RACGP Submission to the Select Committee on Health

Health policy, administration and expenditure

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Executive summary

This submission presents The Royal Australian College of General Practitioners' (RACGP) response to the Senate Select Committee on Health's broad Terms of Reference on health policy, administration and financing.

General practice has been, and remains, the most cost-effective component of the healthcare system. General practice costs per patient have remained steady over the past 20 years while hospital costs have continued to rise. The Australian healthcare system is designed to drive hospital admissions. The RACGP does not support the co-payment model as currently proposed as it removes universal access to healthcare. If mandatory general practice co-payments are implemented, the drive to hospital admission will be reinforced.

It is anticipated there will be growth in preventable disease burden as a result of the aging population. Prevention activities are the key to our future health and integral to the design of the health system. Preventive care is also critical in addressing the health disparities faced by disadvantaged and vulnerable population groups.

General practice is geared towards providing preventive healthcare and must be supported in these activities. General practitioners (GPs) can identify health issues and risks and intervene at the right time to prevent the need for costlier and riskier interventions. The work of GPs is adversely affected by the lack of investment in prevention and early intervention as this reduces the resources GPs can draw on to help patients to change behaviour and reduce risk factors.

Similarly, the lack of national health workforce planning is concerning. The general practice workforce is ageing and a properly resourced and nationally consistent approach to health workforce planning is essential to address future health workforce shortages.

The health and aged care sectors are inextricably linked and the RACGP has concerns about the lack of support for GPs providing aged care services. GPs who provide care to people in aged care settings are often poorly supported, funded and appreciated. Improving remuneration and conditions would better support GPs to continue or commence providing care to this vulnerable and complex population. There are also opportunities for improving the care of people in residential aged care facilities (RACFs) through advance care planning and increasing the use of technology.

Equitable access to quality general practice is key to addressing rural health disparities. GPs play a crucial role in these communities, are often the only available health professional and require a broad skill base to meet patient needs. Fragmenting care through role substitution is not the best approach to helping people in rural areas improve their health outcomes. Investment in preventive and primary care will close the gap between health outcomes for Aboriginal and Torres Strait Islander peoples and non-Aboriginal and Torres Strait Islander peoples.

A high performing and properly resourced primary healthcare sector will address the failures of the health system. Investment in primary care is a cost-effective way to address the needs of patients, funders and healthcare providers when compared to hospitals. The RACGP believes support for the quality general practice of the future, encompassing the medical home, is required and paramount to maintaining good health outcomes for all Australians.

Summary of recommendations

The RACGP has made a number of recommendations throughout this submission:

Recommendation 1: Revisit the Relative Values Study and review the Medicare Benefits Schedule in light of its findings.

Recommendation 2: Mandatory co-payments should not be implemented. Co-payments already exist, and should continue to be determined between GPs and their patients.

Recommendation 3: Prioritise health spending to ensure adequate funding for health promotion and preventive activities which are supported by the current evidence base.

Recommendation 4: Review and improve remuneration for GPs who provide care to residents of RACFs.

Recommendation 5: Explore options to better support advance care planning for residents of RACFs, including MBS rebates for advance care planning activities.

Recommendation 6: Incentivise interoperability for secure messaging and electronic health record systems to improve GPs' capacity to coordinate and share information.

Recommendation 7: Involve the general practice profession in discussions about aged care reform and service provision.

Recommendation 8: Prioritise generalism in addressing workforce maldistribution in rural and remote areas, including recognition of the broad GP skill set.

Recommendation 9: Incentives and payments must be brought in line with the real cost of service delivery in rural towns.

Recommendation 10: Prioritise reform of the ASGC-RA classification system.

Recommendation 11: Invest in primary healthcare to close the gap between health outcomes for Aboriginal and Torres Strait Island peoples and non-Aboriginal and Torres Strait Island peoples.

Recommendation 12: Explore mechanisms and policy reforms to better support the quality general practice of the future, encompassing the medical home.

Recommendation 13: Shift towards a more targeted, yet flexible, overall policy approach delivered against a supportive framework which enables service continuity and practice viability to address future need in rural Australia.

Recommendation 14: Promote and incentivise team-based models that have GPs as the leaders of therapeutic interventions and where professionals work in an interdependent, cooperative relationship.

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Introduction

The RACGP thanks the Select Committee on Health for the opportunity to contribute to discussion regarding health policy, administration and expenditure.

The RACGP believes this inquiry is timely and will help facilitate important discussion between government, the health profession and patients regarding a future health system that supports equity of access, quality and efficiency.

About the RACGP

The RACGP is the specialty medical college for general practice in Australia, responsible for defining the nature of the discipline, setting the standards and curriculum for education and training, maintaining the standards for quality clinical practice, and supporting GPs in their pursuit of excellence in patient care and community service.

RACGP submission to the Select Committee on Health

The RACGP notes the Senate Select Committee on Health has been established to inquire into and report on health policy, administration and expenditure, with particular reference to:

1. the impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting
2. the impact of additional costs on access to affordable healthcare and the sustainability of Medicare
3. the impact of reduced Commonwealth funding for health promotion, prevention and early intervention
4. the interaction between elements of the health system, including between aged care and health care
5. improvements in the provision of health services, including Indigenous health and rural health
6. the better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services
7. health workforce planning
8. any other related matters.

Within the context of the Terms of Reference, the RACGP's submission primarily focuses on health policy, administration and expenditure as it relates to general practice. As per the Terms of Reference, the RACGP's submission provides an overview of the key issues and, where appropriate, recommends solutions for the Senate's consideration.

1. The impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact of elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting

1.1 Current system is designed to drive hospital presentation and admission

The RACGP considers it generally self-evident that reductions in Commonwealth funding for public hospitals will decrease access to emergency, specialist and surgical care. Patients are likely to experience longer wait times and reductions in quality as state and territory governments seek to address budget shortfalls and increased demand for services as the population grows and ages. General practice patients already report they find it difficult to access public hospital services and some GPs encourage patients to seek care via the private sector.

To an extent, our reliance on public hospital services and the likely impact of reduced hospital services on the burden of disease is a reflection of what the Australian health system is geared toward – hospital presentation and admission. The cost of healthcare continues to rise because the Australian health system is delivering what it has been designed to achieve – patients relying on emergency departments and hospital use.

1.2 Reinforcing disadvantage with a two-tier hospital system

Just under half of the Australian population have hospital coverage through a private health insurer.[1] This leaves just over half of the population dependent on access to public hospital services. Facing longer waiting times for access to emergency, specialist and surgical care through public hospitals will lead to people seeking private hospital services.

However, those who cannot afford to pay private health insurance premiums will be increasingly disadvantaged as they will not be able to access timely care. This will be further compounded if uptake of private health insurance lessens due to increasing premiums.

1.3 Primary healthcare – a better and cost-effective investment

The major driver of health costs within the Australian healthcare sector is hospital admission.[2] Despite increasing health costs in relation to hospital expenditure, Medicare cost per person for general practice services (as depicted in *Figure 1*) has remained relatively steady since 1998, particularly when compared to hospital costs over a similar period of time.

