for the MCDT, having structured management plans, and providing clear communication channels for access to prompt help. It is informed by enhanced information exchange and advice between healthcare providers and patients and provides access to unscheduled review by specialist teams when the need arises.[70,71, 72,73]

The Shared Care Model presents an opportunity for people to receive the benefits of non-GP specialist intervention combined with continuity of care and management of comorbidity provided by GPs, who maintain responsibility for all aspects of the patient's healthcare beyond the specified condition.[74] Benefits of the Shared Care Model include patient convenience, reductions in hospital admissions related to specific conditions which drives cost savings to the health system;[73,] improved patient health outcomes; higher levels of follow-up care and patient adherence to treatment.[75]

The model aligns with the RACGP Vision. Below provides an example of a Shared Care arrangement between a GP and non-GP specialist for a person who has developed Schizophrenia.



Clinical handover between health providers is crucial for the success of the model.[76,77,78] Well-coordinated care will result in cost savings by reducing duplication of limited health resources and reducing potentially preventable hospital admissions.[74]

Some examples of existing Shared Care Models include antenatal care, mental health clozapine care, cancer, and diabetes.[69,74,79,80] Other examples include Parkinson's disease and palliative care.

Evidence shows ongoing patient care with a usual GP has higher levels of follow-up[81] and adherence to treatment such as medications,[70] supports patients' independence[82,83,84]and reduces barriers to care in rural Australia where access to non-GPs is limited.[85]

3. GPs with a Specific Interest (GPSIs)

On the Sunshine Coast in Queensland, GPSIs are considered GPs with extra experience, interest or qualifications within a specific field of practice. They develop those skills within a hospital consultant-led specialty team.

GPSIs are employed as senior medical officers and become part of consultant-led clinical teams. They work in one or more hospital outpatient clinic sessions per week, in addition to their main work as community GPs.

Several GPSIs have been extensively trained to provide outpatient procedural services. For example, the GPSI working in the urology team provides cystoscopies, the gynaecology GPSIs provided colposcopy services and the ENT GPSI is trained to do nasal endoscopies.

This integrated workforce solution began with a pilot at five public hospitals and health services in south-east Queensland, including the Sunshine Coast, in 2018. It demonstrated benefits for patients and the health service. Two of the important benefits were:

i. a reduction of long wait lists in two-thirds of the specialties with a GPSI clinic
ii. the discharge rates from GPSI clinics were higher on average than regular outpatient clinics.

At present, GPSIs are required to hold vocational registration with the RACGP or the Australian College of Rural and Remote Medicine (ACRRM) and a minimum of five years of general practice experience is preferred.

Role-planning, selection and interviews are done collaboratively between the hospital General Practice Liaison Unit and the medical directors of each specialty. GPSIs report to the general practice liaison officer as their line manager, and clinically to their specialty director. This provides a collaborative structure to support the GPSI within the role. It is believed to be a success factor for the Sunshine Coast GPSI program.

GPSIs are funded through hospital activity-based funding. The local Primary Health Network (PHN) has also co-funded several GPSI positions.

Linking with community general practice is a fundamental principle to improve the connection between primary care and the hospital sector, resulting in more efficient health services. Future models may include community based GPSI clinics to facilitate more patients being treated in the community, rather than the hospital.

The GPSI model exists in most states and territories in Australia.

4. Pharmacists in general practice

There is a body of evidence to support the benefit and return on investment to the health system of non-dispensing pharmacists in general practice.

- The PINCER study in the UK showed a 30% reduction in medicine-related harms. PINCER is now a national standard of the NHS and has been scaled to every practice and is a core role of the pharmacist.
    - ACTMed clinical trial within the Brisbane South PHN in Queensland has been trialling this model in Australia. It aims to reduce avoidable hospital readmissions, reduce harm and medication misadventure, improve medication adherence and education, reduce unnecessary residential aged care facility admissions, and support quality improvement in general practice. It has recognised that there is a need for dedicated funding for best use of a pharmacist as currently work is driven by reaching financial targets through Home Medicine Reviews.

- The REMAIN HOME trial showed a collaborative pharmacist-GP model of post-hospital discharge medicines management can significantly reduce emergency department presentations and demonstrate a statistically non-significant lower incidence of readmission during the 12 months after discharge, with potential for substantial cost savings to the health system.

- Deloitte Access Economics conducted an independent analysis for the Australian Medical Association (AMA). They found that integrating pharmacists within general practice could deliver an estimated $545 million in net savings to the health system over four years. This would be achieved primarily through fewer avoidable hospital admissions and a reduction in the use of medications. It showed that for every $1 invested in the program it generates $1.56 in savings to the health system.

- The Integrating Pharmacists within ACCHSs to Improve Chronic Disease Management (IPAC Project) was supported by the MSAC and was considered comparable to existing medication review programs and acceptable in the context of providing overall better quality of care that may help improve health inequities for Aboriginal and Torres Strait Islander peoples.

- The Funding pharmacists in general practice: A feasibility study to inform the design of future economic evaluations study determined that $0.61-$1.20 of income could be generated by a pharmacist for each $1 spent on wages. A greater return on investment was associated with more experienced pharmacist(s).

- Every $1 invested in a general practice-based pharmacist generates $1.56 in savings to the health system.[86] The associated costs of overprescribing, medication misadventure and preventable hospitalisations are significant.

  Lim et al estimates there are almost a quarter of a million medication-related hospital admissions in Australia costing AUD$1.4 billion annually. Two-thirds of medication-related admissions are potentially preventable.[87]

5. Rural healthcare teams

There are established guidelines already used in rural and remote areas (eg CARPA Standard Treatment Manual for remote and rural practice) that can guide nurses, Aboriginal and Torres Strait Islander health practitioners and doctors in medication use.

In remote primary care, many treatments are initiated by remote area nurses and Aboriginal Health Workers (AHWs) who followed protocol-driven care for a wide range of conditions (the CARPA Standard Treatment manual). The GPs are

consultants to nurse (and AHW)-led primary care, and the nurses and AHWs initiate medicines, consulting with GPs where needed.

Other team-based healthcare settings such as palliative care, oncology, opioid treatment programs and sexual health clinics may also be useful to review due to a wraparound care model and access to medical professionals and a MDCT. ACCHSs (and other Aboriginal Medical Services) are also strong examples of team-based care.

Facilitating best practice

Q9. What barriers can government, employers and regulators address to enable health practitioners to work to their full scope of practice? Please provide references and links to any literature or evidence.

