RACGP pre-budget submission 2023-24

January 2023

Recommendations

The Royal Australian College of General Practitioners (RACGP) is calling for action in the following key areas:

Support for patients who need to spend longer with their GP, in the way that works best for them

This should comprise:

- a 20% increase to Medicare patient rebates for Level C and Level D general practice consultations
- the re-introduction of Medicare patient rebates for consultations lasting longer than 20 minutes, mental health and GP management plans conducted via telephone.

Targeted care for those who need it most

This should comprise:

- new Service Incentive Payments that support care for:
  - older people
  - people with mental health conditions
  - people with disability.
- tripling of the Medicare patient rebate for the Bulk Billing Incentive items.

Growth in the general practice workforce to ensure all patients can continue to access care

This should comprise

- the introduction of a program of junior doctor placements in general practice.

Keeping patients out of hospital by supporting them to see their GP after an unplanned hospital admission

This should comprise:

- support for GPs who see their patient within seven days of an unplanned hospital admission or Emergency Department presentation.

Better access to medicines for all

This should comprise:

- feasibility study to assess the economic and health benefits of reforms to pharmacy ownership and location laws, and to research and develop alternative models in general practice and Aboriginal Community Controlled Health Organisations (ACCHOs).

The RACGP also supports the implementation of the Uluru Statement of the Heart and Closing the Gap and calls for government action in providing a voice for Aboriginal and Torres Strait Islander people in the Parliament of Australia and investing in equality in health and life expectancy for Aboriginal and Torres Strait Islander peoples.

Overarching RACGP Vision for general practice and a sustainable healthcare system

In the long-term, the RACGP *Vision for general practice and a sustainable healthcare system* sets out a roadmap for sustainable and high-quality healthcare created through a strong primary care system.

General practice is the most efficient part of the healthcare system. The Vision therefore sees that a well-resourced general practice sector is essential to addressing the existing and future challenges facing patients, funders and providers. The Vision places the patient at the centre of care, supported in the first instance by their regular GP and broader general practice team.

GPs and their teams then connect their patients to, and guide them through, the often complex wider healthcare system. The Vision calls for reforms to support building multidisciplinary teams within general practice, to ensure continuity of high-quality care for all patients. This evidence-based approach is particularly important for the growing number of people with chronic and complex conditions.

PwC estimate conservative direct benefits of investing in general practice and implementing the Vision to be in the order of $1.0 billion per year and $5.6 billion over the next five years at a minimum. The direct benefits are derived from savings in preventable hospitalisation, hospital readmission and emergency department presentations, and improved workforce productivity.

Priority area 1 – Support patients who need to spend longer with their GP, in the way that works best for them

Issues

Rising rates of chronic disease and mental ill-health, as well as the ageing population, means more patients are presenting to general practice with increasingly complex needs.[1] These conditions are long term, and require early identification and care that can be provided in the community by GPs and their multidisciplinary teams.

Although short general practice consultations provide support for everyday issues, longer consultations are needed for the chronic illnesses and complex health issues so prevalent in Australia today.[2,3] Longer consultations with a GP have significant advantages, including increased patient education, identification and management of complex issues, preventive health, early intervention, immunisation adherence, counselling, patient satisfaction and participation, and better use of medications.

However, patient rebates are lower per minute for longer consultations, disadvantaging people who require more time with their GP. This can mean the sicker a person gets, the harder it is to get the extra time they need with a GP, and the more they may pay out of pocket costs to see their GP. Concerningly, there are growing trends that patients seeking out bulk billed care can only access shorter consultations, exacerbating access issues for those most in need.

More broadly, patients need an increase in their rebates to ensure they can still access the care they require. Without additional investment, inflation and other factors mean that rebates are failing to keep up with growing healthcare costs.

We have also recently seen the removal of patient rebates for most longer telephone consultations, despite these services proving beneficial to the health of patients throughout the COVID-19 pandemic. Telehealth is an important option of healthcare provision. It helps facilitate a person's access to their usual GP, meaning people can more easily receive high-quality, personalised health services when and where it suits them. Given Telehealth use in Australia is

overwhelmingly phone-based, limiting phone-based consultations effectively removes a key means of access to care for many Australians.

