RACGP

Royal Australian College *of* General Practitioners

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**RACGP Pre-budget submission 2022-23**

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*We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.*

## Preamble

General practice continues to be the backbone of Australian health care. In 2021, general practice stood up again to face the challenges of continuing lockdowns while undertaking the largest vaccination program Australia has ever seen. General practitioners delivered over 20 million COVID-19 vaccinations while maintaining day-to-day care for their patients.

Yet general practice is the least resourced part of the health care system, despite overwhelming evidence of the health benefits and economic savings that could be achieved by investing in primary healthcare[1]. The *RACGP Vision for general practice and a sustainable healthcare system* sets out the areas for investment for Australians to continue to enjoy one of the best health care systems in the world.

Moreover, economic analysis by PricewaterhouseCoopers estimates that implementing the *RACGP's Vision for general practice and a sustainable healthcare system* and boosting primary care funding could provide benefits of $5.6 billion over the next five years[2].

Following nearly three years of development and consultation, the *Recommendations on the Australian Government's Primary Health Care 10 Year Plan* was released in 2021. The RACGP supports the principles outlined. However, without significant investment in general practice the 10 Year Plan will not deliver the changes needed and Australians will struggle to find the care they need.

The general practice workforce is ageing – the proportion of GPs over the age of 65 increased from 11.6% in 2015 to 13.3% in 2019[3]. At the same time, not enough medical graduates want to be GPs. The proportion of final-year students listing general practice as their first preference specialty has fallen to just 15.2% – the lowest since 2012[3].

Investment in time to better manage multiple and complex conditions, prevent complications and ensure the most at risk do not fall through the cracks is critical now that one in two Australians has a chronic disease and two in three have at least three or more risk factors for heart disease, diabetes or chronic kidney disease.

Now is the time to protect the care we all count on.

Dr Karen Price
**RACGP President**

## Recommendations

The RACGP calls on the federal government to commit funds to:

1. **Support regular, continuous and preventive care for people over the age of 65, people with mental health conditions and people with disability**

Improve patient access to general practice services through:

- a new service incentive payment that supports the provision of a grouping of services for older people, including a health assessment for older Australians and/or a GP management plan with at least one review and a frailty assessment
- a service incentive payment that supports the provision of a grouping of services for people with mental health conditions, including a GP mental health treatment plan with at least one review and a physical health assessment
- a service incentive payment that supports the provision of a grouping of services for people with disability, including a GP management plan with at least one review and completion of NDIS reports/documentation

2. **Invest in longer general practice consultations to support complex care**

Improve patient access to general practice services through:

- applying a 10% increase to Medicare rebates for Level C (20-40 minutes) and Level D (40-minute plus) GP consultations
- introducing a Level E (60-minute plus) GP consultation

3. **Support MBS rebates for telephone consultations**

- reinstituting phone consultations for long consultations, mental health and GP management plans as part of the permanent telehealth model

4. **Support followup care after a hospital admission**

- introducing additional support for GPs who see their patient within seven days of an unplanned hospital admission or emergency department (ED) presentation

5. **Strengthen rural health care**

- increasing Workforce Incentive Programs with additional payments for those doctors who use additional advanced skills in the rural areas scaled to rurality
- providing access to the relevant specialty MBS items when a GP holds advanced skills in Internal Medicine, Mental Health, Paediatrics, Palliative Care, and/or Emergency, in a rural area

6. **Build GP workforce**

- creating portability of employment benefits for GP registrars

# Recommendation 1 – Support regular, continuous and preventive care for people over the age of 65, people with mental health conditions and people with disability

**The RACGP calls on the federal government to improve patient access to general practice services through:**

- **a new service incentive payment that supports the provision of a grouping of services for older people, including a health assessment for older Australians and/or a GP management plan with at least one review and a frailty assessment**
- **a service incentive payment that supports the provision of a grouping of services, including a GP mental health treatment plan with at least one review and a physical health assessment**
- **a service incentive payment that supports the provision of a grouping of services, including a GP management plan with at least one review and completion of NDIS reports/documentation**

## The issues

Though the current Medicare rebate structure supports acute, episodic care, it does not adequately support continuous, regular, coordinated care, and therefore does not support Australians who require care over time. Health economists recommend mixed payment systems of fee-for-service and other models to balance two different objectives: (i) productivity and ensuring that priority services are delivered; and (ii) the proactive management of health risks and chronic and complex disease[4].

The therapeutic relationship between an individual and their GP presents an ideal situation to prevent, identify, treat and manage complex health issues. However, the current system does not support a long-term therapeutic relationship between patients and GPs, meaning care can become fragmented.