1. **Reducing Medicare complexity and fear of non-compliance:** GPs have access to a multitude of MBS item numbers and the rules around co-claiming are particularly confusing. Trying to keep on top of changes to MBS items is an arduous task, and why the RACGP has long maintained that MBS complexity is contributing to inadvertent billing errors and technical non-compliance. Item numbers for telehealth consultations and COVID-19 vaccinations, although welcomed, have been subject to numerous changes since the start of the pandemic. DoHAC embedded its focus on telehealth and vaccine administration as compliance priorities in its Health Provider Compliance Strategy 2021–22, released in August 2021. For example:

    - Implementation of the established clinical relationship rule for MBS-subsidised telehealth services has been inconsistent and confusing. Ambiguity around exceptions to this requirement were evident in 2020, constant changes to the rules because of intermittent lockdowns and border closures generated confusion and it took providers time to adapt. The level of misunderstanding became more evident when GPs received targeted compliance letters in March 2021.

      Although DoHAC did make educational materials available, they were not always accurate. The definition of a 'COVID-19 impacted area' was particularly confusing. It was only in December 2020, approximately five months after the rule was introduced, that the Department issued guidance around the existing relationship requirement via an AskMBS Advisory.

    The RACGP does not support changes that will add to the complexity of the MBS and complicate billing arrangements. We have long called for the simplification of GP MBS items. While the RACGP is supportive of the MBS being regularly reviewed and updated to ensure that items remain clinically relevant, clearer education and communication must be provided regarding Medicare claiming rules. Fact sheets must be clear and concise, with examples of scenarios where items can and cannot be claimed.

2. **Avoiding disease specific item numbers, which lead to health issues being treated in isolation. The RACGP generally does not support the introduction of single disease focused MBS items** (eg heart health assessments, smoking cessation items), as they are not patient-centred nor consistent with the generalist approach to care that GPs are trained to provide. Disease-specific items represent fragmentation of MBS funding rather than comprehensive primary care, and result in disintegration of the healthcare system. An ad-hoc, siloed and piecemeal approach to health funding is not conducive to integrated team-based care coordinated by a patient's usual GP. (Refer RACGP's Disease-specific MBS items position statement.)

    The RACGP recognises disease-specific items may be necessary or beneficial in certain circumstances. One example is the Aboriginal and Torres Strait Islander peoples' health assessment (MBS item 715), which enables people of Aboriginal and Torres Strait Islander descent to receive a comprehensive annual preventive health check. A separate MBS item recognises the unique health challenges facing Aboriginal and Torres Strait Islander people and the need for culturally appropriate services for this cohort.

    Disease-specific MBS items may allow policy makers to collect data on specific services being provided by GPs in order to better allocate future funding. While there is value in properly coded general practice data, this should be gathered via appropriate clinical software systems and not by further complicating the MBS.

    Patient rebates for disease/condition-specific items tend to be equal to or lower than rebates for standard consultations. For example:

- the rebate for item 699 (heart health assessment) is $79.70, equivalent to a Level C GP consultation
- the rebate for item 2713 (mental health attendance) is $78.55, slightly lower than a Level C GP consultation
- the rebate for item 16500 (antenatal attendance) is $43.95. This item is not time-based, meaning GPs receive the same rebate regardless of the length of the consultation.

Q9b What enablers can government, employers and regulators address to enable health practitioners to work to their full scope of practice? Please provide references and links to any literature or evidence.

GPs must be enabled to work to the top of their scope through the MBS, PBS as well as through more supportive MDCT that work to their full scope. Incentives need to be provided to encourage GPs (and patients) to consider less expensive, lower intensity interventions in situations where they are likely to be beneficial.

Funding for mental health care in general practice should reflect the time spent caring for individuals with mental health needs. Being able to spend more time with their GP will result in better health outcomes for patients. Shorter consultations mean less time for planning and explanations to patients and discourages comprehensive assessment of the patient's mental health.

To support and enable GPs to deliver the best care possible, they need to be afforded more time with patients.

Medicare should be in favour of co-claiming, as so many things happen in a consultation. If something cannot be co-claimed, then there should be specific rationale for that (such as it's a duplication of the service e.g heart health assessment and an Aboriginal Health Assessment, as one includes the other).

Facilitating GPs to work to their top of scope (by health condition or population group)

Recommendations, case studies and further documentation provided on the following pages.

Psychological and neurological conditions

1. Mental health conditions

Recommendation(s):

- Adequately fund practice nurses to provide injections for a person on regular antipsychotics without being seen by the GP to free up GPs to work to their top of scope.
- Uncouple Focussed Psychological Strategies (FPS) item numbers 2721 and 2725 from the pool of 10 mental health services patients are eligible to receive following preparation of a GP mental health treatment plan. This will improve access and augment any additional psychological service provided by other practitioners (eg clinical psychologist, social worker or occupational therapist).

  This will be especially useful for those in rural and remote communities and anywhere that does not have access to bulk billed psychology, where GPs are often the only providers of care.
- Support integration of social prescribing within general practice to provide more tools for GPs. It can address key risk factors for poor health, including social isolation, loneliness, unstable housing, multimorbidity, and mental health problems.
- Better utilise GPs disaster management skills by embedding them in the wider healthcare response during natural disasters. General practice is federally funded and may be disconnected in this healthcare response. General practice is still poorly written into local emergency response planning. It is essential GPs be supported and included in national and state/territory natural disaster arrangements across prevention, preparedness, response and recovery.

General practice plays a central role in the delivery of mental health care, with the majority of mental health care in Australia being provided in general practice.[88] The RACGP's 2022 General Practice: Health of the Nation report identified psychological issues as the most common health issue that GPs manage (71% of GPs listed these in the top three reasons for patient presentations.)

- Mental health is a core part of the RACGP's Curriculum for general practice as reflected by the Mental Health unit. GPs can also extend skills in the Rural Generalist program through an Advanced Rural Skills Training in mental health. The high uptake of Mental Health Skills Training (the GPMHSC's entry-level competency for assessment, diagnosis and management of mental health issues) reflects a strong commitment to this field of practice within the profession. About 90% of GPs have completed the GPMHSC accredited Mental Health Skills Training and approximately 1600 GPs have completed the more specific FPS training.**Error! Bookmark not defined.**
- Research conducted by RACGP's Rural Faculty indicates that GPs practising in rural and remote locations would like to engage in advanced mental health training but are deterred by the financial cost and the time away from practice. Incentive schemes equivalent to those for procedural skills would support GPs to develop or refresh advanced skills in mental health.[89.]
- GPs should primarily deliver and coordinate mental health support following natural disasters, including bushfires and pandemics. GPs are locally situated with local knowledge, have strong pre-existing connections with their patients and will still be in the community when other responders have left.

