AMA Pre-Budget Submission 2022-23

Chapter 4: Primary healthcare

OVERVIEW

This chapter of the *AMA Pre-Budget Submission 2022-23* draws on *Delivering Better Care for Patients: The AMA 10-Year Framework for Primary Care Reform*, as well as a recent paper published by the AMA – *Putting health care back into aged care* – with some of the modelling adapted and extended to give estimates of impact over the four year forward estimates.

PROBLEM STATEMENT

Primary healthcare is the front line of the healthcare system and usually the first level of contact with the national healthcare system. It is scientifically sound, universally accessible and constitutes the basis for a continuing healthcare process – providing the right care, at the right time, at the right place.

General practice is the cornerstone of successful primary healthcare, underpinning population health outcomes and key to ensuring we have a high-quality, equitable, and sustainable health system. Research in Australia and internationally shows that a well-funded and resourced general practice sector is pivotal for success of primary healthcare, improving the health outcomes of individuals and communities.[1,2] It also shows that it can create significant savings through better care, greater efficiency, and reducing the burden on other more expensive parts of the health system.[3,4,5]

General practice is the most accessed form of healthcare in Australia, with almost 85 per cent of patients seeing a general practitioner (GP) each year,[6] and over 95 per cent of patients attending the same practice.[7] Despite being so heavily accessed and the research supporting a well-funded general practice sector, general practice services represent approximately 7.7 per cent of total government expenditure on health, receiving $9.8 billion in spending in 2018-2019.[8] This is equivalent to only $391 per person annually.[9]

Furthermore, government investment in general practice has not matched the increase in the cost and demand for providing high-quality patient care. General practice is underfunded with the Medicare Benefits Scheme (MBS) systematically devaluing GP services through inadequate indexation and a consultation item structure that fails to keep up with the growing complexity of care and the need for GPs to spend more time with their patients.[10] With a population that is growing, ageing, and increasingly developing more complex health needs, general practice funding models need to change to meet the needs of the community.

POLICY PROPOSAL

Voluntary patient enrolment

The AMA has previously supported the concept of voluntary patient enrolment (VPE), with plans to introduce this first announced in the 2019-20 Budget as a $448.5 million investment over three years from 2020-21.[11] Initially targeted at patients over 70 years old and Aboriginal and Torres Strait Islander people aged over 50, its introduction was delayed by the COVID-19 pandemic. VPE is designed to formalise and strengthen the relationship between a patient and their GP to improve continuity of care and patient experience through the provision of non-face-to face services.[12]

The AMA firmly believes that, provided GPs are appropriately resourced, formalising the doctor patient relationship through VPE will strengthen the continuity and longitudinal nature of care provided. It will give general practices the ability to define their patient population, better understand and address patient needs and gaps in care, as well as measure care outcomes. The AMA also believes that it is time for government to broaden its approach to VPE and offer the opportunity for all Australians to voluntarily enrol with their usual GP or general practice. The process for enrolling patients should be as simple as possible, with funding currently set aside for VPE reinvested in other measures to better support general practice and its delivery of care for patients.

Linking chronic disease management, health assessment, and medication management review MBS items to VPE will support those GPs who are truly the patient's usual GP in providing care that is of value to the patient and appropriate for their care, improving patient experience and health outcomes.

Workforce Incentive Program

The Workforce Incentive Program (WIP) supports access to multidisciplinary care as part of a GP-led and coordinated team and provides incentives for GPs to work in rural areas. The WIP has improved access to care for patients, although its value has diminished over time as payments under its practice stream have not changed since they were established in 2012 under the former Practice Nurse Incentive Program.

Using the $448.5 million previously earmarked for VPE, the AMA proposes that the government remove the current cap on payments under the WIP and commit to annual indexation. This will help embed the medical home model of care in Australia and ensure that general practice continues to evolve into a hub where patients can access care from a range of healthcare providers working in a collaborative model with GPs.

"Extended" Level B attendance item – linked to voluntary patient enrolment

Patients are attending general practice with increasingly complex care needs, yet current Medicare arrangements do not give them adequate support and instead encourage shorter consultations. To enable GPs to spend more time with patients, the AMA is calling for an "extended" Level B attendance item to be introduced for consultations between 15 and 19 minutes. This will reward quality and value-based care and ensure that patients can spend the time they need with GPs.

