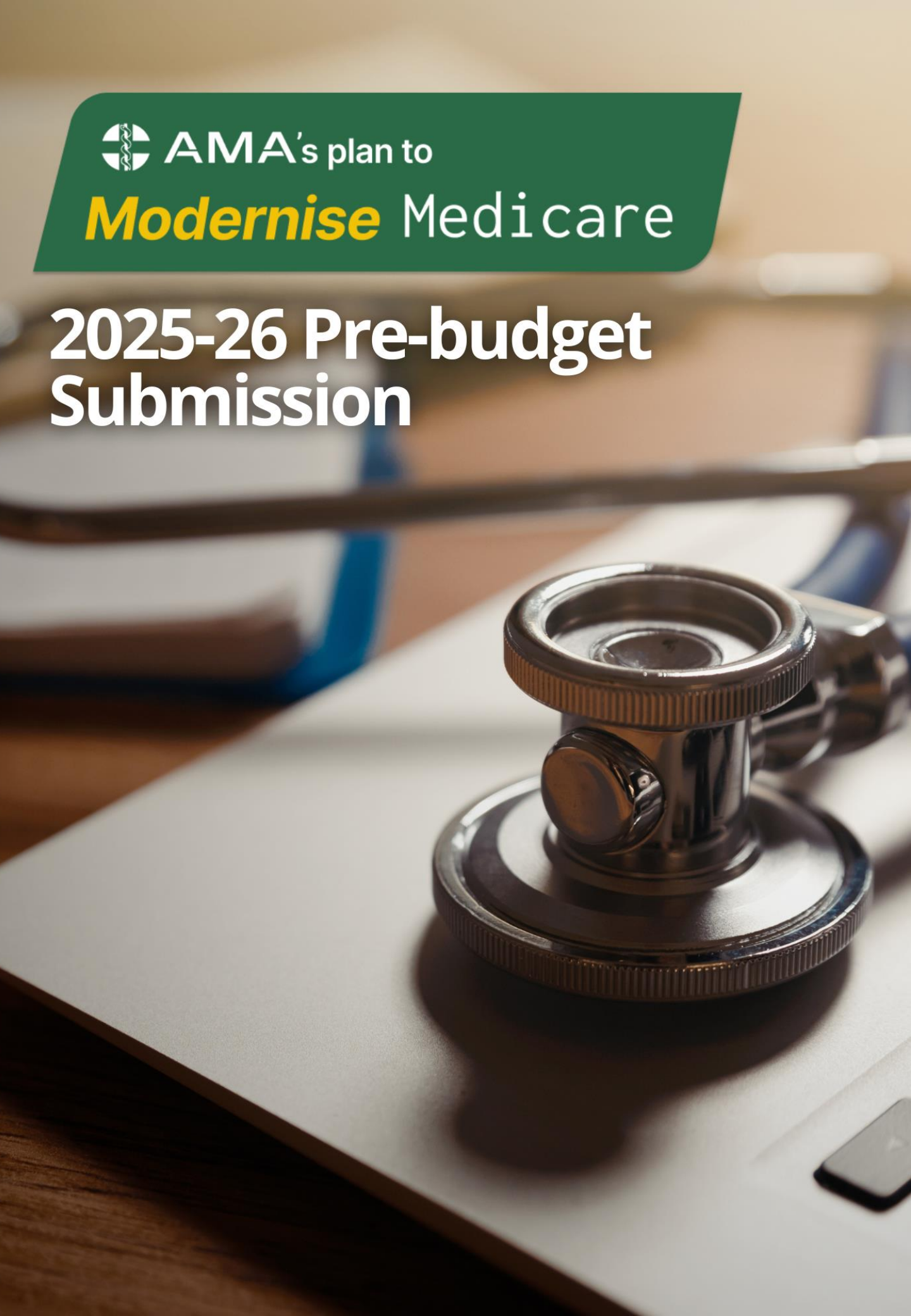
AMA's plan to

Modernise Medicare

2025-26 Pre-budget Submission



CHAPTER 1: GENERAL PRACTICE

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, in 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. National and international research 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]

Several years of the undersubscription of general practitioner training places in the Australian General Practice Training (AGPT) program, combined with growing community demand has left Australia with a shortage of GPs that is projected to get even worse over time. The shortfall projected varies between an estimate of 5,560 FTE by 2033 by the Department of Health, reinforcing the independent modelling by the AMA which projected a range of 3,600 up to a shocking 10,600 (FTE) by 2031 (see AMA report *The general practitioner workforce: why the neglect must end*).[6] General practice is no longer seen as a financially attractive career for many doctors, in part because there is disparity in remuneration and workplace entitlements between general practitioner registrars and their hospital-based counterparts.[7]

Despite investments in the 2023-2024 Budget, access to general practice remains a key issue, and many general practices are struggling to remain viable.[8,9]

The AMA has been advocating for increased Medicare funding, as the MBS no longer bears any relationship to the actual cost of providing services to patients (see AMA report *Why Medicare indexation matters* and *AMA analysis of Medicare indexation freeze*). [10]

To address the need to modernise Medicare to support general practice in the face of Australia's health needs, the AMA has undertaken a project to redesign the standard general practice consultation items, as the current consultation item structure is no longer fit-for-purpose. This proposal, along with the others outlined in this chapter aim to improve access to general practice by supporting patients to spend more time with their GP, encouraging more doctors to become general practitioners, better supporting our existing general practitioners, improve the collection of data to inform research and policy making in the future, and improve our workforce planning for future generations.