Further relevant documents include:

- RACGP position statement - mental health care in general practice
- RACGP submission on Renewing the 2013 National Aboriginal and Torres Strait Islander Suicide Prevention Strategy
- RACGP submission – Select Committee Inquiry on Mental Health and Suicide Prevention
- RACGP submission on the Productivity Commission Mental Health Inquiry Report
- RACGP recommendations on mental health items used in general practice.
- RACGP position statement Provision of mental health services in rural Australia
- Royal Commission into National Natural Disaster Arrangements Report

"Often physical symptoms are a legitimate way for a person to see the GP when they want to discuss mental health. They present with palpitations which can be hyperthyroidism or anxiety; present with tiredness or poor sleep which has a wide differential diagnosis of physical, psychological diagnoses and also may not be a medical problem at all!

Patients can 'test' whether they feel comfortable with the GP before talking about their mental health at the third or fourth consultation.

Importantly, the patient-centred care and comprehensive care components of primary care mean that there are no referral criteria and if they are spotted in the waiting room by a relative, then nobody can guess why they are there. That's not true in the psychologist's room or the mental health ward of the local hospital."

- *NSW GP working in low income outer metropolitan area*

Case study: Tom

"Tom, aged 48, was referred to me for ongoing care following a hospital admission for relapse of his paranoid schizophrenia. He was apprehensive and anxious about his inpatient management which he described as "horrific". He told me that he hated being on antipsychotic medication but now reluctantly accepted that he should continue drug treatment as he did not want to repeat his recent breakdown experience and 3 admissions since he was first diagnosed 25 years ago was "more than enough". He lived in a boarding house and was looking for more secure accommodation after he was evicted from his previous share house just prior to his psychiatric hospitalisation. He maintained contact with his widowed mother and brother but found family occasions stressful and preferred to be alone. He was single and childless, on a disability pension, and had not worked for 10 years. He agreed to see me monthly for supportive care and scripts and to help him access more secure accommodation. I referred him to the mental health nurse in our practice and with social work support, he was able to secure a studio apartment rental nearby.

Despite his guarded demeanour, and ongoing distrust of medical care, he attended regularly and I was able to engage him in his care and his trust and sense of safety gradually improved. To avoid re-traumatisation, we spent most of our sessions together discussing his current problems and his daily activities. My curiosity about his life and genuine interest in his daily experiences helped to maintain therapeutic attunement and pace and build the therapeutic alliance, and when I elicited a definite creative and artistic streak, I encouraged him to pursue his interest in art, journaling and writing, activities that he found soothing and engaging. He was quick to question or challenge me when he felt uncertain or wary of treatment and I responded promptly by repairing any perceived ruptures in our doctor- patient alliance by clinically appropriate reassurance, frequent checking in, and maintaining an empathic and emotionally regulating presence when he was anxious and verging on paranoid thinking. Careful titration of his anti-psychotics was also required at times of stress, particularly as he changed rentals yearly due to difficulties with noisy neighbours.

Psychotherapy techniques that he found valuable included CBT and mindfulness based self-soothing strategies including walking and breathing exercises. Activity scheduling helped him balance the intensity and frustrations of long writing sessions with the need to move outside in nature where it was easier to calm his anger and anxiety. Communication skills coaching increased his assertiveness. He became very curious about his mind-body interactions and became adept at noticing early warning signs of dysregulation and how to regain emotional equilibrium. His self- confidence grew and he resumed more contact with his family and enrolled in a creative writing course. At the suggestion of his teacher, he submitted a short story to a magazine which was accepted and published. We discussed his writing at our monthly consultations and I encouraged him to build on his success and replace his self-limiting illness narrative with an expansive resourceful new story of his life and how he wished to live more fully according to his values. Over the past 10 years, a trauma informed approach to counselling with regular validation, motivational interviewing and the continual monitoring of his emotional state during visits gradually supported Tom to feel empowered to lead himself to a much more fulfilling and stable life including accepting support from his family, secure long- term accommodation and a successful writing career. Additionally, taking a biopsychosocial approach has resulted in Tom improving his diet, maintaining a healthy weight, and compliance with regular medical reviews of the metabolic side-effects related to long term antipsychotic use. By holding hope for Tom when he was feeling hopeless and scared, he was able to learn to trust himself and to now hold his own hope."

- **Metropolitan Victoria GP**

2. Dementia

Recommendation(s):

- Allow GPs to issue prescription for first Authority for cholinesterase inhibitors.
  - There is currently a lack of access to specialists who can initiate treatment

GPs are often the first contact for people experiencing early signs of dementia.

Dementia accounts for approximately 1.6% of general practice encounters,[90] and is the second leading cause of death in people aged 75 years and older.[91] New prevalence estimates for dementia reveal that 3.4% of patients aged 65 years or older had a new record of dementia,[90] making this an increasingly common and important condition for GPs to manage. Guidance on dementia is provided by the RACGP in a number of key resources:

- RACGP Curriculum
- RACGP Aged care clinical guide (Silver book) (in particular Part A- Dementia, Behavioural and psychological symptoms of dementia and Short-term pharmacotherapy management of severe BPSD)
- RACGP Guidelines for preventive activities in general practice
- RACGP Standards for general practice residential aged care (1st edition)
- National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people.

Care of people with dementia is often fragmented across the health and social care system, therefore there is an opportunity to improve patient management across a MDCT.

Barriers to MDCT include:

- lack of clarity around healthcare provider roles
- limited opportunities for information sharing (including radiology and pathology results)
- a lack of current established pathways for communication or direct referrals.
  - Funding and capacity issues have meant that referral pathways are now demand management pathways where the GP is expected to gather the information that would be gathered during the initial assessment and include it on a specific referral form which is then triaged.
  - The forms are returned to the GP if not filled in correctly – a bureaucratic and unhelpful process for patients, their families and the GPs.
- lack of continuous care and care coordination for patients.

