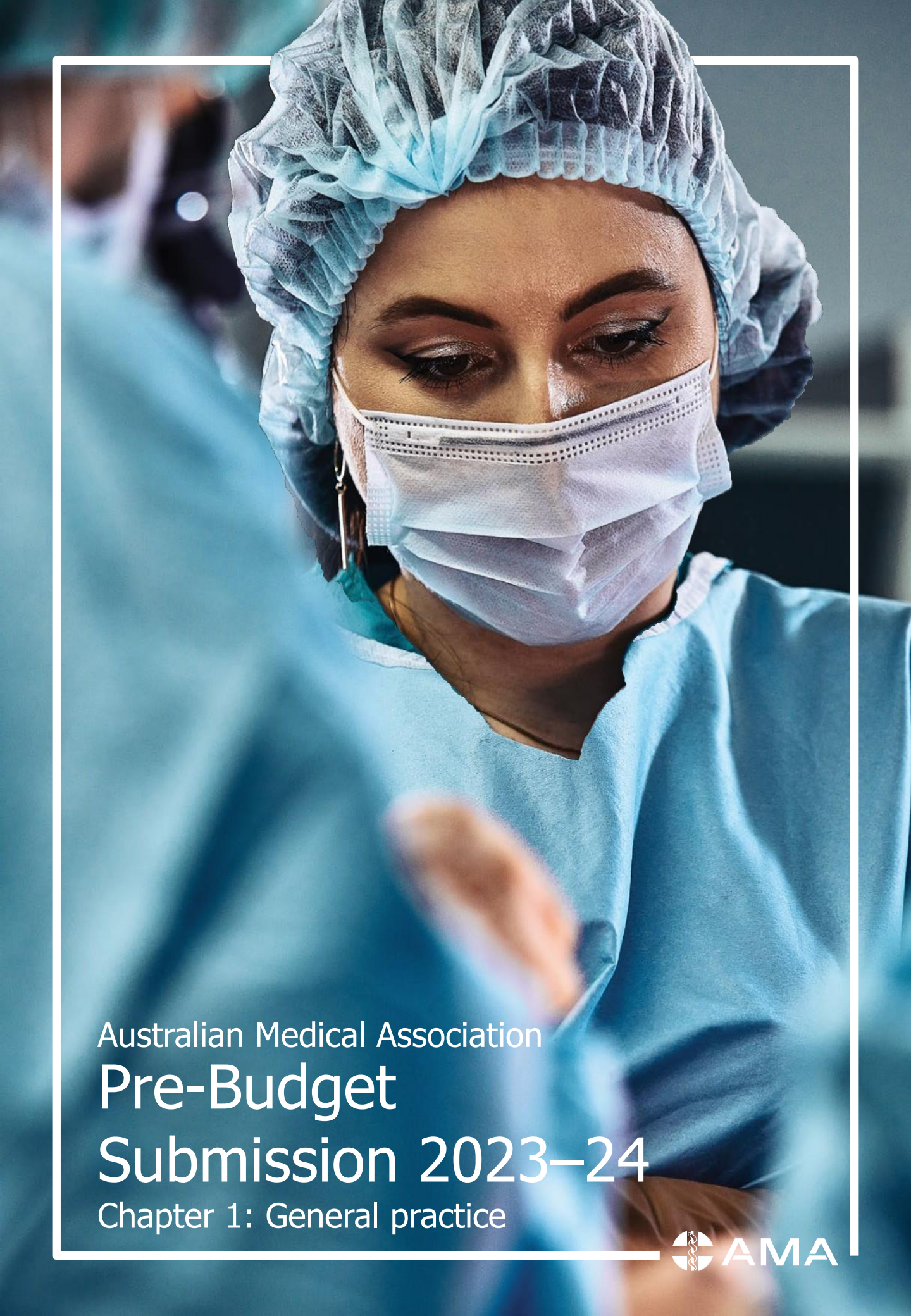

Australian Medical Association

Pre-Budget Submission 2023–24

Chapter 1: General practice

AMA

CHAPTER 1: GENERAL PRACTICE

Note: some of the costings are from 2022–23 to 2025–26 to align with the related AMA research reports.

Overview

This chapter of the *AMA Pre-Budget Submission 2023–24* draws on *Delivering Better Care for Patients: The AMA 10–Year Framework for Primary Care Reform*, the AMA research report *Putting health care back into aged care*, and the AMA research report *Solutions to the chronic wound problem in Australia* with some of the modelling adapted and extended to give estimates of impact between 2022–23 and 2025–26.