Solution

Care for complex health issues must be better supported through Medicare. Longer consultations provide an opportunity to address major risk factors by allowing more time for preventive care and early intervention for chronic conditions.

Increasing funding for standard general practice consultations longer than 20 minutes is a simple and effective way to build additional support for people with complex health needs. Re-introducing patient rebates for longer telephone consultations will also enable access to care for people with complex health needs, including for the elderly and those who are most vulnerable.

Better supporting longer consultations, in-person or via the phone, is also important for rural and remote communities, which are significantly more likely to report barriers to accessing GPs compared with other Australians.[4,5]

The RACGP is calling for:

- a 20% increase to Medicare patient rebates for Level C (20–40 minutes) and Level D (40-minute plus) GP consultations
- the re-introduction of Medicare patient rebates for phone consultations for consultations lasting longer than 20 minutes, mental health and GP management plans as part of the permanent Telehealth model.

Measure	Estimated investment required, annually ($)
20% increase to Medicare patient rebates for Level C and Level D GP consultations	$335.2 million per year
Patient rebate for Level C and D GP phone consultations	$104.1 million per year

Priority area 2 – Targeted care for those who need it most

Issues

GPs are seeing higher numbers of patients presenting to practices with complex, and often unaddressed, health needs.[6] This includes people aged over 65, people presenting with mental health concerns and people with disability. These patients have higher rates of chronic conditions and multimorbidity.[7] As such their care is often complex and requires more time to identify issues, provide ongoing support and undertake monitoring to manage their conditions.

Seeing the same GP for most of an individual's health needs (often referred to as 'continuity of care') is essential for patients to experience the best possible health outcomes. Continuity of care is linked to better patient–provider relationships, better uptake of preventive care, increased access to health services, and reduced healthcare use and costs.[8] Low continuity of care has been linked to higher risk of mortality.[9] Continuity of GP-led care is particularly important for people with complex health needs, ensuring their care is coordinated and effective.

The current structure of patient rebates through Medicare does not adequately support continuous and coordinated care for people with complex needs, and therefore does not support Australians who require care over time. It also does not address the barriers many GPs face when providing care to these patients, including the additional time and costs for this care. Unfortunately, while GPs are committed to providing high-quality care to all their patients, the systemic underfunding of general practice means patient access to care is at risk.

It is also important that care for those who need it most is affordable. Cost associated with general practice now far outweigh patient rebates. As a result, patient out of pocket costs are increasing and many GPs are reducing the proportion of patients they bulk bill. Government data shows that the proportion of general practice services bulk billed recently dropped for the first time in almost two decades, and the most recent quarterly bulk billing rate has dropped from 87% to 83.4%.[10]

Only around two thirds of patients are now fully bulk billed[11] and this is expected to reduce further in the coming years. This is a concern given patients in lower socioeconomic groups, who may not be able to pay for health services, generally have poorer health, and higher rates of illness, disability and death.[12] Patients that cannot afford to pay for their care will struggle to access the services they need unless more support is provided for GPs to bulk bill.

Solution

Introducing targeted funding for patients with complex needs will ensure they can access regular and continuous care from a GP. This investment will build on the therapeutic relationship while also enhancing the provision of complex care, facilitating early prevention and early intervention activities and improved ongoing care management. This will be particularly impactful for people in rural and remote Australia, given the higher total burden of disease and need for more preventative and complex care in these areas.

In addition, increasing the Bulk Billing Incentives across metropolitan and rural areas will support higher bulk billing rates for populations that may not be able to pay for care, including those on low incomes, older people, children under 16, and those in rural and remote areas. Increasing these incentives is a simple solution to strengthen our universal healthcare system and ensure all people can see their GP regularly for high-quality care. This will also help start to address the growing cost of healthcare, and the reality that patient rebates are not sufficient to support patient access to care.