The RACGP does not support micro-credentialing as professionals should work within their scope of practice and seek relevant education to match the need of their patient populations. Credentialing of GPs will create more barriers for patients to access appropriate care, eg the availability, time and capacity needed to complete courses, especially for the rural GP workforce, is often not accessible. A better approach would be to make on-demand resources and appropriate remuneration available for all GPs.

Example of lack of coordination

An example of a communication gap impacting patient care is when people with dementia enter residential aged care facilities (RACF). Prior to admission to a RACF patients are often referred by GPs to undergo an aged care assessment with an aged care assessment team (eg ACAT or ACAS in Victoria) who determine a person's eligibility for government-funded services.

A person's GP does not receive a copy of the ACAT or ACAS and is not informed of the type of aged care services being provided or whether they have been wait listed for packages (or not).

People with dementia are often unable to comprehend this complex system or explain to the GP what has occurred. The use of secure messaging platforms and accessible shared care plans are required to ensure GPs and non-GP specialists have timely access to relevant patient information.

For some people with complex care needs, successful coordination of care is supported by a trusted case manager or nurse coordinator. In all cases there is a need to support the work of care coordination through a combination of funding models, shared clinical records, IT infrastructure and the use of recalls and reminders. Supporting and promoting better integration between the services provided to elderly people must be a priority as it will ensure the health and medical sector is better equipped to deliver care to these patients.

3. ADHD

Recommendation(s):

- Allow GPs to initiate and continue stimulant medication for ADHD. There are lots of other medications that GPs can prescribe that have a higher risk profile than ADHD medicine.
- Remove jurisdictional regulatory barriers. Medication and accessing a prescriber varies between states.
  Support shared care arrangements between GPs and paediatricians and psychiatrists.

GPs are well-positioned to aid in the diagnosis and management of patients with attention deficit hyperactivity disorder (ADHD) and connect patients and their families with other specialists and support as necessary.[92]

- The long waiting times for people diagnosed, or with a suspected diagnosis, to be seen by a paediatrician or psychiatrist identify a significant need for GPs to be better supported to increase their role in this area.
- In addition to evidence-based guidance, there is a need for GPs to be able to access appropriate education and training.
- Regulatory barriers must be addressed as there are limitations in different states and territories regarding stimulant prescribing.
- Shared care arrangements should also be supported in the form of clinical protocols and funding systems, so GPs can access timely assistance from paediatricians and psychiatrists to support diagnosis and management and mitigate the risk of both over and under treatment. This is especially important for GPs in rural and remote areas where access to other specialists is limited.
- Access to diagnosis and treatment is poor in custodial populations and made worse by concerns over diversion of medications prescribed for ADHD to substance misuse.
    - Use of long-acting formulations of stimulants, eg Concerta, Ritalin, LA and Vyvanse reduce the risks of diversion significantly.

"Access to diagnosis and care is limited, with many public sector mental health services not providing any ADHD services. What this means is that the burden falls on the private sector – leading to long wait lists and some missing out on care because they simply can't afford it. One GP recently told RACGP it would cost their patient over $700 for a telehealth ADHD diagnosis from a specialist. Other media reports put the cost at around $3000, a huge sum particularly when considering the high cost of living pressures for Australians."

- newsGP, Paediatricians back greater GP role in ADHD care

4. Addiction medicine

Recommendation(s)

- Recognise the key role of general practice and GPs.
- Build upon support systems to help GPs manage and treat patients who present with AOD issues.
- Improve collaboration and integration between GPs and specialist workers.
- Fund the RACGP AOD GP Education Program beyond 2022.
- Longer consultations through the MBS.

More GPs should be supported and trained in how to support patients who present with alcohol and other drug (AOD) issues, GPs will be in a stronger position to intervene early and, by doing so, potentially decrease harm and reduce the pressure on the AOD workforce and sector.

Chronic Conditions

GPs are the only medical practitioners that specialise in managing multimorbidity across the full patient spectrum, from paediatrics to aged care. People with multimorbidity need to access more health services more often and they want this care to be well coordinated across the system. However, GPs' ability to deliver this care effectively is challenged by the limitations of funding models, inadequate guidelines and fragmented healthcare systems built around single-disease states. **Nearly three in four GPs reported that more than half of their patients have multimorbidity, with 29% saying more than 75% of their patients fall into that category**.[93]

1. Diabetes

Recommendation(s):

- Include GPs on the authorised certifier group for the continuous and flash glucose monitoring initiative forms.

  This decision creates unnecessary barriers to people with Type 1 Diabetes Mellitus access to appropriate and timely care. This form should be managed within a model of current care including the coordinating GP.

According to the 2019–20 MedicineInsight General Practice Insights report, patients recorded with type 2 diabetes accounted for 11.8% of encounters of the 13.3 million clinical encounters with GPs. Patients with type 1 diabetes ever recorded represented 0.9% of clinical encounters, and patients with gestational diabetes ever recorded represented 0.8% of encounters.[6] Endocrine and metabolic issues are regularly seen by GPs (58% of GPs in AMSs were more likely to report as a top three reason for patient presentation compared with 32% across all practice types).[94]
GPs play a fundamental role in the prevention, diagnosis, and management of diabetes.

Technological innovations – such as continuous glucose monitoring (CGM) and flash glucose monitoring, provide greater insights into glycaemic patterns for patients. Implementation and ongoing use of this technology, requires professional support to instruct patients and carers about the appropriate use and interpretation of outcomes.[7,8]
Presently, these services are restricted to specialised diabetes services that not all patients can access. GPs cannot organise a subsidy for a patient's insulin equipment but nurses can.

Specialisation of health services limits the support pathways that patients can access to support their clinical care. Such services are often lacking in regional/rural and remote communities and people with lower socioeconomic status will encounter cost barriers in accessing these types of services.

Barriers have been unnecessarily created to inhibit GPs from supporting their patients to access and use CGM systems.

2. Cancer

Recommendation(s):

- Enable GP access to accurate, locally relevant information to assist them in making an early diagnosis, providing optimal management and support and advocating for patients and their families living with cancer.
- Incorporate current clinical guidance on rare and less common cancers with point-of-care information on assessment, diagnosis and local referral pathways such as within HealthPathways systems.
- Improve funding for this complex work which involves a MDCT including the GP, nurses, Aboriginal Health Workers and pharmacists, alongside hospital treating teams and other specialists. This complex coordination of care is currently unfunded for GPs.
- Further scoping and research should be undertaken to ascertain whether the United Kingdom's "two-week urgent referral system for suspected cancer, along with overall diagnostics, a management plan and treatment (if required) within 16 weeks" would be successful in an Australian context, and if so, ensuring that adequate resources and investment are provided.