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 is 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, the total Commonwealth expenditure on GPs in 2020–21 was $11.2 billion,[8] which is equivalent to only $437 per person.[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, 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.

Policy proposals

Priorities for the Strengthening Medicare Taskforce

The Commonwealth Government has committed to spending $750 million to strengthen Medicare over three years. The AMA's key priorities for the Strengthening Medicare Taskforce include:

- Increasing the cap and indexing the Workforce Incentive Program (WIP), which 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.

  The AMA proposes that the government increase the cap on the incentive available under the WIP to 7,000 Standardised Whole Patient Equivalent (SWPE) initially, with a view to uncapping it in the future, 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.

- Improved access to GPs afterhours, by aligning the definition of afterhours with the Approved Medical Deputising Service (AMDS), which is any period outside 8:00am until 6:00pm on weekdays and outside 8:00am until 12:00pm on Saturdays. As the current Medicare arrangements discourage GPs from offering in-clinic services afterhours, patients are often diverted to an AMDS or the emergency department. Aligning the definition to the AMDS will improve patient access to afterhours care through their usual GP or general practice.

- Implementing Voluntary Patient Enrolment (VPE), which 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.[11] VPE 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. VPE should be offered to all Australians, and the process for enrolling patients should be as simple as possible.

  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. It will also generate savings, which can be used to implement other necessary reforms, such as wound care for targeted chronic wounds.

While the Commonwealth Government's $750 million commitment is welcomed, additional long-term investment will be required to fund the priorities identified by the Strengthening Medicare Taskforce, as well as other priorities to ensure people have access to evidence-based primary care and to stem the immediate GP crisis (outlined below).

Wound care for targeted chronic wounds

It is widely acknowledged that chronic wounds represent a significant health and economic burden in Australia. Research suggests that chronic wounds affect approximately 450,000 Australians at any time, costing the health system around $3 billion each year.[12,13,14] The current funding arrangements do not support general practices to deliver evidence-based wound care, as the costs of providing the appropriate consumables results in a net financial loss for many general practices. Many patients are therefore required to purchase consumables from the pharmacy at retail price, or alternatively seek treatment at community healthcare settings that provide free wound care such as hospital outpatient clinics.

The government should establish a funded wound consumables scheme to subsidise the cost of wound dressings and other consumables for patients with specific chronic wounds. This will remove the cost barrier to accessing appropriate and evidence-based wound care products, reducing the financial strain on both patients and general practices. New MBS items should also be established to better support general practices in assessing and managing chronic wounds, and improve the delivery of evidence-based wound care.

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 managing 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.[15] 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).

New MBS consultation item to support longer consultations

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 a new attendance item to be introduced for consultations between 15 and 19 minutes. This is consistent with the recommendation in the government's own Medicare Benefits Schedule (MBS) Review that Medicare must support GPs to spend more time with patients. This longer item will encourage prevention, support timely access to early intervention, and enable a more comprehensive approach to care. It will also reward quality and value-based care and ensure that patients can spend the time they need with GPs.

Risks and implementation

Priorities for the Strengthening Medicare Taskforce

Increasing the cap and indexing the WIP

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.

Improved access to GPs afterhours

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.

Implementing VPE

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.[16] 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.[17,18]

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.[19]

Wound care for targeted chronic wounds

It is recommended that the wound consumables scheme be initially implemented for concession and healthcare card holders, and then subsequently expanded to all patients with chronic wounds. Prioritising concession and healthcare card holders will ensure that those patients who are likely to be greatly impacted by the costs of consumables are prioritised during the implementation of the scheme.

As recommended by the MBS Review Taskforce Wound Management Working Group, it is recommended that new MBS items be established to support general practices deliver evidence-based wound care, including:

- an item for the general practitioner to perform a comprehensive initial assessment of a chronic wound
- an item for the general practitioner to perform regular assessments of the chronic wound
- an item for an appropriately trained practice nurse, Aboriginal and Torres Strait Islander Health Practitioner, or Aboriginal Health Worker to provide short term treatment of a chronic wound.

These new MBS items would facilitate a stepped care model for wound care, and would be linked to regular education and training to encourage upskilling of those involved in managing wounds and evidence-based practice. Additionally, improved coordination education and training requirements as well as reform initiatives would reduce the duplication of effort and silos that currently exist in the sector. As patients with chronic wounds often suffer from other chronic conditions and comorbidities, it is recommended that the proposed new MBS items and funded wound consumables scheme be linked to voluntary patient enrolment to support the delivery of coordinated care.