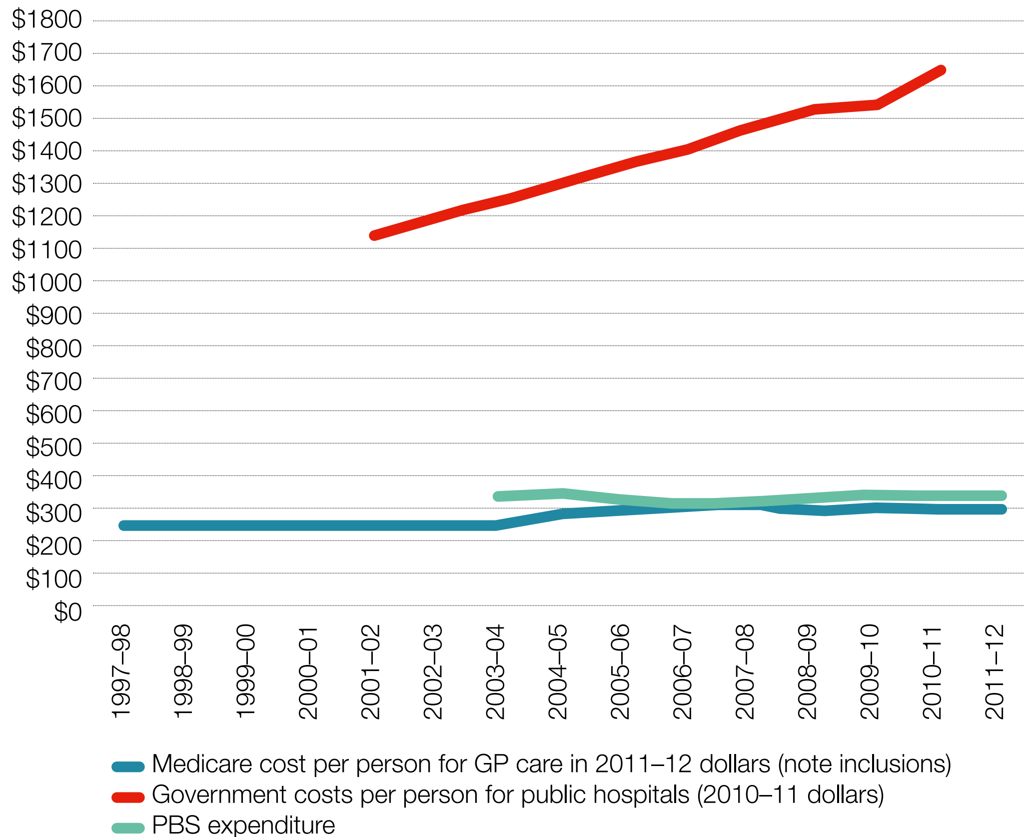

Figure 1. Healthcare expenditure between 1997–98 and 2011–12

Primary healthcare services are the most cost-effective part of the health sector.[3] They can reduce healthcare costs through chronic disease management and health service integration, decreasing emergency department presentations and preventable hospital admissions. Better use of and access to properly resourced general practices will reduce hospital expenditure and stress on the system.

Better use of GP services will result in:

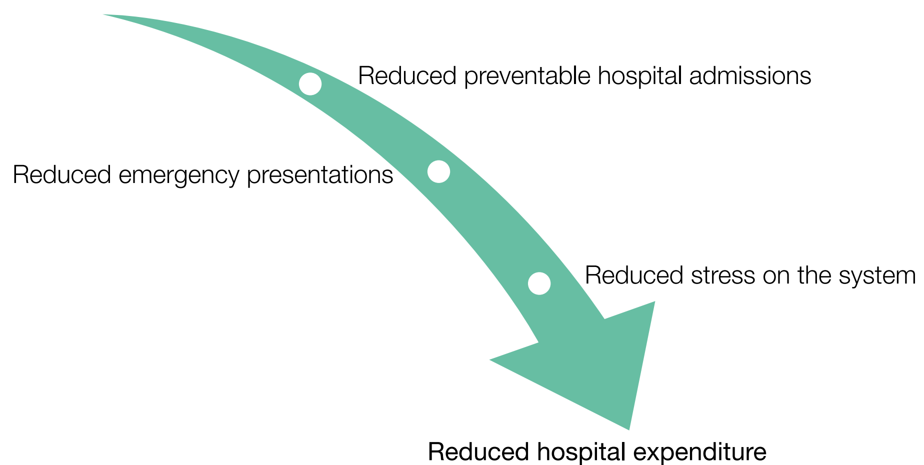

Figure 2. Reaping the rewards of investment in primary care

The Australian Institute of Health and Welfare (AIHW) reports that almost 2.2 million emergency department presentations in 2012–13 were for potentially avoidable GP-type presentations.[4] This represents over a third of emergency department presentations in that year. In 2012, it was reported that the largest proportion of preventable presentations were related to chronic conditions, mainly complications from diabetes and chronic obstructive pulmonary disease.[5]

There is evidence that suggests chronic disease management models and self-management support are effective in reducing admissions to hospital.[6] Of the National Health Priority Areas, the top long-term health conditions experienced by respondents in 2011–12 were:[7]

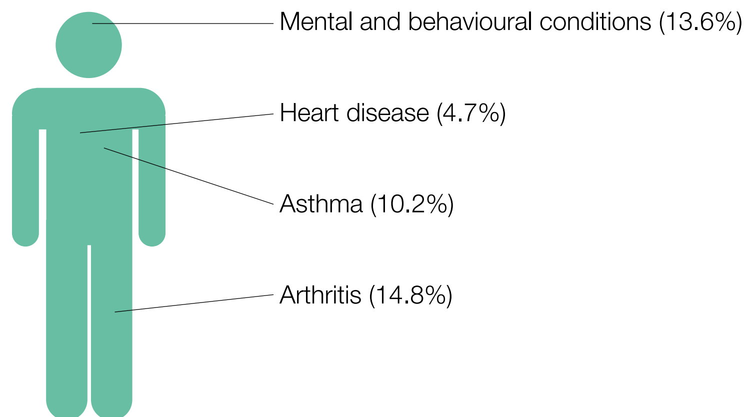

Figure 3. Australia's most common chronic diseases from among the National Health Priority Areas

All of these conditions are manageable in the primary healthcare sector. However, all can also result in hospital admissions if primary healthcare professionals are not supported to manage these patients in the community.

While it is recognised that investment upstream in the health system results in savings downstream,[5] due to a range of reasons, general practice is not fully utilised to address the health challenges Australia currently faces. Demonstrating this, many services delivered in hospitals can be efficiently delivered in primary healthcare for a fraction of the cost with no loss of quality or safety. Many hospital services and procedures unnecessarily cost government 4–7 times more than the cost of the equivalent general practice service.[8,9]

Examples include:

- medical procedures, including basic surgical procedures
- pain management
- anticoagulant screening and management
- wound management.

Table 1 demonstrates the difference in cost to government for selected procedures when delivered in hospital and general practice, using Medicare Benefits Schedule (MBS) item numbers and the Independent Hospital Pricing Authority's (IHPA) National Efficient Price Determination 2014–15.

Table 1. Comparison of cost to government of general practice and hospital services (examples)[8,9]

	Hospital	General practice	Difference
Antenatal care	$263.82 IHPA: 20.40	$47.15 MBS: 16500	$216.05
Sexual health	$180.35 IHPA: 40.10	$71.70 MBS: 36 36	$108.65
Venesection	$563.35 IHPA: 10.13	$72.95 MBS: 13757	$490.40
Skin biopsy	$246.86 IHPA: 20.33	$89.25 MBS: 23 & 30071	$157.61
Wound management	$256.68 IHPA: 40.13	$37.05 MBS: 23	$219.63

1.4 Reform of the hospital sector required to address funding shortfalls

Reforms to the hospital sector will be required in the short to medium term future. Reforms may assist state and territory governments to address shortfalls in reduced government funding.