GPs work across a broad scope of practice with their existing training in differential diagnoses and care coordination. They play a key role in shared care models which should be supported and funded to deliver evidence-based and coordinated care to patients across each stage of diagnosis and treatment. It is also important that up-to-date, evidence-based information on different cancers be available to GPs at point of care.

The role of GPs in cancer care encompasses:

- Screening, testing and diagnosis.
- Active treatment and management of cancer and other chronic conditions as part of shared care teams.
- Coordination of cancer survivorship care, chronic disease management, and secondary prevention.
- End-of-life care. Patients in rural areas of Australia are particularly reliant on their GP for end-of-life care.

While the MBS fee-for-service structures work well for an individual patient's face-to-face care, current MBS funding levels reward short, episodic care rather than long-term management of complex and chronic conditions. Current MBS arrangements fail to adequately support direct communication between members of the healthcare team leading to an overreliance on periodic letters or waiting for MBS-funded consultation visits.

Patient care coordination is also not funded under this system. For example, when GPs receive test results from pathology providers, time is required to review reports to compare and update screening records. For rare cancers, this coordination work requires further research, analysis and liaison with other health professionals involved in the patient's care.

Enabling GPs to have easy access to accurate, locally relevant information will assist them in making an early diagnosis, providing optimal management and support, and advocating for patients and their families living with a cancer diagnosis.

Reproductive health, sexual health and obstetrics and gynaecology

GPs need to continue to develop and maintain skills in the areas of sexual and reproductive health. Access to reproductive healthcare services is improved by the wide distribution of GPs, availability of telehealth, expanded training of GPs and GP-led teams that are supported by practice nurses. Improving access to GP sexual and reproductive health services has additional benefits to patients with less care fragmentation. Additionally, GP services are often less expensive than having substitute providers deliver specialised services requiring additional support from hospitals and GPs. Refer RACGP Submission to the Senate inquiry into universal access to reproductive healthcare for further information.

1. Pregnancy and unplanned pregnancy

Recommendation(s):

- Allow GPs to request HyCoSY scans.
- Allow GPs to prescribe clomiphene citrate.

GPs are often the first point of contact for people seeking support regarding pregnancy and unplanned pregnancy. Pregnancy care encompasses the full spectrum of reproductive health from menstruation, contraception, unplanned pregnancies, preconception, antenatal, intrapartum, postnatal care, menopause and termination options. This is achieved with a focus on patient wellbeing, patient safety and joint decision-making. Patient counselling helps facilitate shared decision-making so that people can make informed decisions. This requires extended consultation time. Additionally, fertility specialists are costly. One of the first management options are hystero-salpingo contrast sonography (HyCoSy) scans and clomiphene citrate (for polycystic ovarian syndrome). The burden on fertility specialist clinics could be eased if GPs could have expanded scope facilitated in a supportive manner.

2. Contraception (Oral Contraceptive Pill [OCP], Long Acting Reversible Contraception [LARC], Vasectomy)

Recommendation(s):

- Increase availability of skills-based training in community settings to enable more GPs and GP trainees to develop competency in LARC insertion and removal and medical abortion provision.
- Provide government incentives to support training particularly in areas of demonstrated workforce shortage.
- Provide ongoing support for the AusCAPPs network which provides peer support through an online community of practice.
- Further increase the Medicare patient rebate for insertion of an IUD (MBS item 35503) so the rebate truly reflects the cost of providing this service in general practice.

Limited skills-based training opportunities currently exist for GPs in LARCs counselling and insertion. This has been identified as a barrier to increasing LARC uptake in Australia. Access to training in LARC insertion and removal needs to be supported by appropriate funding such as training incentives as well as improved Medicare funding to support future provision of these services. This includes higher patient rebates for longer consultations, and ongoing availability of telehealth sexual and reproductive health item numbers.

RACGP members have reported that the high costs of delivering this service and the low value of the patient rebate are a barrier to patient access by discouraging GPs from performing the service. Intrauterine device (IUD) introduction involves significant time, expertise and resources, including:

- equipment for IUD insertion, including the costs of either a disposable kit or equipment sterilisation
- adequate patient consent and counselling
- the insertion or reinsertion procedure, which cannot be adequately performed in less than 30 minutes (for a routine insertion)
- a standby assistant (often another member of the GP's team) to monitor the patient during the procedure
- increased indemnity costs
- if a woman experiences a vasovagal episode or merely feels a degree of pain after IUD insertion, rest and possible monitoring may be required for an additional 30 minutes.

The RACGP supported the MBS Review Gynaecology Clinical Committee's recommendation to increase the patient rebate for introduction of an IUD. However, in the submission to the Committee RACGP stressed that the *level* of increase will be key to increase uptake of GP IUD introduction and access for patients.

3. Antenatal care

Recommendation(s):

- Amend rules to allow GPs to bill MBS Level C and D time-based attendance items (36, 44, 91801, 91802, 91894) for antenatal attendances that extend beyond 20 minutes. This is a simple and positive step that can be taken to support pregnant patients, children, and families.
- Reinvolve GPs in antenatal care.

Routine antenatal attendances are covered by MBS items 16500 (face-to-face), 91853 (video) and 91858 (phone).

- These items currently have a rebate of $43.95 regardless of the duration of the consultation.
- Due to advances in science and technology, there is now a much higher expectations of care provision and a greater awareness of mental health issues and the health impacts of domestic violence.
- Antenatal consultations involve extensive monitoring of health problems and potential complications (eg diabetes, anaemia), providing genetic counselling, advice on nutrition and physical activity, and preparing the mother for childbirth and breastfeeding.

  They are often complex consultations and can extend well beyond 20 minutes. This is particularly true among vulnerable and disadvantaged patient groups, such as those in rural and remote communities, Aboriginal and Torres Strait Islander people and culturally and linguistically diverse patients.

  Results from an RACGP member poll of asking, 'What proportion of your antenatal care appointments last longer than 20 minutes?' indicated almost two-thirds of respondents reported more than 75% of such appointments lasted longer than 20 minutes. A further 23% of respondents reported that between 50–75% of their appointments last longer than 20 minutes.

GPs who provide antenatal care are highly skilled and play a pivotal role in areas where there is a lack of other specialists due to workforce shortages, as well as reducing demand on busy hospital outpatient departments.