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.[20]

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.

New MBS consultation item to support longer consultations

Implementing the proposed longer consultation item for consultations between 15 and 19 minutes 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.

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.[21] 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,[22] 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.[23] It will also result in poorer health outcomes for patients, which in turn is associated with absenteeism, presenteeism, lower productivity, and lower workforce participation.[24,25]

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 2022-2023 Budget.

Priorities for the Strengthening Medicare Taskforce

Note: The below priorities have not been costed as the Commonwealth Government has committed to spending $750 million ($250 million per year from 2023–24) to strengthen Medicare over three years. These initiatives however will require long-term funding to ensure their value does not deteriorate over time.

Increasing the cap and indexing the WIP

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,[26] as well as the current distribution of GPs working in practices of size 1, 2–5, 6–10 and ≥11 in 2019.[27,28,29] 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 1: 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
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**

Improved access to GPs afterhours

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

	2022–23	2023–24	2024–25	2025–26	Total
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	90.6	**339.7**

Implementing VPE

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 between 2022–23 and 2025–26. This assumes that there is a 75 per cent uptake of services through VPE.

As outlined above, this $224.7 million saving could be used in establish a funded wound care scheme and wound care MBS items to improve the delivery of evidence-based wound care in general practices (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 3: 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
Cost recovery by linking chronic disease management MBS items to VPE ($m)	22.7	48.2	51.2	54.3	176.5
Cost recovery by linking health assessment MBS items to VPE ($m)	5.1	10.9	11.6	12.3	39.9
Cost recovery by linking medication management review MBS items to VPE ($m)	1.1	2.3	2.4	2.5	8.3
Net revenue to government ($m)	**29.0**	**61.5**	**65.2**	**69.1**	**224.7**

Wound care for targeted chronic wounds

For patients with chronic wounds (note: the AMA's analysis focused on diabetic foot ulcers, arterial leg ulcers, and venous leg ulcers, and does not include pressure wounds or acute wounds), the consumables scheme is estimated to cost the Commonwealth Government $3.7 million in 2022–23 ($16.1 million from 2022–23 to 2025–26) for the estimated 30 per cent of concession and healthcare card holders that would access wound care through a general practice (as opposed to another healthcare setting such as a hospital outpatient clinic). If this program was expanded to all patients (i.e. not just concession and healthcare card holders), this scheme is estimated to cost $5.3 million in 2022–23 ($22.9 million from 2022–23 to 2025–26).

Implementing the new MBS items for the general practitioner and appropriately trained practice nurse, Aboriginal and Torres Strait Islander Health Practitioner, or Aboriginal Health Worker is estimated to cost the government an additional $1.7 million in 2022–23 (7.4 million from 2022–23 to 2025–26). This additional cost is on top of what is already funded for the treatment of wounds through the existing MBS consultation structure and the WIP, and accounts for the proposed changes to the consultation structure.

The total savings for the delivery of evidence-based wound care is estimated to be $47.1 million in 2022–23 ($203.4 million from 2022–23 to 2025–26). Additionally, the implementation of the MBS items for trained practice nurses, Aboriginal and Torres Strait Islander Health Practitioners, or Aboriginal Health Workers is estimated to "free up" around 148,000 general practitioner consultations in the first year, and 162,000 consultations by the fourth year, as under the current consultation structure a general practitioner is required to be present on all occasions to bill the MBS.

Table 4: Summary of the impact of evidence-based wound care[30]

	2022–23	2023–24	2024–25	2025–26	Total
Cases	76,250	78,750	81,000	83,250	319,250
Hospitalisation	27,750	28,750	30,000	31,250	117,750
Investment					
MBS ($m)	1.7	1.8	1.9	2.1	7.4
Consumables ($m)	3.7	3.9	4.1	4.3	16.0
Total cost to government ($m)	**5.3**	**5.7**	**6.0**	**6.4**	**23.4**
Savings					
Savings in-patient hospital ($m)	19.9	20.8	21.6	22.6	84.9
Patient savings ($m)	3.7	3.9	4.1	4.3	16.0
Out-patient savings ($m)	22.0	23.4	24.7	26.1	96.2
Other community savings ($m)	1.4	1.5	1.6	1.7	6.3
Total saved ($m)	**47.1**	**49.6**	**52.1**	**54.7**	**203.4**
Return on investment multiple	8.808	8.72	8.65	8.57	8.68
Total government savings ($m)	16.6	17.4	18.3	19.2	71.6
Net savings to government ($m)	**11.2**	**11.8**	**12.3**	**12.9**	**48.2**

Refer to Appendix B of the AMA's research report *Solutions to the chronic wound problem in Australia* for further details and assumptions on how the cost of a funded wound consumables scheme and MBS items was estimated.