Addressing avoidable costs and the price differences between hospitals may be one method for absorbing the Commonwealth funding cuts.

Reducing the average length of stay through fast tracking discharge to the community is also an option likely to result in savings. Shortened lengths of hospital stay will require primary health services to provide support and care to vulnerable patients in greater numbers, increasing demand for primary healthcare services. Reducing the average length of stay could affect patient outcomes if general practice and primary healthcare are not properly supported.

Role substitution or redefinition has also been identified as an option for hospital administrators to reduce labour costs.[10] While there is evidence supporting some elements of role redefinition, poorly implemented and monitored role substitution initiatives could significantly reduce the quality of care received at public hospitals. The RACGP acknowledges the need to improve efficiencies and best deploy the health workforce, however, these kinds of initiatives need to be properly supported.

Consultation with the affected professions and sectors needs to be extensive before any of these measures are implemented.

Recommendation 1: Revisit the Relative Values Study and review the Medicare Benefits Schedule in light of its findings.

2. The impact of additional costs on access to affordable healthcare and the sustainability of Medicare

2.1 The impact of additional healthcare costs

Out-of-pocket expenses – on the rise

According to the AIHW, patient out-of-pocket expenses for primary healthcare have significantly increased over the past 10 years, rising from $9.7 billion in 2001–02 to $17.1 billion in 2011–12, representing a 76% increase in out-of-pocket expenditure.[2]

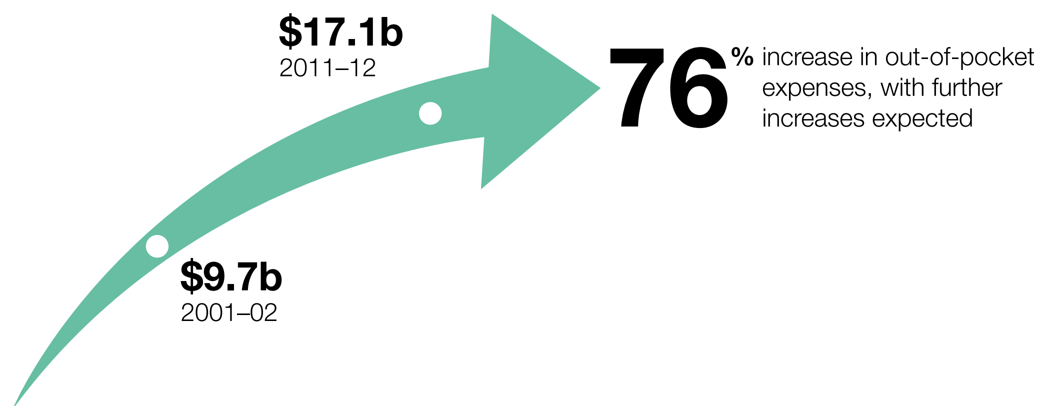

Figure 4. Out-of-pocket costs continue to rise

The overall share of patient out-of-pocket expenses in primary healthcare expenditure also increased from 31.6% in 2010–11 to 33.9% in 2011–12, a 10.7% increase for families and individuals.[2]

A significant barrier to access

According to the Australian Bureau of Statistics (ABS), in 2010–11 nearly 1.8 million Australians (8% of the population) indicated they delayed or avoided seeing their GP because of incurred costs. With the proposed increase of patient out-of-pocket expenses in primary healthcare, it is expected the number of Australians delaying GP visits will continue to rise.[10]

The government's proposed co-payments for GP services and out-of-hospital pathology and diagnostic imaging aims to reduce perceived unnecessary demand for and alleged overuse of these services. As part of the proposal, the rebate to all patients for GP consultations is reduced and GPs will be disempowered by being required to impose a co-payment.

The proposed co-payment model will impose an additional barrier to access for the socioeconomically disadvantaged, who already pay a significant proportion of their household income on out-of-pocket health expenses. People do not choose to be sick and should not be financially disadvantaged because they are. Additionally, the prospect of increased financial pressure means those in greater need may further delay key prevention activities such as child vaccination and the management of chronic conditions.

Similarly, the RACGP believes an increase in co-payments and safety net thresholds for the Pharmaceutical Benefits Scheme (PBS) will negatively impact on patients from low socioeconomic backgrounds who will not be able to access necessary medications. Out-of-pocket expenses for medications have been steadily increasing over the years.

The RACGP supports GPs to make decisions about how they choose to bill their patients. After careful consideration, many GPs set fees that reflect the true cost of the service they have provided to the patient, with the patient receiving a partial rebate of the cost from the government.

Reduction of MBS rebates affects all patients, not only those who are currently bulk billed.

The most recent major increase in co-payments was a 21% rise in 2005, followed by an annual increase in both general and concessional safety nets. The PBS Safety Net threshold has also increased from $874.90 to $1421.30 since 2005.[10] The 2014–15 budget announced further increases to the PBS Safety Net thresholds by 10% each year, in addition to existing indexation.[11] Just like GP co-payments, increasing the cost of medications will result in poor health outcomes and greater use of the public hospital system.

A study from the University of Western Australia that analysed the 2005 increase in patient contribution indicated that higher co-payments disproportionately impacted concessional patients' ability to afford prescription medicine. Although they reduce the cost burden to the government, higher co-payments contribute to other costs to the health system through increased hospitalisation due to omission of medication.[12]

Reduced preventive care, higher utilisation of emergency department and longer wait times

Increasing costs for primary healthcare services not only impacts on GP visits for episodic and acute care, but also reduces opportunities to provide preventive care. A reduction in preventive activities results in higher utilisation of more expensive secondary and tertiary care systems, inefficient use of services and overall worse health outcomes.[13,14]

Although there is a need to address the rising government costs in health expenditure, strong international evidence suggests the most efficient way to do this is to support a universal healthcare system.

It is expected the proposed co-payment model will lead to more primary care patients presenting in hospital emergency departments, or delaying care to present later with more complex issues. Shifting care from the community to an already under-resourced hospital system has the potential to increase the average emergency department wait time from 5.6 hours to 8.5 hours, and the number of waiting emergency department patients from 9.1 to 38 per hour.[15,16] In addition to this, tertiary care for patients with avoidable hospital conditions results in worse health outcomes and greater costs to the health system.[15–19]

Although there is a need to address the rising government costs in health expenditure, strong international evidence suggests that the most efficient way to do this is to support a universal primary healthcare system.[20]

2.2 Sustainability of Medicare

Supporting primary healthcare to reduce healthcare expenditure

In a comparison of the healthcare systems of 11 developed countries, Australia ranks highly in terms of efficiency.[4] Despite its low proportion of GDP expenditure on health (9.5%), Australia has demonstrated its ability to deliver quality healthcare and good health outcomes.[21]

Figure 5 represents the composition of Australian government spending in 2012–13, showing that less than a quarter of Australian government spending is on health.