- During the pandemic, many patients who previously received antenatal care in a hospital setting instead accessed this care through the primary care sector.
- GPs have augmented the work of hospital-based doctors and must be appropriately supported to deliver this critical care.
  - GPs are restricted to billing MBS items 16500, 91853 and 91858 for antenatal attendances regardless of the length of appointment.
  - Access to antenatal care in rural hospitals is limited, with some hospitals no longer supporting deliveries.
  - Availability of these services within rural and remote hospitals would enhance antenatal support for pregnant people.

4. Medical or surgical abortion

Recommendation(s):

- Harmonise legislation. Access is inhibited by legislative variations between states and territories which GPs must be aware of when offering or referring for medical and surgical termination.
- Provide direct GP phone access to termination clinic teams located in public hospitals to aid timely referral.
- Support GPs to train in surgical abortion provision and be provided access to hospital facilities so that patient choice in terms of having access to either a medical or surgical abortion can be maintained.
- Low and no-cost direct pathways through public hospitals must be more transparent and accessible for people in rural/remote areas as well as for those of limited financial means.
- Removing barriers to accessing private abortion services could result in long-term savings to the public hospital system and relieve pressure on state and territory governments.

The RACGP recognises the significant barriers to access reproductive healthcare for patients in rural and remote communities across Australia, especially those who wish to access termination of pregnancy services. Cost is a key barrier to accessing these services.

- Low and no-cost pathways through hospitals and other settings must be more transparent and accessible for people living in rural and remote communities.
- There are also access issues for many rural GPs who want to provide termination services. These include hospital services being too far away, a lack of access to blood products, lack of access to a gynaecologist to provide backup care in the rare event it is needed, as well as difficulty accessing relevant drugs from pharmacies.

While the RACGP supports the need for affordable and accessible medical and surgical abortion services, we do not support the creation of specific MBS items for medical termination of pregnancy services in general practice.

- Current rebates are not adequate to cover the cost of providing medical abortions, which includes highly skilled person-centred care accounting for factors such as education about all options in unplanned pregnancy, contraceptive needs, interaction with co-morbid health conditions, cultural diversity, trauma, domestic violence, and abortion stigma.
- The rebates also do not cover practice nurse time in supporting medical abortions.
- If practices become financially unviable and are forced to close, patients will no longer have access to high-quality, local and accessible general practice care.

5. Obstetric care (births, LSCS)

Recommendation(s):

- Allow credentialled GPs at least the same access in delivery of obstetric care as midwives.
- Support GP Obstetricians to work to top of scope, including working in collaboration with obstetricians and midwives and provide funding for ongoing training.
- Address the issue of medical indemnity insurance for GP Obstetricians. Sometimes this is prohibitive for the volume of work they provide.
- Reinvolve GPs in antenatal care.

GPs are important providers of obstetric care, particularly in rural areas. The benefits of GP obstetric care can include continuity and an ongoing relationship with the patient and their family. GPs are often blocked in rural locations where highly expensive fly-in-fly-out city-based specialists are used instead.

6. Sexual health

Recommendation(s):

- Continue the eight telehealth items beyond 31 December 2023, ongoing, when they are scheduled to expire. Enabling access to sexual and reproductive health services via telehealth provides flexibility and choice for patients to consult with their GP (or an alternative GP to their usual GP if they do not provide medical termination of pregnancy or is a conscientious objector) on sensitive health matters.
- Continue the telehealth items for non-directive pregnancy support counselling (items 92136 and 92138) to be ongoing beyond 31 December 2023.

On 1 July 2021, eight new MBS GP telehealth items were introduced for blood borne viruses, sexual or reproductive health consultations (video and telephone). These items are time-based and can be used for services related to blood borne viruses, sexual or reproductive health, excluding assisted reproductive technology and antenatal care. Section 100 drugs can be prescribed under these items, if clinically relevant. Unlike most GP telehealth items, these items do not require a patient to have an existing clinical relationship with the GP providing the service (i.e. the patient has had a face-to-face consultation in the past 12 months).

7. Procedures (e.g Dilation and curettage, colposcopy)

GPs with advanced skills should be supported to provide appropriate gynaecological procedures, with gynaecologist support where appropriate. Refer GPSI best practice example in “Real life examples” section.

Common procedures in general practice

1. Immunisation

Recommendation(s):

- Introduce a new MBS item (based on existing item 10988) that would enable practice nurses and general practice-based pharmacists to administer vaccinations in general practice.

Immunisation conducted in a general practice setting is integrated into the rest of the patient’s care, such as management of other health problems. Currently, GPs must be present when vaccines are administered in order for patients to receive an MBS rebate. Pharmacists working in general practice settings cannot administer vaccines in some jurisdictional authorities even though they are working in supported and safe environments.

Claiming rules for MBS COVID-19 vaccine items have historically been highly complex, as evidenced by 15–18-page fact sheets outlining different scenarios for billing the items. An educative approach on these items, including condensed fact sheets, is essential. The vaccine item structure was simplified on 1 February 2023, but not before DoHAC sent compliance letters to GPs in November 2022 relating to high levels of claiming MBS COVID-19 vaccine suitability assessment items with an attendance item and/or practice nurse item.

The RACGP advised DoHAC that episodes of co-claiming standard time-based attendances with COVID-19 vaccine items are likely to increase as GPs are being urged to opportunistically vaccinate by their local PHN. Opportunistic preventive care is one of the key benefits of comprehensive general practice care.

2. Wound care

Recommendation(s):

- Allow practices to charge for the cost of a wound dressing applied during a bulk billed consultation and establish a Commonwealth-funded wound consumables scheme to reduce out-of-pocket costs for patients.
- Increase funding for primary care nurses to review and dress wounds as this is currently unfunded and doesn't support multidisciplinary team care.

The system prevents members of the primary care team working to full scope of practice, especially in areas where patients cannot afford a co-payment. When a patient is bulk billed for wound care treatment, no additional costs (eg dressing costs) can be passed on to that patient. This automatically precludes bulk billing or any use of bulk billing incentives. General practices are more likely to refer these patients to wound clinics for their care, resulting in skill decay in primary care and more expensive delivery of wound care in other settings.