Seeing the same GP for most of an individual's care (often referred to as 'continuity of care') is essential for high-quality care. Continuity of care is linked to better patient–provider relationships, better uptake of preventive care, increased access to care, and reduced healthcare use and costs[5]. Recent research shows the benefits of continuity of care in general practice, demonstrating association with fewer hospital admissions[6], which in turn generates health system savings and indicates good management of a person's health condition.

Continuous care with a regular GP is beneficial for people, particularly those with higher rates of chronic conditions and multimorbidity that require ongoing management. Care for these patients often requires more time to identify issues, as well as ongoing care and monitoring to manage their conditions.

The RACGP recommends this care initiative be offered to patients who often present to general practice with complex health issues, particularly older people, people with mental health issues and people living with disability.

**Care to support older people in Australia**

People over the age of 65 have much higher rates of chronic disease and multimorbidity compared with the general population[7], so the healthcare they require is often more complex.

Older Australians are significantly more likely to be admitted to hospital or visit an emergency department[8]. Falls are also a key contributor to the higher rate of hospitalisations; approximately one in three older people living at home experience a fall annually, with approximately 20% of these requiring hospitalisation[9].

Falls are Australia's largest contributor to hospitalised injury cases and a leading cause of injury deaths[10]. People over the age of 65 make up 58% of hospitalisations for unintentional falls and 95% of falls deaths[11]. Frailty is a predictor of

falls in older Australians. Therefore, the RACGP strongly recommends introducing a frailty assessment as part of targeted care for older people in general practice.

**Improved support for mental healthcare**

Mental health and behavioural conditions are the most common chronic conditions in Australians, affecting 4.8 million (20% of the population)[7]. People with mental health conditions are twice as likely to report having a physical chronic condition[11], which can be due to a variety of factors associated with poor mental health, such as medication effects, lifestyle factors, alcohol or drug use, and comorbid physical health disorders[12]. A physical health assessment will help prevent poor physical health outcomes experienced by people with mental health conditions. Introducing a physical health assessment as part of a targeted care strategy for people with mental health conditions will improve outcomes for these patients.

Mental health care is a core component of general practice, with GPs providing more than three million mental-health-specific Medicare-subsidised services each year[13]. This does not include the mental health care provided as part of a standard GP consultation.

GPs are trained to provide whole-person care, including and combining both mental and physical health. Over 90% of vocationally registered GPs in Australia have also undertaken additional mental health skills training[14].

**Supporting people with disability**

Chronic conditions often coexist with disability – 50% of Australians who have a chronic condition also report having a disability[7]. People living with disability also experience high or very high levels of psychological distress compared with people without a disability (32% versus 8%)[15].

GPs have a role in supporting the overall health of their patients with disability, including supporting their application for support through the National Disability Insurance Scheme (NDIS). Although the Department of Health has confirmed that access to the NDIS is considered relevant for the purposes of managing the medical condition of a patient, there is currently no support for GP completion of NDIS reports or documentation unless the patient is present.

## Actions required

The RACGP recommends the following target areas for government investment.

**A new service incentive payment that supports the provision of a group of services for older people**

The RACGP proposes to offer a service incentive payment for a group of services that includes a health assessment for patients over the age of 65 years (or over 50 for Aboriginal and Torres Strait Islander Australians) and/or a GP management plan with at least one review and a frailty assessment.

An annual payment of $100 per annum would require an investment of $86.4 million in the first year. This is based on 20% uptake in the older than 65 years population (with the addition of the older than 50 years in the Aboriginal and Torres Strait Islander population).

| Measure | Investment required, year 1 ($m) | Investment required, 3 years ($m) |
|---|---|---|
| **Annual payment of $100** | $86.4 | $259.2 |

**A new service incentive payment that supports the provision of a group of services for people needing mental health care**

The RACGP proposes to offer a service incentive payment for a group of services that includes a GP mental health treatment plan with at least one review and a physical health assessment.

An annual payment of $100 per annum would require an investment of $61.2 million in the first year. This is based on 15% uptake amongst adults (15 to 84) experiencing mental health issues each year.

| Measure | Investment required, year 1 ($m) | Investment required, 3 years ($m) |
|---|---|---|
| **Annual payment of $100** | $61.2 | $183.5 |

**A new service incentive payment that supports the provision of a group of services for people living with disability**

The RACGP proposes to offer a service incentive payment for a group of services that includes a GP management plan with at least one review and completion of NDIS reports/documentation.