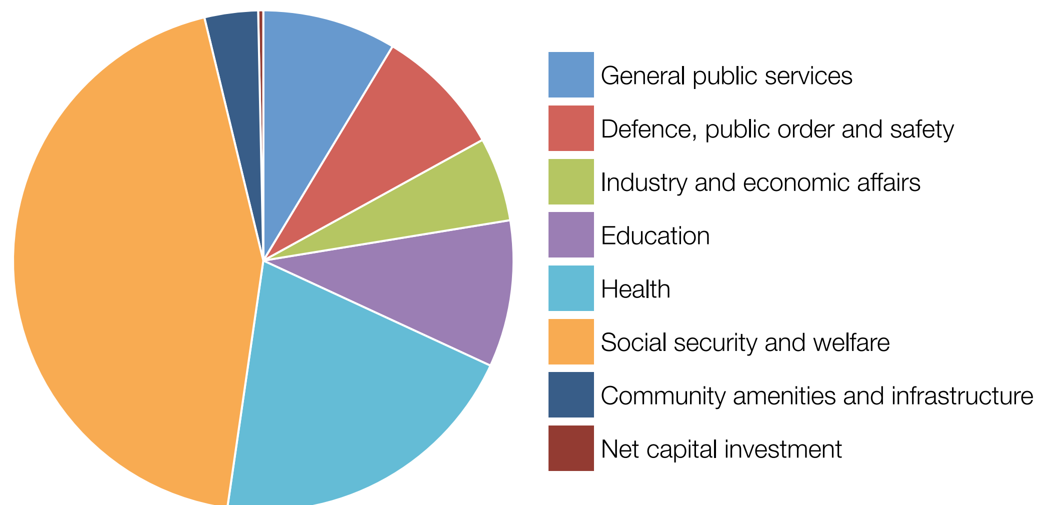

Figure 5. Total composition of Australian government spending 2012–13[23]

Table 2 compares health expenditure between 2001–02 and 2011–12, demonstrating a large increase in the contribution of patients to health expenses.

Table 2. Comparison of health expenditure: 2002–03 to 2012–13[24,25]

	2002–03	2012–13	% increase
% GDP	8.6	9.67	12
Recurrent expenditure per person*	$4,593	$6,430	40
Avg. GP out of pocket expenses	$12.97	$ 28.58	120

*Expenditure is constant. 2002–03 expenditure is expressed in terms of 2011–12 prices) (AIHW, Expenditure in Aus 2012–13, p2)

As outlined in *Section 1*, despite increasing costs in hospital expenditure, health costs per person for general practice services have remained relatively steady for the last 15 years, particularly compared to hospital costs over a similar period of time. Hospital expenditure is the greatest cost and the greatest area of growth in Australia, continuing to rise over the last 10 years.

Increasing barriers to access to primary care leads individuals to delay care, later presenting to more expensive health settings. While bulk-billed GP visits cost government $37.05 per presentation, avoidable inpatient admissions cost nearly $5000. Encouraging the use of primary healthcare services, in particular among those affected by health inequities, is the most cost-effective measure to improve health and reduce pressure and costs to government in hospital and acute settings.[15, 20–22]

There are different funding models for the provision of primary healthcare, each with their own advantages and disadvantages. However, the evidence comparing international health systems shows systems which concentrate on universal access and less on a private health insurance model perform more effectively and are more cost effective.[22]

Australia has a high performing health system but the move towards a user pays co-payment model with mandatory co-payments and increased private health insurance, while achieving short-term budget goals, is likely to worsen the performance of our health system.[21] Investment in primary care also supports a stronger economy, with greater workforce participation due to improved health.[22]

Increasing health system efficiency

The administrative costs involved in the management of the proposed co-payment model may override the financial returns generated for the government, according to international experience.

In 2004, Germany introduced a nominal GP fee (Praxisgebuehr) with an aim to reduce the number of unnecessary GP visits. However, in late 2012, the fee was abolished as the additional revenue generated was minimal in relation to the costs related to accounting and paperwork required from doctors and the health system. Further analysis of the policy demonstrated health inequalities increased in Germany due to the practice charge, with those in the lower income group delaying or avoiding necessary GP visits.[31]

More efficient measures to reduce healthcare expenditure include the removal of the private health insurance rebate and the improvement of health system efficiency.

Private health insurance has not reduced public hospital activity, with studies suggesting the removal of private health insurance subsidy would save the health system $20 billion by 2018.[32] In addition, improving the management of the PBS by changing funding and incentives could save Medicare up to $1.3 billion a year.

Essentially, there is no ‘ballooning’ of general practice costs. General practice remains one of the most efficient components of the health system, and patients should be encouraged, rather than discouraged, to see their GPs. Focusing on primary health and improving healthcare efficiency will result in long-term savings for the government, with a sustainable Medicare system.

Recommendation 2: Mandatory co-payments should not be implemented. Co-payments already exist, and should continue to be determined between GPs and their patients.

3. The impact of reduced Commonwealth funding for health promotion, prevention and early intervention

3.1 General practice well placed to undertake key health promotion, prevention and early intervention activities

Health promotion seeks to improve knowledge and adoption of healthy behaviours and, along with preventive medicine, is designed to avert and avoid the onset of disease.* Early intervention prevents deterioration and promotes management of chronic disease, preventing the need for hospital-based or specialist care. Evidence shows significant impact on population health can be achieved through cost-effective prevention activities. It is generally accepted that prevention is a more cost-effective way of improving population health than addressing chronic diseases once they have developed.[29]

Prevention is the most cost-effective function of the health system.

General practice is at the forefront of healthcare in Australia and is pivotal to the delivery of health promotion, prevention and early intervention activities. More than 134 million general practice consultations take place annually in Australia and 83% of the Australian population consults a GP at least once a year.[25] The people who make up the 83% of the Australian population that visits general practice every year make an average of six visits each year. This presents many opportunities for GPs to offer and provide recommended preventive care. Personal recommendation by the patient's GP has the greatest influence on uptake of preventive activities. Prevention programs with good uptake have achieved this by making GPs central in recommending testing and reminding the patient when testing is due.

In contrast, the National Bowel Screening Cancer Program, which has relied on posting screening kits to people without any prior involvement by the person's GP, demonstrates the short-falls of prevention activities when GPs are not made central in prevention programs. Considering the 2014–15 budget, the RACGP welcomes the funding provided for screening activities, youth mental health promotion, Aboriginal and Torres Strait Islander sexual and reproductive health programs and the Sporting Schools initiatives. However, the RACGP is concerned the scrapping of national agencies that supported prevention and primary healthcare signals a move away from strategic development of preventive policy, partnerships, programs and support for the primary healthcare sector.

* The RACGP notes that health promotion encompasses a range of activities that do not all fall within the scope of or are delivered by the health system. For example, taxation or financial incentives to influence behaviour and design of urban spaces and transport systems are health promoting activities.

3.2 Australia's preventable disease burden

Chronic diseases are the leading cause of illness, disability and death in Australia, accounting for 90% of all deaths in 2011. A small number of modifiable risk factors – unhealthy diet, physical inactivity, tobacco and alcohol use – are responsible for the development of the most common chronic diseases: cardiovascular diseases, diabetes, chronic obstructive pulmonary diseases and cancers.[40]

Prevention is the key to Australia's future health, both individually and collectively. Around one third of the Australian population report having a chronic disease.[40] It is estimated that 80% of premature heart disease, stroke and type 2 diabetes, and 40% of cancer could be prevented through interventions that address modifiable risk factors.[40] Preventive care is also critical in addressing the health disparities faced by disadvantaged and vulnerable population groups.[40] An ageing population will see the chronic disease burden become even more pressing.