- As part of the MBS Review, the Wound Management (WM) Working Group recommended that the restriction prohibiting practitioners from charging patients for the cost of a wound dressing applied during a bulk billed consultation be removed. The RACGP supported this recommendation in our 2020 submission.
- The WM Working Group also recommended that a Commonwealth-funded wound consumables scheme be developed to ensure patients have access to appropriate wound care products with reduced out-of-pocket costs. Both recommendations were endorsed by the MBS Review Taskforce. Last year the AMA published a report outlining solutions to the chronic wound problem in Australia.

3. Point of care testing

Recommendation(s):

- Allow GPs to claim MBS item 11714 (ECG trace and clinical note) in line with other specialists and consultant physicians.
- Allow Medicare patient rebates when GPs order MRIs.

  Some MRIs currently require a specialist referral. This limits scope of practice, as at present, the GP must refer to a non-GP specialist so as to enable a patient rebate.

There was widespread concern following removal of the rebate for GPs reading and interpreting electrocardiogram (ECG) services. Patient rebates for GP-performed ECGs are restricted to MBS item number 11707 for tracing only. Reading and interpreting an ECG is a core skill taught in medical school and is supported by RACGP's curriculum. Removal of the rebate does not recognise the GPs' scope of practice. The changes have significantly reduced the support available for ECGs conducted by GPs, who provide this care at lower cost and greater convenience and speed to patients than other medical specialists.

Medicare rebates for MRIs also require review.

Further relevant documents include:

- RACGP submission to DoHAC's ECG Review Committee in April 2021

Dermatology/Skin Cancer medicine

Skin conditions comprise 17% of all problems encountered in general practice.[95] General practitioners (GPs) require a wide range of expertise for skin complaints, including diagnosis and management of acute and chronic skin conditions, skin cancer screening and diagnosis, performance of diagnostic biopsies and/or definitive excisional treatment, referral or collaborative care with non-GP specialists and preventive care. GPs should be aware of the medical and psychosocial dimensions of chronic skin disease, where a biopsychosocial approach is more likely to result in a more personalised and holistic management plan.

1. Acne

Recommendation(s):

- Allow all GPs to prescribe oral isotretinoin under Authority.

Acne scarring is often dismissed as a superficial cosmetic concern. However, it contributes to sentiments of hopelessness and low self-esteem in the patient which in turn leads to a perceived loss of control further magnifying existing psychological distress. Acne scarring often appears in highly visible parts of the body, heightening self-consciousness and self-evaluations of attractiveness. The patient's perceived visibility of their own disfigurement predicts psychological disturbances better than objective clinical assessments.

- Early and consistent management of mental health is necessary to reframe negative cognitions and prevent the recurrence of psychiatric disorders related to acne and acne scarring. Stigma related stress also leads to impaired social functioning.[96]
- There is poor access to dermatologists across Australia and patients are unnecessarily suffering while they wait to access dermatology services, some of which are inaccessible due to cost.
- GPs are skilled to be able to prescribe medicines with a low therapeutic index and oral isotretinoin is no exception.

Case study – Emma, age 26
Emma presented to me for a routine skin check after I was recommended as a local GP with specific interests in dermatology, obstetrics and mental health care. Emma revealed she had severe anxiety surrounding her acne and body image. She was particularly concerned that her wedding was in one month and her acne was not improving after seeing a dermatologist and being prescribed topical retinoids. She had been unable to attend for review due to the long wait time in the public system. On closer questioning, Emma revealed that she was actively trying for a baby and was unaware that the medications she had been prescribed were harmful to pregnancy. During the consultation she required urgent education on contraception, a meaningful discussion on her acne goals and mental health, as well as antenatal planning and coordination with other health professionals.

Due to the severity of her acne, a shared decision was made to trial her on oral isotretinoin. As GPs in Queensland are not permitted to prescribe this medication, she had to fly to Brisbane for a private dermatologist consultation where she was subsequently placed on the medication to good effect.

Over the course of several months, she returned to me for acne review where we also performed STI screening, dietary and lifestyle advice, mental health care planning and counselling. She demonstrated an excellent response with both her acne and mental health. Within 2 years we coordinated withdrawal from her medication and she was able to successfully complete a pregnancy. She still attends our clinic to this day with her family and continues to do so with a strong sense of rapport and trust. If Emma had been seen in Western Australia or the UK, a GP could have prescribed oral isotretinoin and saved her a trip to the dermatologist (and an airfare).

- North Queensland GP with specific interest in dermatology, obstetrics, and mental health

Vulnerable or underserviced groups

1. Trans and Gender Diverse

Recommendation(s):

- Reform PBS requirements for prescription of testosterone to include specialist GPs. This will assist those with financial strain who are currently unable to afford the cost of a private script. It will also decrease the need for specialist involvement where this can be a barrier to care in the adult TGD population.
- Improve access to publicly funded gender affirming surgical procedures. A summary of issues can be found here.
- Enable patients to access care through their own GP, rather than being forced into specialist care or services with long wait lists.
    - Provide regional and rural health incentives for gender affirming GPs to provide outreach or telehealth services. In particular, to access specialist mental health providers, for youth in regional and remote Australia
    - Patients can receive the most timely and holistic care from a provider who knows them and in their community.
    - When necessary, patients with more complex mental or physical health needs can be referred to tertiary care.
- Support through appropriate funding MDCTs to enable case discussions.
- Ensure medical indemnity is available for practitioners adhering to best practice TGD care.
- Ahpra to consider revising data collection forms at the time of registration each year to be gender inclusive.
- Support reforms in the Australian Standards of care and treatment guidelines that are currently underway through the Royal Children's Hospital (Victoria). This will enable increased access for children and adolescents in regional and remote communities, and also take the pressure off the tertiary centres.

The RACGP has training within the curriculum (Sexual health and gender diversity) and in the Capability profile of the general practitioner and this will have a direct impact on the cultural safety of primary health care and specialist care delivered to the TGD community. RACGP has also included TGD content within the Standards for general practices 5th edition.

However, there is inadequate medical indemnity provided by some insurance providers due to lack of understanding of the scope of practice of a general practitioner trained in TGD care. These barriers to access indemnity are amplified in the provision of care to young people, especially those aged 16-18yo.

- Long tertiary hospital wait times of over 2 years mean that in some states, young people referred to paediatric gender services at 16yo will not be seen before they "age out" of the service. Perversely, they are not able to be referred to adult services until they approach 18yo.

- Lack of support by some medical defence organisations has made it very difficult for these young people to access care at all, as private providers feel unsupported to provide care. One provider issued a blanket exclusion to their indemnity policy for private providers initiating gender affirming hormone therapy in people under 18. This decision was out of step with the existing expert guidance in this area as well as an increasing body of evidence demonstrating the strong benefits and low risk of harms associated with this care.

