AMA's plan to

Modernise Medicare

Policy Brief

WHY WE NEED A MODERN MEDICARE

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. A well-funded and resourced general practice sector is pivotal to improving the health outcomes of individuals and communities, and can create significant savings through better care, greater efficiency, and reducing the burden on other more expensive parts of the health system.

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. General practice services however only represent around 8 per cent of all governments expenditure on health, and government investment in general practice has not matched the increase in the cost and demand for providing high-quality patient care.

Additionally, since its introduction in 1984, Medicare has become increasingly out of date when it comes to a visit to the GP. The Medicare Benefits Scheme (MBS) has systematically devalued GP services through inadequate indexation, and the consultation item structure is failing to keep up with the growing complexity of care and the need for GPs to spend more time with their patients to deliver comprehensive care.

With a population that is growing, ageing, and increasingly developing more complex health needs, we need a modern Medicare so patients can spend **more time** with their trusted GPs, access **more care** from their general practice, and receive **more health** though comprehensive and evidence-based care.

MORE TIME

Supporting patients to spend more time with their GP

Evidence shows Australians are experiencing rising rates of chronic disease, multiple morbidities, and the need for more complex care, particularly as the population ages. Increasingly patients attend their GP for multiple health problems, and often these are both of a physical and psychological in nature. The current Medicare GP attendance items however are structured to support shorter consultations with a GP rather than the more comprehensive care that many patients need.

When patients see their GP, the most used Medicare consultation item is a Level B, which is for consultations between six and 19 minutes. This promotes a more rapid approach to care, as the Medicare funding is the same regardless of whether the GP spends six minutes or 19 minutes with the patient.

The time that the GP spends with a patient can make a real difference, as it means the GP is able to have more in depth conversations with patients to arrive at a suitable diagnosis and treatment plan, without the need for repeat visits. Those GPs that choose to provide this comprehensive care are penalised financially, unless they choose to pass on the costs of providing this care to their patients by asking them to pay a out-of-pocket gap.

Recommended in the Government's own Medicare Benefits Schedule (MBS) Review, Medicare must support GPs to spend more time with patients. This will support GPs in helping to keep people healthier and, for those complex patients at risk of hospitalisation, ensure that their conditions are well controlled.

To enable a modern Medicare, a new Medicare consultation item should be introduced to encourage and support GPs to spend more than 15 minutes for those patients that need more time. This will encourage prevention, support timely access to early intervention, and enable a more comprehensive approach to care.

Improving access to care for people outside of normal business hours

People get sick outside of business hours, and our 24/7 economy also means that people cannot always visit their GP during the day. When patients need medical care outside of normal hours, they prefer to access this through their usual GP or general practice.

Current Medicare arrangements, however, discourage GPs from offering in-clinic services after 6pm on a weeknight, as well after 12pm on Saturdays. This means that patients are often diverted to an Approved Medical Deputising Service (AMDS) or choose to visit a local emergency department. Accessing services through these alternative models is expensive, with the average cost of an ED attendance being around $540.

To enable a modern Medicare, the definition of after-hours for general practices should be changed so that in clinic GP after hours rebates are available from 6pm on weeknights and 12 noon on Saturdays. This will better enable general practices to deliver after-hours services on weeknights and weekends. Supporting general practices to stay open for longer into the evening will save money and ease pressure on our public hospital system.

MORE CARE

Delivering the care patients' need in general practice – all under one roof

Most general practices in Australia employ a practice nurse, who works with GPs to deliver care for patients. Practice nurses support GPs in a variety of areas including immunisation, wound care, health assessments and chronic disease management.

General practices are increasingly looking to employ other health professionals as part of a modern team-based approach to delivering comprehensive care for patients. This team may include practice nurses, pharmacists, dieticians, physiotherapists, podiatrists, Aboriginal Health Workers, or a range of other allied health workers. This is convenient for patients, as it allows patients to access more types of care under the one roof, strengthening general practice as the medical home.

GPs are also at the front line of mental health services, as GPs are often the first port of call for patients with mental health conditions. GPs lack sufficient support for this role, however employment of dedicated mental health staff, such as mental health nurses or case coordinators, would support general practices in the delivery of comprehensive mental health services.

Medicare and other funding sources do not adequately support general practices to employ other health professionals. The Government's Workforce Incentive Program provides subsidies, however these have been capped since their introduction in 2012. They have also failed to keep pace with wages growth, with no indexation applied since their introduction. The way health care is delivered in primary care is changing and funding arrangements need to be modernised to reflect this.

To enable a modern Medicare and support the move towards a Medical Home in Australia, the Workforce Incentive Program must be strengthened by raising the current cap on subsidies and introducing annual indexation. This will give general practices greater capacity and flexibility to employ the range of clinical staff that best supports the care needs of their patients.

Supporting better care for people in aged care

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.

After years of building a trusted relationship with a GP, who knows their medical history and family supports, patients should be able continue to receive care from their GP of choice when moving into Residential Aged Care Facilities (RACF).

Unfortunately, too few GPs currently visit aged care facilities as Medicare funding does not properly recognise the time and complexity involved in providing GP services to patients in RACFs. As a result, RACF residents are not always able to access the care they need when they need it. While some residents will be able to access a GP that they don't know through an after-hours deputising service, many will be transferred to a public hospital. This fragmented approach to care is costly, puts more strain on our public hospitals, and often results in poorer health outcomes for these older patients.