3.3 Reductions in preventive healthcare spending

The AIHW estimates around 36% of all allocated health spending is spent on chronic diseases.[40] In the 2011–12 financial year less than 2% of total health expenditure was spent on prevention, protection and promotion. This spending largely comprised of immunisation programs, health promotion activities promoting healthy lifestyles and cancer screening programs.[40] Australia also spends less on prevention than many other Organisation for Economic Co-operation and Development (OECD) countries.[40]

Further reductions in Commonwealth expenditure on public health or support for GPs would compound reductions of state and territory government spending in this area. The AIHW reports that state and territory government expenditure on public health declined by 3.3% between 2006–07 and 2011–12.[2] Additionally, while the expenditure by individuals on healthcare grew between 2001–02 and 2011–12, individual spending on community or public health also declined.[2,33]

3.4 The impact of reduced funding on general practice

Many health promotion and prevention interventions can be delivered by GPs and their teams – the most cost-effective part of Australia's health system.[3] Preventive care is based on a partnership between a GP and a patient, designed to help each patient reach their goal of maintaining or improving health. When delivered as part of a consultation between the GP and the patient, the intervention is partially or fully funded by Medicare. However, the scrapping or lack of investment in prevention or early intervention resources or programs will reduce the support available to GPs and their teams to deliver these interventions. It will also increase demand for GP services as more Australians will present with emerging or established chronic diseases, requiring early intervention and more intensive management.

The flow-on effect of mandatory co-payments and reduced rebates for GP services and increasing co-payments for PBS medications will inevitably be a reduction in the uptake of health promotion and preventive activities. Patients will seek to minimise their health expenditure and will deal only with acute or immediate health issues.

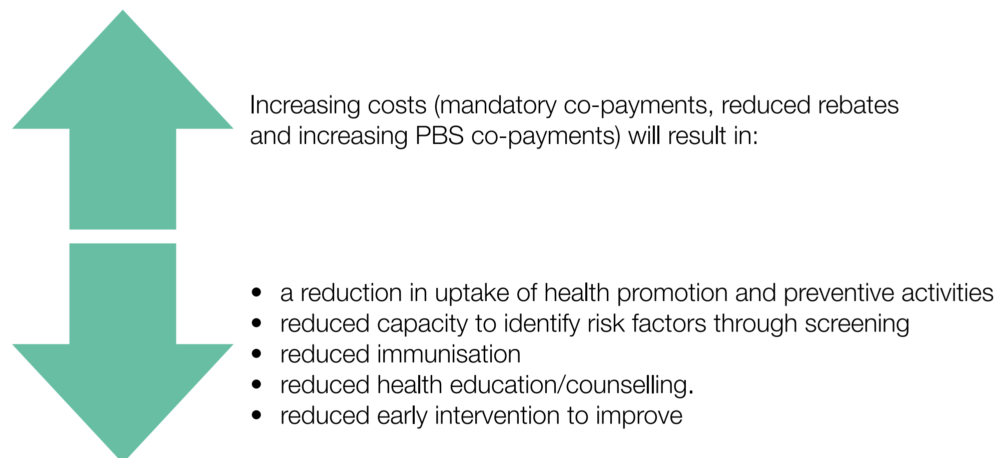

Figure 6. An increase in costs will reduce the likelihood people will spend on preventive activities

Recommendation 3: Prioritise health spending to ensure adequate funding for health promotion and preventive activities which are supported by the current evidence base.

4. The interaction between elements of the health system, including between aged care and healthcare

GPs are the primary medical providers for older people in the community, including those living in residential aged care facilities (RACFs). Residents of RACFs and older people living in the community are often the most complex patients for GPs to manage. Coordination and continuity of care is complex due to the movements between RACFs, home, hospitals and sub-acute settings. The large number of healthcare providers involved in the care of multi-morbid conditions requires significant time and expertise to manage these patients, irrespective of their living arrangements.

4.1 GPs face numerous barriers to providing care in RACFs

Half of GPs participating in the University of Sydney's Bettering the Evaluation and Care of Health (BEACH) study, conducted between April 2011 and March 2012, had provided care in an RACF. Providing care to residents in RACFs requires a special set of knowledge, clinical skills, attitudes and practice arrangements. Unfortunately, GPs face numerous barriers to providing care in this setting.

The current MBS rebates for GP consultations in RACFs are inadequate. Payments to GPs should reflect the cost of providing primary healthcare services in an RACF to enable GPs to continue to provide care. Part of the problem is the current structure of the rebate, which reduces with the number of residents seen during a visit. This form of funding is unreasonable and a disincentive for GPs to carry a large RACF case load.

A recent RACGP survey for GPs involving 802 participants, found:

- 31% reported that improved funding arrangements would be a key incentive to commence work in the area.
- 54% indicated that adequate remuneration would encourage them to continue activities in providing care in RACFs.

Further, GPs undertake a significant amount of unremunerated, non-clinical work to support RACF residents. This includes care coordination, communication with the RACF and liaison with other health professionals and families or carers. The RACGP estimates the total amount of unpaid activities performed by GPs is worth more than $15,000 per GP per year.

Lack of adequate staffing negatively impacts on patient monitoring and reporting activities, which results in increased workload for GPs. Standards for healthcare staffing in RACFs and reduction in the reliance on agency staff would result in improvements in continuity and coordination of care.

This in turn would support GPs to provide care to residents, reducing duplication of effort and minimising the risk of adverse events or outcomes.

Further reforms around the access to medications, medication management, coordination between GPs and pharmacies and reducing red tape around prescription authorities would also improve resident access to care. Poor access to appropriate consultation or clinical treatment rooms can also be a barrier.

To support improved interaction between primary healthcare and aged care, significant investment to support adoption of health technologies is required. The RACGP supports the use of technology for the delivery of care. Remote access to medical records, MBS rebates for telehealth consultations and facilities for timely and secure communication between GPs and RACF staff are all options to improve the conditions for GPs providing care to RACF residents.

The capacity to remotely monitor wellbeing indicators and health status would also improve the ability of GPs to provide care to RACF residents. Initiatives to decrease GPs' travel time while increasing access to information and consultation through technology would improve the efficiency of healthcare delivery. The Productivity Commission recognises the cost of investing in these technologies is the primary barrier to their adoption.

Advance care planning has the capacity to reduce hospitalisation and costly interventions in the final stages of life, improving conditions for people who are dying. GPs are well placed to undertake advance care planning with their patients and this should be supported by appropriate financial remuneration for the work. At a minimum, support to undertake advance care planning and coordination for residents of RACFs could be captured at admission or following significant changes to the health status, improving the outcomes for residents. Similarly, support for discharge planning between hospitals and RACFs will improve outcomes for residents who are transferred between those settings. Policy measures to support this work with accompanying remuneration schemes will enable better healthcare in aged care settings, improving cost efficiency and reducing avoidable hospital admissions.

4.2 Supporting GPs to provide care to older people choosing to stay in their home

The Productivity Commission reported that over 3.5 million people access aged care services each year, with 80% of services delivered to people living in the community.[43] The move toward models of care and service provision that support older people to live at home for longer is a welcome move.