- Substantial service gaps, leave these young people vulnerable to self-harm, intense suicidal thoughts and, potentially, suicide attempts. TGD young people are also at high risk of school nonattendance, creating risk to their education and future employment prospects.

Instances have occurred of general practitioners working in regional areas being reported to Ahpra for prescribing hormones to a young person between the age of 16-18 years of age, despite the practitioner abiding by best practice guidelines.

- The current standard of care that is outlined by the "Australian Standards of Care and Treatment Guidelines".

- These advise that this age group requires a MDCT approach either in a tertiary care service or facilitated by a GP in the community.
- It was ultimately deemed appropriate by Ahpra that the GPs who had prescribed to this age group did so in accordance with the best standard of care they could offer in regional settings, the young person had adequate multidisciplinary care and this prescription was the safest thing for patient care. However, these incidents and the lack of clear, emphatic support for GPs working to their full scope in this area creates a chilling effect and causes GPs to avoid providing this care due to fear of litigation.

2. Disability

Recommendation(s):

- Recognise a GP diagnosis on a disability support pension form.
- Remunerate GPs for time spent preparing reports and other relevant documentation to support National Disability Insurance Scheme (NDIS) applications when patients are not present.

  MBS items for GP consultations can only be billed if the patient attends a face-to-face or telehealth appointment. Despite the fact that attending a consultation is an additional financial, access and time burden on a person living with a disability, MBS rebates are not available for documents completed in the patient's absence.

GPs working in these sectors have consistently raised concerns about the need for support staff to be better trained and appropriately recognised for the work they do.

RACGP's submission to the independent review of the NDIS outlines seven key principles designed to support the involvement of GPs in disability care and management.

Complex care case study – 45-year-old man with two serious behaviour concerns

AB presented to the practice with two serious behaviour concerns. The first being agitated obsessive behaviour resulting in extreme property destruction (including smashed reinforced windows, slamming doors off their frames and de-threading carpets) costing over $50,000 per year. He also engaged in intense self-injurious behaviour (self-punching his head or head-butting door frames). These behaviours escalated over 2-3 weeks with a 4-week break when he was calm and compliant. He was taking haloperidol 5mg with limited effect.

AB has no contact with his family and has been in institutional care since early childhood, transferring to community-based care at the closure of the institution. He had a functional diagnosis of severe intellectual disability, with a history highly suggestive of a coexisting autism spectrum disorder (ASD)and anxiety as a major driver of behaviour. Intellectual disability (ID) made it difficult to diagnose an underlying mental health disorder. His short stature, congenital heart disease (VSD), facial features, and bifid uvala suggested a genetic cause of his ID.

Examination identified a raised arc on his central forehead with a healing sore, mid-systolic flow murmur (VSD), bifid uvula and most teeth missing. Otherwise, fit, good mobility and unrestricted movement. Ordered a microarray to establish aetiology, LFTs, electrolytes and FBE to review for adverse effects of haloperidol and gave staff behaviour charts to monitor behaviour daily. No initial change in medication while monitoring behaviour. Referred for baseline echocardiography and considered antibiotic cover. Referred to dentist. Provided information to his support staff and behaviourist to improve their understanding of ASD. Assisted AB to establish a medical treatment decision maker through the Office of Public Advocate due to concern with the introduction of lithium and potential for serious side effects. Set up next appointment to continue with monitoring of behaviour and consider medication changes.

Highlighted the importance of genetic testing even in older patients and the critical issue of having support staff working collaboratively and consistently.

- Metropolitan Victoria GP

Additional views

The broadest range of views will give the Scope of Practice review a thorough foundation on which to consider new policy and regulation.

Q10. Please share with the review any additional comments or suggestions in relation to scope of practice.

1. RACGP's Reform Private Health Insurance position statement states that funding to allow delivery of primary care by allied health professionals and nurses, should be approached with caution. There remain concerns that any private health insurance reforms may cause further inequity of healthcare provision between patients who have private health insurance and those that do not. **The RACGP does not support amendment of the Private Health Insurance Act 2007 to allow private health insurers to fund services currently funded by Medicare or to cover gap payments, without further investigation of how this model could impact universal access to care.** Services already being provided by a patient's usual GP, such as chronic disease management, should not be duplicated by private health insurance at this time, as this could lead to adverse events, fragmentation and inefficient use of health resources. This approach would need to ensure all features of primary care are able to be integrated.

2. The RACGP welcomes commitment to support Aboriginal and Torres Strait Islander community-controlled organisations (ACCHOs) and improve the health outcomes for Aboriginal and Torres Strait Islander people. We strongly support the ACCHO model of comprehensive primary health care, including by supporting integration of non-prescribing pharmacists in ACCHOs. Further efforts to develop and support the Aboriginal and Torres Strait Islander workforce are welcomed. Growing the Aboriginal and Torres Strait Islander GP workforce is fundamental in closing the gap in life expectancy and health outcomes.

3. Cultural safety must form a critical component of any primary care reforms, incorporating support for changes throughout the system and meaningful involvement of Aboriginal and Torres Strait Islander people. As part of this, cultural safety training should be embedded throughout primary care and should include an understanding of context and a tailoring of practice with face-to-face training, and regular follow-up and refreshment of training The RACGP curriculum has a specific unit on Aboriginal and Torres Strait Islander health and considerations of appropriate care are integrated throughout the entire curriculum. Additionally, there is a capability in the profile to 'deliver culturally safe care'. Cultural safety training has been included in training programs. It is also part of the Aboriginal and Torres Strait Islander Cultural and Health Training Framework which will be released soon.

4. The RACGP considers the MBS Review initiated by the former government in 2015 to be a missed opportunity to reform the MBS. The purpose of the review was to consider how MBS items could be better aligned with contemporary clinical evidence and practice, to improve health outcomes. Between 2015 and 2020, the MBS Review Taskforce looked at more than 5,700 MBS items to see if they needed to be amended, updated or removed.

   The MBS Review has provided little benefit for general practice. Recommendations such as streamlining chronic disease MBS items and expanding MBS health assessments to other at-risk groups are yet to be implemented after several years. Furthermore, changes that did result from the MBS Review caused significant concern among GPs, including new items for eating disorder treatment and management and a reduction in support for electrocardiogram (ECG) reporting in general practice.

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