Outlined in the AMA research report *Putting health care back into aged care*, it is estimated that investing an additional $643 million for GPs to provide services in RACFs will save around $2 billion over 4 years from avoidable public and private hospital admissions, presentations and stays from older people in the community and in nursing homes.

To enable a modern Medicare, GPs should be appropriately funded and incentivised to provide care in RACFs. This will require establishment of a new funding model that makes it sustainable for GPs to deliver increased and continuing services in RACFs. 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, and communicating with RACF staff via telehealth in circumstances where patients are unable to effectively communicate due to underlying health conditions).

Encouraging more doctors to work in general practice

Despite record numbers of graduates from medical schools around the country, interest in GP training is declining. Medical graduates are turning to other specialty areas, with the growth of the non-GP specialist workforce continuing to outpace any growth in the GP workforce.

The Australian General Practice Training Program has fallen short of its recruitment targets every year since 2017. The number of medical graduates applying for GP training has fallen, as has the number of acceptances. This has long term implications for the GP workforce and community access to GP services.

While general practice remains a rewarding career, the reality is that other medical specialties are proving more attractive to medical graduates. One of the key reasons for this is the significant loss of pay and conditions that trainees incur when they leave their salaried position in a public hospital to train in general practice.

On average, these trainees face a pay cut of more than $500 per week, and have inferior access to personal leave, annual leave, long service leave, and parental leave. This is discouraging doctors from entering general practice, especially those with parental responsibilities. General practice is a recognised medical specialty, just like any other specialty in Australia, and this difference in pay and employment conditions is inequitable.

To enable a modern Medicare, renumeration and employment conditions must be equitable between GP registrars and other medical specialities. This should be implemented through a 'single employer model' for GP training, allowing GP registrars to transfer practices without losing their entitlements. This model has proved successful in supporting rural generalist training in Queensland and now must be adopted across the whole of the GP training program.

MORE HEALTH

Supporting better health care through voluntary patient enrolment

85 per cent of Australians visit a GP every year, with 76.3 per cent of Australian's seeing a usual GP and almost 95 per cent attending a usual practice. International evidence shows that having a long-term relationship with a GP leads to lower mortality, fewer acute hospital admissions, lower use of after-hours care, lower use of Emergency Departments, a more trusted relationship between patient and GP, improved patient satisfaction, and improved patient engagement in preventive health care measures.

To enable a modern Medicare, this relationship between patients and GPs should be formalised and strengthened by supporting patients to enrol with a GP or general practice of their choice. Moving to a system of Voluntary Patient Enrolment (VPE) has been recommended in key government sponsored reviews including the Medicare Benefits Schedule (MBS) Review and the Report of the Primary Health Reform Steering Group.

The introduction of VPE in Australia will support improved care for patients. It will encourage more patients to develop a long-term relationship with a local GP or general practice, and provide the foundation for every Australian to have their own 'medical home', which will:

- Support continuity of care, leading to less fragmentation in our health system and better outcomes for patients;
- Provide the basis to link the provision of some Medicare funded services, in areas such as chronic disease management, to a patient's nominated GP or general practice, enabling the delivery of better quality care that is well coordinated and best meets the needs of patients;
- Encourage greater preventive health care within general practice, as practices develop a better understanding of their patient population and their health care needs;
- Encourage innovation in general practice, supported by new blended models of funding; and
- Support better discharge planning by ensuring that hospitals can communicate more effectively with a patient's nominated GP or general practice.

Delivering better care for people suffering from chronic wounds

It is estimated that approximately 450,000 Australians currently live with a chronic wound. Most of those are aged over 65 years. These Australians, who are often on limited incomes, can face significant out-of-pocket costs of around $140 per month for wound dressings when they are purchased through a pharmacy along with additional GP visits to have the dressing applied.

While GPs will often supply dressings at no cost to patients, the costs of these are not covered by the Government and this makes it difficult for patients to access the most appropriate dressing for their needs. This means that wounds often take longer to heal, patients suffer unnecessary complications and patients need to visit their GP more often.

Hard to heal wounds are estimated cost the health system around $3 billion a year. This cost, wound healing times, infections, long-term complications, amputations, and hospitalisation could be significantly reduced if patients could access best practice wound care through their general practice.

Medicare does not help patients with the costs of wound dressings. Patients are expected to pay for these out of their own pocket or general practices are expected to supply these from an already inadequate rebate for a Medicare funded consultation. Australia needs to implement a wound consumables scheme, particularly for those patients that have hard to heal wounds,

The Medicare Review Taskforce has acknowledged wound care is currently a significant issue and similarly called for a wound consumables scheme.

The implementation of a national wound consumables scheme would mean that GPs could provide patients with the most clinically suitable dressings, reducing patient out of pocket costs, avoiding the need for a pharmacy visit and improving people's quality of life. Such a scheme should focus on ensuring those most at risk can access the care they need, targeting:

- Patients with diabetes who have a diabetic foot ulcer or diabetic leg ulcer;
- Patients with a venous or arterial leg ulcer; and
- Patients 65 years of age and over.

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