Aged care funding model

These costings represent a much-needed increase 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 costings assume that growth in RACF residents will slow due to the expansion of the Home Care Program, impact of the pandemic incentivising people to remain in their homes longer, with services delivered in RACFs now assumed to grow at 2.0 per cent per annum.

Table 5: Cost of increasing payments to GPs delivering services in RACFs

	2023–24	2024–25	2025–26	2026–27	Total
Cost of increasing payments to GPs delivering services in RACFs ($m)	128.1	133.4	141.6	153.4	556.5
Net cost to government ($m)	**128.1**	**133.4**	**141.6**	**153.4**	**556.5**

New MBS consultation item to support longer consultations

Implementing a new consultation item for consultations between 15 and 19 minutes will require a $1.03 billion investment from government from 2022–23 to 2025–26. The fee is assumed to be $54.66 (100 per cent of proposed MBS fee in 2021–22, where the new consultation 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 25 per cent of all Level B attendances are between 15 and 19 minutes. There is an estimated increase 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 longer consultation item MBS fee. There is also a conservative assumption that the entire increase in the new MBS item claims comes at the expense of fewer standard Level B attendances. The final cost may be lower if the new MBS item results in a reduced number of Level C attendances.

Table 6: Cost of implementing new MBS consultation item for consultations between 15 and 19 minutes

	2022–23	2023–24	2024–25	2025–26	Total
Cost of implementing a longer attendance item between 15 and 19 minutes ($m)	95.4	198.5	309.8	429.8	1,033.6
Net cost to government ($m)	**95.4**	**198.5**	**309.8**	**429.8**	**1,033.6**

Other policy priorities

Encouraging a career in general practice

Employment reform

The AMA is calling for the introduction of a single employer model for general practitioners in training. Under a single employer model, general practitioner registrars would be able to move between general practices without losing their entitlements. It would also bring remuneration and benefits like accrual of leave (sick/maternity) in line with hospital-based registrars to make entering a general practice training program a more attractive and viable option for registrars.

Exposure to general practice in medical school and prevocational medical training

The AMA is calling for the implementation of initiatives to increase exposure to general practice and primary care in medical school and during prevocational training. This includes:

- embedding exposure to primary care in the medical school curricula and reintroducing the John Flynn Placement Program for medical students (this was discontinued in early 2022)
- establishing a Community Residency Program (or similar) to promote stronger recruitment into general practice, by providing doctors in training with more opportunities to undertake prevocational training in general practice and ensuring more doctors have a fundamental understanding of the functioning of general practice and primary care.

Incentives to encourage rural practice

The AMA is calling for the introduction of incentives to encourage general practitioners (as well as all medical practitioners) to work in rural areas:

- provide rural, emergency/on call and advanced skills loadings and incentives that encourage doctors to work in rural areas and reward long service
- fund the establishment of networks between rural and city general practices to support non-metropolitan general practice e.g. share administration, provision of locum relief
- provide tax free infrastructure grants to rural practices to support investment in new technologies e.g. telehealth, home monitoring
- provide extra funding and resources to rural and regional hospitals to support the provision of adequate facilities, improved staffing levels and flexible work arrangements, e.g., core visiting medical officers, locum relief for GPs and non-GP specialists
- provide family support that includes spousal opportunities/employment, educational opportunities for children, subsidy for housing/relocation and/or tax relief
- improve access to educational support for rural doctors including continuing professional development and mentoring
- provide access to high-speed broadband in rural areas including the rollout of the National Broadband Network.
- implement models to address the market failure of small rural practices e.g. funding for local governments to adopt the AMA easy entry, gracious exit model.

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Note: each chapter of the AMA Pre-Budget Submission has its own reference list

Chapter 1: General practice

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[30] AMA modelled calculations of cost based on per case treatment cost under the proposed MBS items in a general practice setting compared with existing cost of treatment options under existing MBS Level A, B,C,D structure and the WIP. Other community savings was estimated per dressing change. Out-patient services cost was estimated by AIHW 'wound management' non-admitted item number 40.13. Consumables was estimated at $20.00 per dressing. Further detail is provided on all key assumptions in Appendix B of the research report.

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