Improved access to GPs after-hours care

Patients would prefer to access after-hours care through their usual GP or general practice, yet current Medicare arrangements discourage GPs from offering in-clinic services after 6pm on a weeknight and on weekends. This means that patients are often diverted to an Approved Medical Deputising Service (AMDS) or choose to visit a local emergency department.

To encourage better access to services from a patient's usual GP or general practice after 6pm on weeknights or on weekends, the AMA calls for the definition of after-hours for general practices to be aligned with the AMDS.

Wound care for targeted conditions

It is estimated that approximately 450,000 Australians currently live with a chronic wound, costing the health system around $3 billion a year.[13,14,15] Because of the high costs of some dressings, some patients are unable to access optimal wound care through their general practice or required to pay significant out-of-pocket costs.[16]

Using savings generated from linking chronic disease management, health assessment, and medication management review MBS items to VPE (outlined above), the government should establish a funded wound care scheme to cover the costs of dressings provided in general practice for patients with hard-to-heal wounds.

This will improve the quality of life for these patients as well as generate downstream savings as a result of fewer avoidable hospital admissions.

Aged care funding model

Healthcare for older people is getting more complex. Increasing life expectancy is resulting in more years of life lived with chronic diseases, and often greater complexity of medical care in old age (such as the management of comorbidities). This, combined with our ageing population, means that demand for aged care and healthcare services will only continue to increase in the future.

Positioning GPs at the centre of healthcare provision in aged care is central to improving the health outcomes and quality of life for older people, as well as reducing avoidable hospitalisations.[17]

GPs however are not well supported to deliver healthcare in residential aged care facilities (RACFs), with the MBS rebates not adequately compensating for the additional time and complexity involved in delivering care in RACFs compared to their own practices (refer to the AMAs Putting health care back into aged care report for further details).

The AMA calls for government to review the incentives for GPs to attend RACFs and establish a new funding model which makes it sustainable for GPs to deliver increased and continuing services in RACFs, including via telehealth with RACF staff in circumstances where patients are unable to effectively communicate due to underlying health conditions. This funding model should support the provision of coordinated, high-quality, person-centred, and longitudinal healthcare, and should compensate for the time and care spent with an older patient in an RACF and the other activities required to support the patient (such as discussing treatment plans with relatives and RACF staff).

Rural General Practice Infrastructure Grants

General practice in rural Australia faces unique challenges in providing healthcare and attracting and retaining an adequate health workforce. The Rural General Practice Infrastructure Grants Program, last offered in 2016, is designed to support rural general practices through additional infrastructure and space to support the teaching and training of medical students, prevocational doctors, and registrars. They also enable rural general practices to provide patients with improved facilities and access to a broader range of services, such as nursing and allied health services.

Previous rounds of infrastructure grant funding have been shown to deliver results for rural communities, with practices taking realistic steps to improve patient access to services and support teaching activities. Additionally, the Australian National Audit Office reports that infrastructure grants are effective and a good value-for-money investment.[18] The AMA is therefore calling for these grants to be reintroduced, with funding provided for 425 grants of up to $500,000 each across four year forward estimates.

Continued COVID-19 support

As Australia enters the recovery phase of the COVID-19 pandemic, general practices will be under increased pressure to deal with the backlog which has built up as well as continue to deliver COVID-19 related services, such as the COVID-19 booster program.[19] The AMA recommends that additional funding be allocated to support general practices with this increased demand, and ensure access to the required resources (e.g. access to personal protective equipment (PPE) from the National Medical Stockpile).

RISKS AND IMPLEMENTATION

Voluntary patient enrolment

A key enabler of VPE is the embedding of patient-centred medical homes (PCMH), which facilitate a partnership between individual patients, their usual treating GP, and extended healthcare team to provide healthcare that is comprehensive, patient-centred, coordinated, accessible, and focused on quality and safety.[20] While implementing the PCMH model would require a significant investment of time and resources, the 10 building blocks of high-performing primary care – outlined in The AMA 10-Year Framework for Primary Care Reform and originally published in 2014 by Bodenheimer et al. – presents a roadmap to guide transformation of primary healthcare towards the PCMH.[21,22]

Linking chronic disease management, health assessment, and medication management review MBS items to VPE will also be key to successfully implementing VPE, as this will facilitate and reward longitudinal care. GPs will be only able to claim these items for enrolled patients, noting that there would need to be some flexibility for vulnerable and hard-to-reach populations and a sufficient period for transition.