However, this will also increase the need for GPs to provide care to people with limited mobility. BEACH has shown a decrease in the number of home visits conducted by GPs from 2011–12, reflecting similar barriers to GPs providing care at RACFs.[42]

Similar to RACFs, investment in technologies to support GPs to provide care for people at home would improve access to care.

4.3 Supporting interaction across the health system to improve health outcomes through electronic two-way communication between GPs and other health professionals and organisations

Electronic communication integrated into the clinical information systems that are routinely used in various healthcare settings is the most efficient method of communication. Most general practices are now heavily, if not fully, computerised and many practices now use two-way electronic communication routinely. The main factor inhibiting universal adoption of two-way electronic communication is that users of any one system of secure message delivery currently are not able to correspond with users of any of the other available systems.

This issue is close to being solved but needs further government support and incentives to encourage the vendors of secure messaging systems to resolve the remaining issues and for all GPs to start using one of these systems.

The introduction of Medicare benefits for GPs who use secure messaging systems to seek advice from medical specialists about care of a patient may reduce the need and attendant costs of patients having to consult medical specialists.

Lastly, GPs are not always recognised as the primary provider of comprehensive healthcare in RACFs, as reflected in recent reforms of the aged care sector. As the key primary healthcare provider, GPs and their representative groups should be included in any future considerations of how the aged care system works, particularly as it interfaces with community-based healthcare and facilitates transition between aged and hospital care systems.

Recommendation 4: Review and improve remuneration for GPs who provide care to residents of RACFs.

Recommendation 5: Explore options to better support advance care planning for residents of RACFs, including MBS rebates for advance care planning activities.

Recommendation 6: Incentivise interoperability for secure messaging and electronic health record systems to improve GPs' capacity to coordinate and share information.

Recommendation 7: Involve the general practice profession in discussions about aged care reform and service provision.

5. Improvements in the provision of health services, including Indigenous health and rural health

Efficiencies found in healthcare budgets through investing in primary care and preventive health must be realised. Cost shifts and delayed spending now will be more costly over time, as the burden of disease rises and population ages, particularly in rural and remote areas. It has been demonstrated beyond doubt that investing in primary healthcare results in better health outcomes. In fact, the supply of primary healthcare physicians results in both better health outcomes and lower total costs of health services.[16]

The features of primary care that achieve this are:

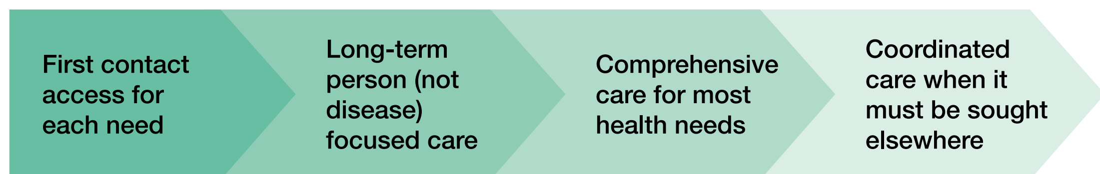

Figure 7. Primary care is a continuum of care, from simple care to complex conditions requiring a team approach

A more sustainable, quality healthcare system can only be achieved through an increased focus on robust primary healthcare. Therefore, the majority of overall health expenditure, which is currently prioritised for the hospital sector and acute care, must give precedence to primary care and increase the capacity of general practice for long-term outcomes.

There is evidence that a strong primary care system is necessary for reducing socioeconomic disparities in health. There is also evidence that primary healthcare in Australia has the potential to work on these disparities and the social determinants of health, but there are not currently supportive policy frameworks to do so.

As described in *Section 1*, Australia is a high performing health system, but the move towards a user pays co-payment model and increased private health insurance is likely to worsen the health system performance.[21]

Current key system constraints (including access and cost impacts and the policy imperative in factoring need into future policy design to ensure policy is more targeted) is discussed further below.

5.1 Rural health

Addressing patient need through prioritising primary care

For the one-third of Australia's population that live in regional, rural and remote areas, securing a sustainable rural health system, including a rural health workforce that enables improved health outcomes, must be a priority. Urban–rural health disparities in Australia, including health status, life expectancy and prevalence of disease, are widely documented. But it is access to primary healthcare which remains one of the main barriers to achieving equitable health outcomes for those living in rural and remote areas.

Ensuring equitable access

For rural and remote areas, the prevalence and burden of chronic disease is compounded by the availability of, and access to, health services. Geographical location impacts, transport and access to appropriate services are major impediments to accessing quality health services in these areas and generally there is an under-supply of facilities and healthcare professionals also impacting on service waiting times and, conversely, patient load.

Equitable access to quality general practice is key to addressing rural health disparities. GPs play a crucial role in these communities, are often the only available health professional, and require a broad skill base in meeting patient demand. Rural communities therefore need well trained GPs who can work across a broad scope within diverse and complex communities.

The training discussion in *Section 7 – Workforce Planning* of this submission is also relevant to the equity and access discussion as GPs tailor their practice to the community they serve. The broad skill set required to provide timely, appropriate patient care depends very much on the health needs and context of the community. GPs need to be able to access training to meet a skill need in their community and in turn address access and service gap issues.

Valuing the role of advanced skills and addressing the current policy inclination (by governments) to prioritise or value certain skills, namely procedural, over others is very much part of this discussion. Specialist competition and differing state arrangements also impact on access to services in these communities.[45] There is a need for stronger investments in, and rewarding of, advanced skills (procedural and non-procedural) in redressing health inequalities.

More generalists will be needed in tackling multimorbidity and an increasing disease burden, particularly in rural and remote communities and among disadvantaged populations. Multimorbidity occurs at a younger age in individuals in areas of high socioeconomic deprivation. These patients will need generalists, not multiple specialists, and consultations will need to deal with more complex problems, last longer, and rely on a strong multidisciplinary referral network.

Cost impacts and the utilisation of primary care

Cost impacts continue to have a direct correlation and impact on the utilisation of primary care services in rural areas. Affordability issues remain despite the government's higher bulk-billing incentive. Many of the recent health budget items set to impact on the general population, such as GP co-payments and the PBS, will disproportionately affect rural and remote communities.

Cost concerns translate to patients rationalising treatment, particularly in the more vulnerable communities, who already suffer an unequal distribution of health outcomes and significant health system constraint. Expanded and prioritised investments are required for those areas of most need, not funding cuts or service reductions, to ensure sustainable primary healthcare delivery.

Strengthening chronic disease management

The coordination of care for patients with chronic disease in the rural context depends largely on resolving the access and equity issues discussed throughout this Section as these have a direct impact on health outcomes. System redesign is required to ensure our health system is better equipped to respond to emerging challenges, particularly in the country, where the disease burden is greater and where resources are limited.

Preventive strategies coupled with increased investment in team based multidisciplinary care are needed to better manage and reduce the prevalence of chronic and complex conditions. Patient-centred, integrated care and multidisciplinary approaches need to target the patient or community level rather than a uniform approach targeting a specific risk area. Responsive policy therefore must consider capacity and resourcing in rural areas, be needs-based for locations, include a broad range of approaches and be flexible enough to encourage local innovation.

Strategies to increase access to quality primary care in rural and remote communities are predominantly GP-led and achieved through innovations in technology, through building sustainable networks and skill-specific solutions that address services gaps.