An annual payment of $100 per annum would require an investment of $64.2 million in the first year. This is based on 15% uptake in people living with disability in Australia.

| Measure | Investment required, year 1 ($m) | Investment required, 3 years ($m) |
|---|---|---|
| **Annual payment of $100** | $64.2 | $192.7 |

# Recommendation 2 – Invest in longer general practice consultations to support complex care

**The RACGP calls on the federal government to improve patient access to general practice by:**

- **applying a 10% increase to Medicare rebates for Level C (20-40 minutes) and Level D (40-minute plus) GP consultations**
- **introducing a Level E (60-minute plus) GP consultation**

## The issues

Good care requires time – time to listen, time to assess, time to collaborate with multidisciplinary healthcare providers and time to work with families. Time is especially important for patients with complex health needs.

Although short consultations provide support for everyday issues, longer consultations are needed for people with complex physical and mental healthcare needs including chronic illness so prevalent in Australian today. Evidence shows that 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[16,17].

Federal Government expenditure on preventive care is estimated to be only 1.8% of total health expenditure[18]. This is despite approximately 32% of our total burden of disease being attributable to modifiable risk factors[19]. To curb the growth of chronic disease in Australia, the major risk factors that contribute to them must be addressed. Longer consultations provide an opportunity to address these factors by allowing more time for preventive care and early intervention for chronic conditions.

The current Medicare rebate structure devalues longer consultations, with patient rebates decreasing significantly as a person spends more time with their GP. Often, people with the most complex health conditions require the longest time with their GP, meaning the sicker a person gets, the harder it is to get the time needed, and the more they may pay out of pocket to see their GP.

Care for complex health issues must be better supported through Medicare. Increasing support for longer consultations to support complex care is a simple and effective way to build the required support into the system.

Devaluing longer consultations not only negatively affects patient care – it can also have long-term effects on the medical workforce pipeline. Training GPs requires time, and often consultations take longer if provided by GP registrars or observed by medical students. Therefore, devaluing longer consultations affects the future GP workforce and undermines access to general practice care.

The need to urgently address the issue of diminishing rebates for GP care is well recognised. The RACGP and other profession-led bodies have long called for additional funding for longer GP consultations[20].

## Actions required

The RACGP recommends government investment in care for people with complex care needs who need longer with their GP by:

- applying a 10% increase to Medicare rebates for Level C (20–40 minutes) and Level D (40-minute plus) GP consultations
- introducing a Level E (60-minute plus) GP consultation.

The increase in Level C and D rebates would require an investment of $88.1 million in the first year and the introduction of a new Level E item would require $40.7 million in the first year.

| Measure | Investment required, year 1 ($m) | Investment required, 3 years ($m) |
|---|---|---|
| **10% increase in Level C and D rebates** | $88.1 | $264.3 |
| **New Level E item number with rebate of $200** | $40.7 | $122.1 |

# Recommendation 3 – Support MBS rebates for telephone consultations

**The RACGP calls on the federal government to support MBS rebates for phone consultations for long consultations (greater than 20 minutes), mental health and GP management plans as part of the permanent telehealth model.**

## The issues

The benefits of telehealth in Australia have been clearly demonstrated, with significant acceptance and uptake and strong demand for this continued flexibility from providers and patients. Telehealth 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. Telehealth is beneficial for all Australians, but particularly important for patients with compromised mobility, such as older people or people with disability.

Despite the high uptake of telehealth, more than 80% of GP consultations are still provided face to face[21]. This shows that telehealth complements face-to-face care, with GPs and their patients deciding how best to meet their needs. The RACGP therefore welcomed the implementation of permanent telehealth as announced in December 2021, which includes video consultations and short to medium telephone consultations.

Telehealth use in Australia is largely phone-based. Between March 2020 and March 2021, video consultations comprised only 2.4% of telehealth services, whereas phone consultations comprised 97.6%[26]. Removing or limiting phone-based consultations will effectively remove telehealth access for most Australians.

Although a video call is sometimes considered the 'gold standard' of telehealth due to the perceived benefits of having visual cues, research has found that health outcomes and patient satisfaction are generally comparable between video and telephone consultations[22]. However, unlike phone consultations, video consultations are associated with infrastructure and accessibility issues that make them unusable for many people, leading researchers to recommend that decision- makers refrain from rolling out video calling in mainstream healthcare until these issues are addressed[23].

It is vital that the gains achieved in improving patient access through telehealth are not compromised by restricting access to a limited telehealth model.

Although video calling has its place, many Australian patients and practices do not have access to the skills or technology required to support it. This is especially the case for patient groups with increased health needs, such as rural and remote communities, Aboriginal and Torres Strait Islander people, and older people. These groups are much more likely to have access to and are more comfortable using a phone than video technology. Allowing patients multiple ways to access their regular GP considers a person's preferences and life circumstances, including where they live, their level of comfort with technology, their access to technological devices and their socioeconomic status.

## Actions required

The RACGP recommends government investment in access to telephone consultations for people with complex care needs by retaining phone consultations for long consultations, mental health and GP management plans as part of the permanent telehealth model.