To avoid administration costs associated with implementing VPE it will be essential for the process to be streamlined and incorporated into practice software systems. A clear outline of the patient's role in enrolment should be developed, noting the importance of patient consent. Enrolment also presents challenges for people living in rural and remote areas, mobile populations, and those living with disability and / or transport limitations.[23]

Workforce Incentive Program

Raising the cap on the incentive available under the WIP to 7,000 SWPE and indexing the program will better support the employment of nurses, pharmacists, and allied health professionals within general practice. It will also better support earlier reforms announced by the Commonwealth Government in the 2018-19 Budget where it expanded the range of health practitioners that could be engaged under the WIP but did not provide any extra funding to support this. Additional funding will offer general practices the flexibility to employ clinical staff that best support GPs to care for their local communities which will be key to the future success of the WIP. Additionally, without appropriate indexation, the objectives of the WIP are undermined as the rising costs of employing staff erodes the value of the incentive.

"Extended" Level B attendance item – linked to voluntary patient enrolment

A Level B attendance item is the most commonly used GP attendance item,[24] utilised for a consultation lasting less than 20 minutes for cases that are not obvious or straightforward. Implementation of the proposed "extended" Level B attendance item would be relatively straightforward as GPs are accustomed to changes to the MBS and would welcome this item as a means of better supporting their patients.

Failure to support GPs to spend more time with patients will, as the population ages and care needs become more complex, drive health costs up in the longer term as it will undermine efforts to improve prevention, better manage conditions in primary care, and likely result in more tests and investigations being required.

Improved access to GPs after-hours

Failure to implement this change will support the status quo, which sees patients accessing care through more expensive options including their local emergency department. The new definition will need to be clearly communicated to GPs so that they are encouraged to take up this opportunity. It will also need to be promoted to patients to encourage them to see their general practice as the first point of call for care in after-hours periods.

Wound care for targeted conditions

Research shows that the cost of providing optimal wound care for patients results in a net financial loss to practices.[25] This encourages the use of sub-optimal dressings as they present a lower immediate cost burden, which can result in inferior management of the wound and prolonged healing times, increasing the cost of wound care over the longer term.[26] It also may result in increased hospitalisations due to infections and other complications.[27]

Supporting general practices to provide optimal wound care for patients with hard-to-heal wounds will improve wound healing, prevent hospitalisations, and minimise the costs of care for patients, general practices, and the healthcare system. It is proposed that this wound care scheme be initially implemented for concession and health care card holders, and then expanded to all patients with hard-to-heal wounds.

Aged care funding model

Unless the government funds initiatives to improve access to GPs in aged care facilities, residents will have a lower quality of life and downstream costs will be incurred through costly hospital transfers and unnecessarily long hospital stays.[28]

In implementing additional funding, the AMA supports the adoption of blended funding models. This will address problems identified by the Royal Commission into Aged Care Quality and Safety that relate to patients not being able to access sufficient services or the right mix of services. Future arrangements should encourage both.

Rural General Practice Infrastructure Grants

It is recommended that reintroduction of the Rural General Practice Infrastructure Grants Program consider the findings and recommendations from the 2012 Australian National Audit Office review. Currently, grant funds awarded as part of the Rural General Practice Infrastructure Grants Program are assessable as income, which negates the potential benefits of the grant for many recipients. The AMA recommends that the government review the impact of subjecting the grants to taxation and either exclude them from tax or adjust grant amounts to ensure the funding is sufficient to achieve the intended outcomes of the program.

Continued COVID-19 support

The funding allocated to general practices to support our COVID-19 recovery should be flexible enough to cater to the changing needs of patient care through this recovery period. This will ensure general practices have the capacity to address the backlog while continuing to deliver COVID-19 related services and meet the demand for other services.

The risks of not taking action

The Australian population is growing, ageing, and developing more complex health needs as the incidence of chronic disease and mental ill-health continues to increase. GPs are therefore managing more problems in each consultation and are spending more time with patients.[29] Inadequate support for general practices will therefore have a significant impact on the capacity of general practices to continue providing quality care into the future. Missed opportunities for timely preventive and holistic care increases healthcare expenditure over the longer term and contributes to fragmentation of care, inefficient use of resources, and poorer patient health outcomes.