The RACGP is calling for:

- new Service Incentive Payments[i] (SIPs) that support care for:
  - older people through the provision of a grouping of services, including:
    - a health assessment[ii] for older people and/or a GP management plan with at least one review
    - a frailty assessment.
  - people with mental health conditions through the provision of a grouping of services, including:
    - a GP mental health treatment plan with at least one review
    - a physical health assessment.
  - people with disability through the provision of a grouping of services including:
    - a relevant health assessment or GP management with at least one review
    - completion of NDIS reports/documentation.
- the Medicare patient rebate for the Bulk Billing Incentive items to be tripled.

Measure	Estimated investment required, annually ($)
Service incentive payment for older people	$223.2 million per year for two-tiered payments
Service incentive payment for mental health	$181.6 million per year for two-tiered payments
Service incentive payment for disability	$163.8 million per year for two-tiered payments
Tripling the Medicare rebate for the bulk billing incentives	$1.4 billion additional investment per year

[i] The RACGP sees that these payments would be made up of $100 for each patient where a target level of care is provided by the GP in a calendar year and a $150 payment to GPs for providing the majority of care for a patient in a calendar year.
[ii] This measure should include expanding eligibility for the Medicare Benefits Schedule (MBS) health assessment to include patients 65–74 years (and 50–74 for Aboriginal and Torres Strait Islander Australians).

Priority area 3 – Grow the general practice workforce to ensure all patients can continue to access high-quality GP care

Issues

General practice is the backbone of the Australian health system, with nine out of ten Australians seeing their GP each year. However, declining rates of doctors entering general practice, and increasing numbers of GPs retiring means that the workforce is struggling to meet demand. Without action, it's expected this issue will worsen in the next decade, and patients will be unable to access the critical services they require from their GP.

Recent reports note only 13.8% of medical students consider general practice as their preferred medical speciality, while a deficit of 11,517 GPs is expected by 2032.[13] The 2022 General Practice: Health of the Nation suggests that one-quarter of GPs plan to retire within the next five years, an increase from 18% in 2021. In real numbers, this equates to more than 7500 GPs, worsening already worrying workforce projections.[14] The number of active doctors in the Australian General Practice Training Program is also declining, likely due to the impact of the decreasing number of doctors entering general practice training from 2017 to 2020.[15]

Currently, junior doctors experience a range of medical specialties before choosing their career. However, exposure to general practice for these doctors is inconsistent and limited. This limits opportunities for all doctors to build important generalist skills, which would allow them to better serve their patients across their career of choice (whether general practice or other speciality) and experience the value of general practice as a career.

Solution

Medical education and training opportunities need to shift from the hospital to community. Exposure to and experience in general practice early in medical training is key to a more skilled medical workforce, a better performing health system and efficient use of health resources.

Expanding junior doctor exposure to general practice will increase the number of doctors in general practice, embed important generalist skills across the medical profession, and encourage more junior doctors to choose general practice. Ultimately this measure will ensure patients can access the general practice care they need, when they need it.

Surveys of the Pre-vocational General Practice Placements Program, which previously provided interns and residents with a rotation in general practice, suggested this program exposed participants to positive experiences and role models, is clinically useful and a positive formative experience.[16,17]

The RACGP is calling for:

- the introduction of a program of junior doctor placements in general practice.[iii]

Measure	Estimated investment required ($)			
	2023-24	2024-25	2025-26	2026-27
Introduce program for junior doctor placements in general practice[iv]	$0.95 mil	$9.3 mil	$18.7 mil	$37.3 mil
	-	*200 placements*	*400 placements*	*800 placements*

[iii] The introduction of this program should include recognition under Section 3GA of the *Health Insurance Act 1973* that allows Post-Graduate Year (PGY) 2 doctors to bill Medicare.

[iv] The costings outlined represent approximate funding necessary to develop and implement a successful training program of this nature. These costs should be reviewed and revised prior to and during program planning. This funding estimate includes $0.95 million for program development in 2023-24, as well as ongoing costs from 2024-25 for practice infrastructure and administration, supervision, intern salaries and indirect placement costs.