The retention of telephone consultations would require an investment of $15 million in the first year.

| Measure | Investment required, year 1 ($m) | Investment required, 3 years ($m) |
|---|---|---|
| **Level C and D consultations** | $15 | $45 |

# Recommendation 4 – Support followup care after a hospital admission

**The RACGP calls on the federal government to support followup care after a hospital admission by introducing additional support for GPs who see their patient within seven days of an unplanned hospital admission or emergency department presentation.**

## The 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 both improve patient health outcomes and 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.

Preventable hospital readmissions make up a significant proportion of PPHs. Approximately 718,000 readmissions to hospital occur each year. Local and international evidence shows that better support for, and use of, general practice is associated with reduced ED visits and hospital use and decreased hospital readmission rates[24-26].

Dedicated time for seeing a GP following an unplanned hospital admission will help reduce a person's chance of readmission. Research shows that patients who complete a post-hospital discharge visit with their GP within seven days of an unplanned hospital admission have a significantly lower risk of readmission within 30 days[27].

Conservative estimates indicate that general practice can prevent at least 12% of hospital readmissions by implementing a dedicated follow-up consultation, improving health system efficiency saving the health system $69 million every year[4].

## Actions required

The RACGP recommends government invest in reducing hospital admissions by introducing additional support for GPs who see their patient within seven days of an unplanned hospital admission or emergency department (ED) presentation. Due to the estimated savings, this investment is cost neutral.

# Recommendation 5 – Strengthen rural health care

**The RACGP calls on the federal government to strengthen rural health care by:**

- **increasing Workforce Incentive Programs with additional payments for those doctors who use additional advanced skills in the rural areas scaled to rurality**
- **providing access to the relevant specialty MBS items when a GP holds advanced skills in Internal Medicine, Mental Health, Paediatrics, Palliative Care, and/or Emergency, in a rural area**

## The issues

Australia's rural and remote communities have poorer health outcomes than communities in metropolitan areas[28]. We also know that the way people in rural and remote areas access primary care can differ to those in metropolitan areas. GPs are relied upon to provide a broader range of services to a more widely distributed population. There is less infrastructure, and less availability of local specialist services[28].

A reduced range of medical and health professionals in rural communities means that GPs in these communities often provide care which, in an urban setting, would be provided by another health professional. GPs often take on these skills to meet the needs of their community. In Australia, while around one third of the population live outside major cities with older Australians more likely than the general population to live outside of major cities[29].

Without increased investment to retain the rural and remote workforce, many rural and remote communities will see minimal benefits from other structural reforms. Practical measures are needed to support rural GPs in these communities. This could include providing greater incentives, rebates, and scholarships for rural GPs to gain and maintain additional skills to benefit their community.

## Actions required

The RACGP recommends government invest in care in rural health care by increasing incentives for rural general practice.

The increase in Workforce Incentive Programs and access to specialist MBS items would require an investment of $38 million in the first year.

| Measure | Investment required, year 1 ($m) | Investment required, 3 years ($m) |
|---|---|---|
| **Workforce incentive payments based on rurality** | $33 | $99 |
| **Access to specialty items for advanced skills** | $5 | $15 |

# Recommendation 6 – Build GP workforce

**The RACGP calls on the federal government to build the GP workforce by creating portability of employment benefits for GP registrars**

## The issues

The future workforce supply of general practitioners is in jeopardy. The number of medical graduates choosing to enter GP training each year has stagnated. Eligible applications for GP training dropped by 22% between 2015 and 2020. Unfilled rural training places increased from 10% (65 places) in 2018 to 30% (201 places) in 2020[30].

New and significant investment in training GP registrars is needed. While no single change to the training program will be the 'solution', action is needed to put general practice training on equal, or greater, footing with other medical specialty training programs.

It is widely acknowledged that GP registrars do not retain their employment benefits during training as they move to a new employer each rotation. Moreover, junior doctors lose accrued entitlements from their time in the hospital setting when transitioning to community-based practice. Junior doctors make crucial decisions about their career based on a range of factors, including remuneration, available entitlements and their family and personal circumstances.

The RACGP supports allowing portability of employment benefits through a third-party portability fund for GP registrars. This is a solution which could provide the incentives of the single employer model while still allowing GP registrars the flexibility of moving employers and locations. Any introduced scheme should also ensure portability of benefits interstate.

The protection of entitlements and guaranteed salaries must be offered to all registrars in GP training. If protection of entitlements and guaranteed salaries are only offered to those training as rural generalists or rural GPs, a two-tiered system will be created, dividing the profession, exacerbating AGPT recruitment issues, and undermining patient care.

## Actions required

The RACGP recommends government invest in care in the general practice workforce by allowing portability of employment benefits through a third-party portability fund for GP registrars.

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