This will result in significant cost increases to the health system,[30] with 6 per cent of all hospitalisations in 2016-2017 due to 22 preventable conditions that could be managed by general practice, accounting for over 2.8 million bed days.[31] It will also result in poorer health outcomes for patients, which in turn is associated with absenteeism, presenteeism, lower productivity, and lower workforce participation.[32,33]

TIMEFRAMES AND COSTING OVER FOUR YEARS

The figures below are in nominal dollars, and are in addition to the Government's budgeted funding outlined in the 2021-2022 Budget.

Voluntary patient enrolment

Modelling indicates that linking chronic disease management and health assessment MBS items to VPE will result in a 4 per cent reduction in claiming of these items (as these items will only be able to be claimed for enrolled patients, preventing potential misuse of these items). Linking medication management review MBS items to VPE are expected to reduce claiming by 10 per cent. Over four years, this would translate to government revenue of $224.7 million across the forward estimates. This assumes that there is a 75 per cent uptake of services through VPE.

As outlined above, this $224.7 million saving should be used in establish a funded wound care scheme to cover the costs of dressings provided in general practice for patients with hard-to-heal wounds (refer to costing below). The VPE savings would begin from date of first enrolments in January 2022 but would not become fully realised until the financial year 2023-24 when utilisation of these item numbers is exclusive to VPE (from July 1, 2023).

Table 1: Impact of linking chronic disease management, health assessment, and medication management review MBS items to VPE

	2022-23	2023-24	2024-25	2025-26	Total across forward estimates
Cost recovery through linking chronic disease management MBS items to VPE	22.7	48.2	51.2	54.3	176.5
Cost recovery through linking health assessment MBS items to VPE	5.1	10.9	11.6	12.3	39.9
Cost recovery through linking medication management review MBS items to VPE	1.1	2.3	2.4	2.5	8.3
Net revenue to government ($m)	29.0	61.5	65.2	69.1	224.7

Workforce Incentive Program

Raising the cap on the incentive available under the WIP to 7,000 SWPE will cost the government $206.9 million across the forward estimates. When an annual indexation of 80 per cent Wage Price Index (WPI) and 20 per cent Consumer Price Index (CPI) is introduced alongside raising the cap, the net cost to government is $326.1 million. The cost however would be covered by using the $448.5 million previously earmarked for VPE.

The number of GPs currently at or above the SWPE 5,000 cap have been calibrated to match the current program. This calibrates the expenditure on the former PNIP in 2018/19 to the practice stream of the WIP,[34] as well as the current distribution of GPs working in practices of size 1, 2-5, 6-10 and ≥11 in 2019.[35,36,37] There is also an allowance for a greater proportion of part-time workers in larger practices as outlined in the Royal Australian College of General Practitioners General Practice: Health of the Nation 2020 report,[38] which lowers the maximum SWPE of larger practices compared with survey results based on head count.

Table 2: Impact of raising the cap on the incentive available under the WIP to 7,000 SWPE and introducing annual indexation

	2022-23	2023-24	2024-25	2025-26	Total across forward estimates
Cost of raising the cap to 7,000 SWPE ($m)	48.1	50.4	52.9	55.5	206.9
Cost of annual indexation ($m)	10.1	22.5	35.8	50.8	119.2
Total cost to government ($m)	58.2	72.9	88.7	106.3	326.1

"Extended" Level B attendance item – linked to voluntary patient enrolment

Implementing an "extended" Level B attendance item, linked to VPE, for consultations between 15 and 19 minutes will require a $1.03 billion investment from government over the four year forward estimates. The rate of fee is assumed to be $54.66 (100 per cent of proposed MBS fee in 2021-22, where the new level B item increases by 85 per cent of the mid-point of Level B and C consults). BEACH data on the mode, median and mean length of consult was used to establish the distribution of time for standard Level B attendance item in 1 minute increments. An estimated 20 per cent of all Level B attendances are between 15 and 19 minutes. There is an estimated up-lift to 31 per cent of items billed for the 15-19 minute consultations using the number of consults that are close to the 15 minute window that might be extended to claim the "extended" Level B attendance item MBS fee. There is also a conservative assumption that the entire increase in "extended" Level B attendance item claims comes at the expense of fewer standard Level B attendances. The final cost may be lower if these "extended" Level B attendances result in a reduced number of Level C attendances.