Priority area 4 – Keep patients out of hospital by supporting them to see their GP within seven days of an unplanned hospital admission

Issues

Public hospitals are experiencing high demand across Australia, resulting in significant delays for ambulance and emergency department (ED) services. The RACGP sees a significant opportunity to reduce the pressure on these services by addressing potentially preventable hospitalisations (PPHs). More than 748,000 PPHs occur each year in Australia, accounting for 6.6% of all hospital admissions and 9.8% of hospital bed days.[18] PPH rates in very remote areas were 2.6 times higher than in major cities as of 2019-20, with the rate in remote areas 1.8 times as high.[19]

Preventable hospital readmissions make up a significant proportion of these potentially preventable hospitalisations. Approximately 718,000 readmissions to hospital occur each year.[20] Unplanned or unexpected hospital readmissions may arise as a result of the need for care that can only be delivered in a hospital or as the result of a lack of appropriate post-discharge care in the community.

Better support for, and use of, general practice is associated with reduced ED visits and hospital use and decreased hospital readmission rates.[21,22,23] Patients who see their GP soon after discharge from hospital experience significantly fewer hospital readmissions. Dedicated time for seeing a GP following an unplanned hospital admission will help reduce a person's chance of readmission by up to 24%.[24] New South Wales data shows:

- a visit to the GP in the first week is followed by 7% fewer readmissions within 28 days
- a visit to the GP in the first 4 weeks is followed by 22% fewer readmissions over 1 to 3 months.[25]

Conservative estimates suggest that a reduction of 12% in hospital readmissions could save the health system a minimum of $69 million per year.[26] In addition to the savings achieved, patients experience better health outcomes and the pressure on the hospital system is reduced.

Solution

Funding to support continuous and coordinated GP-led care post-hospital discharge will help to address unsustainable hospital demand and improve outcomes for patients. Introducing targeted funding for GPs to see patients within seven days of an unplanned hospital admission or ED presentation will reduce readmissions and ensure people with complex needs do not get lost in the system, particularly those in rural and remote Australia.

The RACGP is calling for:

- support for GPs to see their patient within seven days of an unplanned hospital admission or ED presentation.

Measure	Estimated investment required, annually ($)
Expanding eligibility for Medicare Health Assessment Items	$63.1 million per year *Estimates indicate that a reduction of 12% in hospital readmissions could directly save the health system a minimum of $69 million per year, which would offset the above investment and see a total net savings of more than $5 million annually.*[27]

Priority area 5 – Better access to medicines for all

Issues

The health of our patients is a top priority for general practitioners. Pharmacist workforce shortages, particularly in rural and remote locations, impact on patient access to medicines and convenience in obtaining medicines. GPs and Aboriginal Community Controlled Health Organisations (ACCHOs) are available in greater numbers and better distributed across the country, as are supermarket chains.

State legislation restricts pharmacy ownership to registered pharmacists and limits the number of pharmacies a single pharmacist can own. No other health provider has these restrictions. The Australian government regulates the location of retail pharmacies approved to dispense subsidised medicines under the Pharmaceutical Benefits Scheme (PBS). These regulations are additional to professional registration requirements for pharmacists, pharmacy licensing requirements, the Competition and Consumer Act 2010 (Cwlth), land-use planning regulation and other rules.

Restrictions on retail pharmacy location and ownership appear to be focussed on protecting the vested interests of incumbent pharmacists, rather than the interests of people across Australia. The rules limit competition and make it harder for some people to access discounted pharmacy services where individual pharmacists or small groups of pharmacists have been able to monopolise some or all pharmacies in towns, resulting in patients paying more for their medicines and having limited choice of pharmacy services. Over the past decade there have been several reviews and reports on the need for the removal of pharmacy location and ownership rules:

- The Competition Policy Review conducted by an independent panel of experts in 2015 recommended as part of immediate reform the removal of pharmacy location and ownership rules, concluding they did not serve the objectives of the National Medicine Policy as it limits both consumers' ability to choose where to obtain pharmacy services and suppliers' ability to meet consumers' demands.[28]
- The Productivity Commission Research Paper – Efficiency in Health in April 2015 stated that there is no reason to treat pharmacy differently from other sectors of the economy and recommended removing location and ownership restrictions.[29]
- The Review of Pharmacy Remuneration and Regulation Final Report in September 2017 recommended the Australian Government should:
    1. Reform the Pharmacy Location Rules to remove barriers to community access and competition between pharmacies and to ensure they continue to support equitable and affordable access to medicines for all Australians in accord with the National Medicines Policy.
    2. Reduce pharmacy monopoly by the Australian Competition and Consumer Commission to review overlapping ownership impact on competition.
    3. Remove any restrictions on the ability of an Aboriginal Health Service to own and operate a pharmacy located at that Aboriginal Health Service.
    4. Trial the use of machine dispensing in a small number of relevant secure locations in communities that are not currently served by a community pharmacy.
    5. Increase transparency of community pharmacy expenditure and funding for programs to demonstrate value and performance.
    6. Harmonise all state, territory and Commonwealth pharmacy regulations to simplify the monitoring of pharmacy regulation and consider a single pharmacy regulator.[30]

To date, none of the above recommendations have been actioned.

The pandemic has brought about a number of challenges and changes in healthcare delivery. There have been significant changes in workforce numbers and distribution requiring better utilisation of health resources, so it is an opportune time to refresh and implement some of these recommendations. With the deadline for the end of the Seventh Community Pharmacy Agreement approaching, the time is now.

Australia's population is ageing and by 2066 it is projected that older people will make up 21-23% of the total population. Pharmaceutical dispensing rates increase with age, the highest rates are among those 85 and over.[31]

Therefore, access to medicines will become increasingly important. However, the Pharmaceutical Society of Australia's Medicine Safety: Rural and Remote Care March 2021 report indicates that without intervention, by 2027 there will be as few as 52 pharmacists per 100,000 people in regional and remote areas compared to 113 pharmacists per 100,000 people in major cities. So regional and remote older Australians may need to travel further to access their medicines. Other models of accessing medicines should be explored.

Solution

The current pharmacy ownership and location regulations are anti-competitive and reduce opportunities for innovation and entrepreneurship. The restrictions on competition inflate the costs of pharmacy medicines and reduce consumer choice and convenience. In areas of low competition, the $1 discount is less likely to be offered and the location and ownership rules are undermining the ability to set up pharmacies in existing healthcare sites. This reduces access for regional and remote communities where it has been found that patients travel the furthest to access their nearest pharmacy.[30] In the United States, United Kingdom and Europe, supermarket pharmacies are highly prevalent.

Supermarket pharmacy models can potentially offer lower prices of medicines while still providing high-quality advice to patients receiving their medicines. Online pharmacy options and automated dispensing machines are all innovations that could be better utilised in the community to improve access and increase competition, ultimately benefiting patients across Australia.

Throughout Australia there is variation in the availability of pharmacy services. The RACGP would like to explore reforms to pharmacy ownership and location laws and regulations to better support patients access to medicines in general practice and ACCHOs.

These changes could have a significant impact on the pharmacy sector and a transition period would be required. It would be timely to undertake this task now given the seventh Community Pharmacy Agreement is ending in 2025.

The RACGP is calling for:

- $2 million to assess the feasibility and economic and health benefits of reforms to pharmacy ownership and location laws and to develop and research alternative models to address the inequity encountered by regional and rural and remote populations accessing medicines and evaluate the effects of changes in terms of savings to patients, better patient access and improving the viability of general practice through GP-owned and ACCHO-owned pharmacies and/or automated dispensing machines. This work will build on recommendations from previous reviews and make use of general practice and ACCHO infrastructure.

Measure	Estimated investment required ($)
Assess the feasibility and economic and health benefits of reforms to pharmacy ownership and location laws and develop and research alternative models in general practice and ACCHOs.	$2 million in 2023-2024.

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