Local service solutions for the treatment of chronic diseases provide significant cost savings for government (by local management and treatment and avoidable hospital admissions) and enhance patient care.[45]

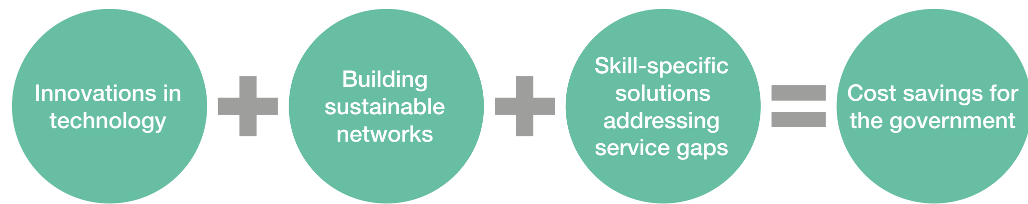

Figure 8. Improving care in regional areas will result in cost savings to government

While it is clear there are many economic, social and environmental factors that influence health outcomes in rural communities, general practice has a central role to play in improving the quality of health services to these communities. Rural communities need multiple strategies to attract and retain the most appropriate GPs. Flexibility is the key to this aim. A strong investment in general practice, together with a more accurate needs assessment, will go a long way to improving the health outcomes for rural and remote Australians.

Factoring need in future policy design

Despite significant investment and many reforms, long-standing health disparities remain for rural communities when compared with health status measures (such as life expectancy and the prevalence of disease).[40] The growing demand for health services and the associated pressure on health systems will be compounded by broader socioeconomic concerns, including the ageing population, the impact of climate change and workforce capacity issues.

In future policy design there is a need to ensure increased investment is targeted to meeting specific community needs and interventions are appropriate and respond to the different rural and remote contexts. Factoring need is essential to ensuring fair policy reach and, despite considerable review and discussion, the lack of an accurate policy filter in capturing need continues to provide for inequitable funding outcomes.

Rural health reform can only be as effective as the system which determines program eligibility. Yet progress has lagged in terms of reforming the Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) classification system and fixing the anomalies limiting success despite sector-wide support for a modified ‘Monash model’. As a first step, this review must be prioritised in order to accurately target and prioritise funding to the areas of most need.

In shifting long-standing health disparities, a more refined approach to needs analysis and benchmarking is needed, one which goes beyond current locational aspects. The complexity of the issue requires a measure that encompasses geography with broader health service elements, including skill mix against both community need and patient population analysis (or social determinants of health). Therefore, to redress entrenched rural health disparities, there is a need to shift towards a patient-centred approach to health needs analysis.

Health policy cannot be considered in the absence of the social determinants of health – the living circumstances and opportunities available to people to be able to make choices about their life. We know many underlying issues of ill health lie well beyond the health system, which can be influenced by a broad range of factors including social, political, economic, cultural or environmental. It is how these factors impact on health and wellbeing that provide a true measure of disadvantage.

The influence these factors have on population health and health equality can be addressed through stronger collaborative reform in incorporating the social determinants of health targets. A social determinants framework would provide the required funding mechanism to encompass fairness at a whole-of-government level, thereby providing a marker for health and health equality to ensure a more equitable distribution of public funding.[24]

5.2 Aboriginal and Torres Strait Islander health

Two of the main drivers of poor health are socioeconomic deprivation and inequality. In Australia, this is most visible in the health of Aboriginal and Torres Strait Islander peoples, but is not limited to them. Aboriginal and Torres Strait Islander peoples also have historical and current dispossession and racism as major causes of poor health.

Twenty-six per cent of Aboriginal and Torres Strait Islander peoples reported in the National Aboriginal and Torres Strait Islander social survey that they had difficulty accessing health services.[25] There was a range of reasons reported for this, including cost and services not being culturally appropriate. The importance of the social determinants of health, particularly the effect of racism, needs to be acknowledged, including in the health system.

The model of primary care provided by Aboriginal Community Controlled Health Services (ACCHS) in being run by and for the local community, with a broader range of services often not conceived as 'health', such as legal or financial, shows what primary care is capable of in Australia, especially for underserved communities.[26,27]

ACCHS is a proven model for successful health service planning and delivery to the Aboriginal and Torres Strait Islander communities. Future service planning and delivery and the overall health advancement of the community must be made a high priority within the new Primary Health Networks (PHNs). The PHNs will be key in setting key priorities and improved coordination of health services at the local level.

Savings could be made by better supporting primary care.

For diabetes, spending $248 in primary care prevents spending of $2915 in hospital care.[28]

Recent research from the Northern Territory shows the savings that could be made in supporting primary care more fully. For diabetes, spending $248 in primary care prevents spending of $2915 in hospital care. Research also highlights primary care funding in a remote Northern Territory clinic fell short for each patient with renal failure or diabetes by $1733.[29]

These results highlight the need for stronger investments in primary care to strengthen chronic disease management and the key system changes discussed throughout.

Strengthened policy alignment can be achieved through all services working closely and in partnership with Aboriginal and Torres Strait Islander communities. The inclusion of private general practices in initiatives to help close the gap formalised through policy would support this aim.

Recommendation 8: Prioritise generalism in addressing workforce maldistribution in rural and remote areas, including recognition of the broad GP skill set.

Recommendation 9: Incentives and payments must be brought in line with the real cost of service delivery in rural towns.

Recommendation 10: Prioritise reform of the ASGC-RA classification system.

Recommendation 11: Invest in primary healthcare to close the gap between health outcomes for Aboriginal and Torres Strait Island peoples and non-Aboriginal and Torres Strait Island peoples.

6. The integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic and dental and allied health services

6.1 Current system is failing to support 'good health'

Australia's primary healthcare system is a complex mix of Commonwealth, state and territory, and privately funded and delivered services. While it performs reasonably well for many, for the growing number of people with chronic disease, and especially those with multiple and complex conditions, this is not the case.

There is an increasing number of patients with complex health needs who experience unnecessarily poor health outcomes. Inadequate linkages between general practice, state and territory funded services, other medical specialists and health professionals can leave patients with insufficient follow up advice, medication management and information, ultimately resulting in poorer health outcomes.

6.2 The solution to health system failure – a high performing primary healthcare sector

As discussed in previous sections of this submission, a high performing primary healthcare sector will address the health system failure and is a cost-effective way to address the needs of funders, healthcare providers and patients.

Increased primary health capacity and improved services will result in downstream (ie. secondary and tertiary healthcare) cost savings through reduced hospital presentations, admissions, length of stay and re-admissions.[30–42]

Proportional to overall health spending, investment in general practice continues to decrease. A re-distribution and re-alignment of existing funding across the health sector is required to support GPs and primary healthcare deliver quality patient services within the medical home. Primary healthcare needs to be supported in order to deliver appropriate and high quality services that are valued by patients, the community and healthcare funders.

6.3 Supporting the quality general practice of the future, encompassing the medical home

To address the failings as described above, the RACGP believes support for the quality general practice of the future, encompassing the medical home, is required. The adoption of the medical home initiative will have significant benefits for patients, healthcare service providers and funders. *Table 3* outlines the features and benefits of the medical home.