Table 3: Cost of implementing an "extended" Level B attendance item

	2022-23	2023-24	2024-25	2025-26	Total across forward estimates
Cost of implementing an "extended" Level B attendance item ($m)	95.4	198.5	309.8	429.8	1,033.6
Total cost to government ($m)	95.4	198.5	309.8	429.8	1,033.6

Improved access to GPs after-hours care

Aligning the definition of after-hours for general practices with the AMDS will cost the government $339.7 million across the four-year forward estimates. This assumes that 5 per cent of the additional GP services will replace ADMS services. It also assumes that there is no change in the proportion of Level A, B, C and D services currently delivered under after-hours care. No other price changes are assumed other than standard MBS indexation.

Table 4: Impact of aligning the definition of after-hours for general practices with the AMDS

	2022-23	2023-24	2024-25	2025-26	Total across forward estimates
Total number of GP services delivered 6pm-8pm (million)	6.61	6.77	6.94	7.11	27.43
Proportion of additional GP services delivered 6pm-8pm that would have otherwise not been delivered by any other healthcare provider	*165,277*	*169,301*	*173,434*	*177,680*	*685,693*
Net cost, after allowing for reduction in ADMS ($m)	79.4	83.0	86.7	90.6	$339.7
Total cost to government ($m)	79.4	83.0	86.7	86.7	**339.7**

Wound care for targeted conditions

It is widely acknowledged that there is limited data on the prevalence and costs of chronic wounds in Australia. For the purposes of this modelling, the following conservative assumptions were made:

- Persons 65 years and older account for 85 per cent of chronic wounds.[39]
- A current cost of $140 / month for dressings for each patient, with dressings purchased from the pharmacy.[40]
- A 40 per cent saving from GPs purchasing wholesale dressings.[41]
- A healing time of six months for chronic wounds.[42]
- 450,000 Australians currently live with a chronic wound.[43]
- Only patients with a concession or health care card are eligible.[44]

Note: the proportion of patients with diabetic foot or leg ulcers and venous or arterial leg ulcers was unable to be calculated due to limited data, and therefore calculations could only be based the proportion of concession and health care card holders from the estimation of 450,000 Australians living with a chronic wound. It is however recommended that the wound care scheme focus on the target cohort of patients (outlined above).

Covering the costs of dressings for concession and health care card holders with hard-to-heal wounds will cost the government $714 million over the four-year forward estimates. This represents a saving of $1.19 billion for these patients, and a net saving of $476 million from GPs purchasing wholesale dressings (a 40 per cent saving from wholesale price compared to patients purchasing dressings from the pharmacy).

Table 5: Impact of covering the costs of dressings for patients with hard-to-heal wounds

	2022-23	2023-24	2024-25	2025-26	Total across forward estimates
Number of patients with hard-to-heal wounds	323,442	331,799	340,374	349,173	1,344,787
Savings to consumer ($m)	278	290	304	318	1,190
Net overall savings ($m)	111	116	122	127	476
Total cost to government ($m)	167	174	182	191	714

Aged care funding model

These costings represent a much-needed uplift in funding to support GPs to deliver health care in aged care settings. Using some of this funding, government should review incentives for GPs to attend RACFs and establish a new long-term funding model which supports the delivery of coordinated, high-quality, person-centred, and longitudinal healthcare which compensates for the additional time and complexity involved in delivering care in RACFs. These costing assume that growth in RACF residents will slow due to the expansion of the Home Care Program, with services delivered in RACFs now assumed to grow at 2.5 per cent per annum.

Table 6: Cost of increasing payments to GPs delivering services in RACFs

	2022-23	2023-24	2024-25	2025-26	Total across forward estimates
Cost of increasing payments to GPs delivering services in RACFs ($m)	144.9	155.1	169.3	183.2	652.4
Total cost to government ($m)	144.9	155.1	169.3	183.2	652.4

Rural General Practice Grants Program

These costings assume that all grant recipients receive the maximum grant amount ($500,000). As the funding is delivered through a grant program, the number of grants are fixed and costs have not been indexed to adjust for inflation.

Table 7: Cost of reintroducing the Rural General Practice Infrastructure Grants Program

	2022-23	2023-24	2024-25	2025-26	Total across forward estimates
Number of grants	100	100	100	125	425
Maximum total cost of grants ($m)	50	50	50	62.5	212.5
Total cost to government ($m)	50	50	50	62.5	212.5

Continued COVID-19 support

Due to the unpredictable nature of COVID-19, specific costings have not been outlined for the additional support general practices require to deliver increased services through the COVID-19 recovery period. It is recommended that funding be made available when it is required, and that this funding be flexible enough to ensure general practices can meet the changing needs of patients through the recovery period.

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