Table 3. Features and benefits of the medical home	
Features	**Benefits**
• **Long-term relationship with a personal GP and nominated general practice** • **GP-led care teams** – GPs lead a team of healthcare professionals, including nurses and allied health professionals, who collectively provide and coordinate patient care • **Coordinated and integrated care** – Care is coordinated and integrated across the continuum of the health system. Coordination is enabled by patient registration, dedicated services coordination time, information technology and health information exchanges • **Preventive health** – Facilitation of preventive health activities for patients through improved access, coordination and continuity of GP-led care.	• Improved continuity of patient care[73] • Improved quality and cost effectiveness of care for patients with a chronic disease, achieved through reduced hospital presentations (32–40% drop), hospital admissions (16–24% drop) and length of stay (36% drop)[74–77] • Reduced disparities in access to traditional hard to reach groups[78,79] • Improved overall population health[16] • Lower overall healthcare spending.[71,75,80]

Recommendation 12: Explore mechanisms and policy reforms to better support the quality general practice of the future, encompassing the medical home.

7. Health workforce planning

7.1 The need for a national coordinated approach to medical and health workforce planning

The need for a national, coordinated approach to medical and health workforce planning to meet Australia's needs now and into the future must continue to be a priority, regardless of the entity used.

The Government announced the closure of Health Workforce Australia (HWA) as part of the 2014–15 budget measures. In the announced measures, the Government also stated the roles and functions of HWA will be managed by the Department of Health.

Traditionally, the Department of Health has not had the resources to effectively coordinate and manage health workforce planning. This is evidenced by HWA's *Health Workforce 2025* series released in 2012, which provided Australia's first major, long-term national projections for medical practitioners by specialty.

The work commenced by HWA must continue, with a national system of workforce planning based on patient population and health needs analysis. A strategic approach to workforce planning will ensure there are medical and health workers to meet the needs of all Australians in the short, medium, and long term.

It is vital that the Department of Health (or other appropriate body) has the capacity, both in terms of resources and expertise, to continue national workforce planning and initiatives to ensure that Australia has a sustainable health workforce.

7.2 General practice workforce planning

Workforce projections by HWA conclusively demonstrated the need to maintain and increase GP numbers.[51] Increased general practice workforce capacity is required to facilitate the ongoing delivery of effective and efficient patient services. However, there is an ongoing general practice workforce shortage that is likely to persist in the medium- to long-term. As identified by HWA, despite ongoing investment in general practice prevocational and vocational training numbers, there will continue to be general practice workforce shortages, particularly in rural and remote areas, without further action. *Figure 9* demonstrates the ageing of the GP workforce.[52]

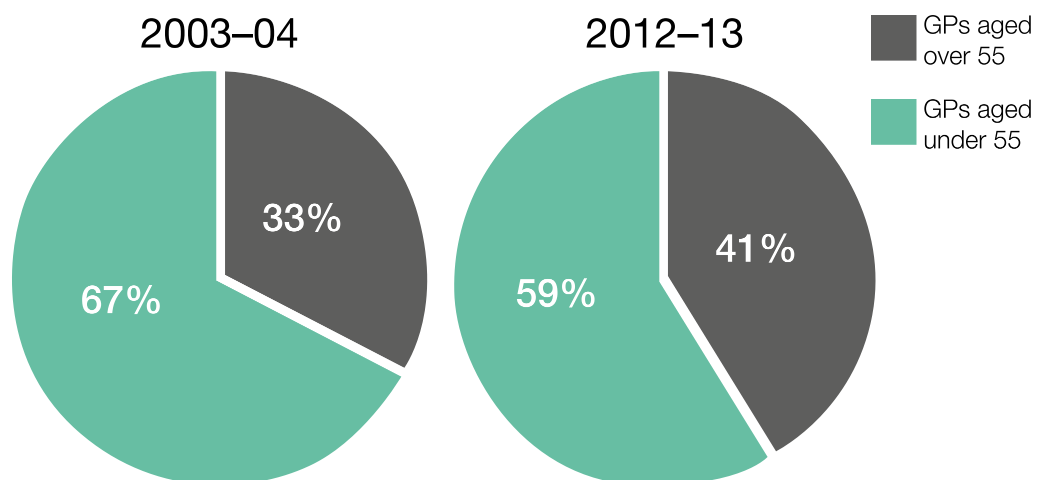

Figure 9. The ageing of the GP workforce between 2003–04 and 2012–13

7.3 Meeting the needs of rural and remote communities

In addition to overall general practice workforce planning, centralised planning is also required to accurately map and fund training requirements to meet the need of rural and remote communities.

Targeted workforce policy

In setting the key policy requirements to address maldistribution, there is a need for more targeted opportunities to meet the training needs of the existing rural and remote workforce, as well as the next generation. Overall, a balance is required to ensure future policy meets the needs of, and values the existing rural and remote workforce, and builds the next generation of rural GPs.

A more considered policy response would ensure the training opportunity (including up-skilling and skills maintenance) and broader interventions or incentives align well with both career stage and community need.

Flexibility in workforce policy

More flexibility and opportunity for rural GPs to address patient need in their community is needed. The focus needs to be on ensuring a broad range of skills, core general practice skills, are supported and prioritised in both policy and training. To support a true generalist workforce to meet the complex health needs of rural communities there is a need to address the procedural bias currently embedded in workforce policy, with an equalled investment in non-procedural advanced skills.

For those at the earlier learning stages, more flexibility and choice will empower career decisions. Providing greater certainty through prioritised rural training positions, removing compulsion, will make rural practice a more attractive training option. There is a need for increased investment in the coordination of training on the ground.

Integrated approach to workforce planning

There is currently little mechanism to support training integration in the current arrangements; these must be built in across the full training continuum, with jurisdictional barriers lifted. Strategies to promote connectedness (across disciplines), support of rural intention and maintaining a link to community are vital aspects of a successful and more integrated rural training model.

7.4 Using the right professional to deliver the best service

Role and task substitution as a strategy for increasing the health workforce, access to services and improving the skills and experience of clinicians has some merits. These include re-organising the workforce so that suitable tasks are moved to less specialised health workers, which may result in a more efficient use of the resources available.

However, the RACGP has significant concerns about the potential outcomes of this approach. While health outcomes can be improved with task or role substitution, positive outcomes can only be reached if there is good management, supervision and support for the health workers involved. For example, the expansion of a community pharmacist's role to provide services traditionally the remit of GPs (ie. immunisation, basic 'health checks') outside the general practice setting could result in increased inefficiencies, including:

- duplication of services
- provision of unnecessary services
- fragmented care
- miscommunication between healthcare providers
- compromised patient safety
- compromised health worker liability (legislative changes would be required to allow pharmacists to deliver vaccination)
- creating shortages in traditional roles.

The issues identified above in relation to expanding the role of pharmacists will arise in other role or task substitution scenarios. Roles, responsibilities and boundaries need to be clear and role or task substitution must not come at the expense of quality and coordinated patient care. This can be achieved through training, credentialing, certification and ongoing professional development, to ensure task shifting is not associated with second-rate services.

Aligning health professionals with service need is a valid response to workforce pressures. The goal of role and task substitution in the primary healthcare sector should be to integrate a broader range of health professionals into the multidisciplinary primary healthcare team. The GP, as the centre of the team, should be the in position to lead and coordinate the care provided to the patient.

Recommendation 13: Shift towards a more targeted, yet flexible, overall policy approach delivered against a supportive framework which enables service continuity and practice viability to address future need in rural Australia.

Recommendation 14: Promote and incentivise team-based models that have GPs as the leaders of therapeutic interventions and where professionals work in an interdependent, co-operative relationship.

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