Previous AMA budget submissions have given support to the implementation of voluntary patient enrolment, which the government has adopted and called MyMedicare. MyMedicare recognises the central role of general practice in the health system and can support the delivery of better health care outcomes by strengthening the linkage between patients and their GP and providing a strong foundation to improve access to care through the better use of teams within a well co-ordinated GP led model. The AMA will continue to work with the government to develop MyMedicare as part of Australia's Primary Health Care 10 Year Plan 2022-2032.

Policy proposals

Reforming funding arrangements to basic GP item numbers

Until recently, the current basic GP Item structure, Level A, Level B, Level C, Level D had barely changed since the advent of Medicare. The only minor change was the recent addition of the Level E for consultations over 60 minutes in length.

A modern Medicare needs to recognise the changing nature of General Practice, evolving from frequent acute individual presentations to more complex conditions with patients increasingly suffering from mental health concerns and chronic illness. Patients need to spend more time with the GP, yet the structure of Medicare does not adequately support this care.

Clearly, our existing Medicare structure does not reflect modern health issues faced by patients and their treating GPs and as consultations get longer, inadequate Medicare rebates are forcing more GPs to pass on the costs to patients through an increase in out-of-pocket costs. The measures proposed here are part of the investment needed, but clearly more will be needed in future years as demand continues to grow for services.

A modernised Medicare that supports longer consultations will also better support Australia's female GPs. BEACH data has shown that female GPs often spend longer in consults with patients, despite the current Medicare system effectively providing a disincentive to do so.[11]

We also need to attract more GPs. In particular, attract GPs and simultaneously support them to treat people with the type of mental health, co-morbid and chronic conditions which can take more time, but if treated effectively at the primary care level, lead to a reduction in avoidable hospital admissions. Medicare funding must increase to reflect the growing cost of providing the care patients need, and support GPs in undertaking this critical work.

Risks and implementation

This reform requires a new standard consultation item structure for general practice that can support GPs in adaption to a changing health care environment. Medicare must be reformed so that it supports patients with acute presentations as well as those with more complex needs.

The AMA has undertaken extensive consultation with a broad range of GPs across the AMA. These GPs reflect a wide range of practices across diverse patient cohorts, and were chosen in order to use available data to find the best lengths to include in a new rebate structure, reflect the existing patient demand and how it is spread over time different periods, and account for the need to encourage longer consults to allow better treatment of complex and chronic conditions.

Importantly, the AMA invested the time to examine behavioural change for GPs to embrace the new funding structure and incorporated these changes into the base costing. The micro-level analysis of individual GP behaviour to the proposed new patient rebate levels (Level 2 to Level 5) underpins this change, recognising the government's previously stated intention to deliver more support for GPs to care for patients.

The proposed reformed rebate structure has 7 tiers, ranging from Level 1 (0-5 mins), Level 2 (6 –15 mins), Level 3 (16 – 25 mins), Level 4 (26 – 35 mins), Level 5 (36 – 45 mins), Level 6 (46- 59 mins), Level 7 (60 and over mins).The proposed rebates are Level 1 - $19.60, Level 2 - $45.00, Level 3 - $78.25, Level 4- $111.75, Level 5 -$149.00, Level 6 - $186.30, and Level 7 - $260.80 (Level 6 and Level 7 are stepped rebate levels based on consistent time intervals with the micro-level analysis of Level 2- 5 GP behaviour).

This reformed rebate structure provides a modest lift for shorter consultations - $2.15 in additional funding for a 10-12 minute patient consultation. However, it simultaneously recognises that the patients who need to see their GP for an extra 5-10 minutes will receive an additional $35.40 in the patient rebate to allow this to occur. This will enable the patient to pay less out of pocket, with more GPs able to provide the longer care, while limiting the out-of-pocket impact.

Risks of not taking action

Failure to act now to reform Medicare to equip general practice to face the future health demands of the nation will have significant impacts on both patients and the health system.

Firstly, those with chronic conditions, mental health concerns and complex care requirements will continue to be underserviced, and result in higher costs as they rely on the hospital system once their conditions worsen.

Secondly, Australia will fail to attract sufficient doctors to general practice, further worsening the current workforce shortage. Without better funding and sustainability, it is also likely GPs will seek to retire earlier than planned and this will mean patient access to care will deteriorate further.

Failure to invest properly in general practice is already seeing band aid solutions being implemented, including by state/territory governments. These fragment care by increasing the scope of practice for the non-medical workforce outside of a GP led model, which undermines the very system that has served Australia so well. It is not the optimum model of care, and detracts funding from the system that has served Australia so well.

Timeframe and costing

The AMA has estimated the cost of reforming basic consultation item structure over the forward estimates, allowing for additional supply from GPs, growing by more than 5 per cent.

Table 1: Estimated cost of reforming basic consultation items from 4 to 7 tiers

	2025–26	2026–27	2027–28	2028–29	Total
Reform to basic consultation items ($bil)	1.01	1.08	1.15	1.23	4.5
Total cost to government ($bil)	**1.01**	**1.08**	**1.15**	**1.23**	**4.5**

Policy proposals

Improving access to general practice by encouraging more doctors to become general practitioners – Equalise salary and leave conditions for GPs in training

After years of AMA advocacy, the Commonwealth Government has recognised the need to address the inferior pay and conditions of GP trainees, investing in single-employer model trials, with an additional $4.5 million for 10 trials and evaluation announced in the 2023–24 federal budget, and continued in the subsequent budget.[12]

While the announcement of these recent models was welcomed, the current workforce shortages and access issues are critical and must be addressed, and therefore reforms to general practitioner trainee employment conditions must be sector-wide. This will act as a lever to encourage more doctors to choose a career in general practice, as they will no longer need to face the prospect of a large reduction in pay and conditions when leaving the hospital system, and reduced access to entitlements during their training.

Beyond this proposal, we will need a comprehensive plan for workforce that considers public and private hospitals, primary care, aged care and NDIS, not to mention rural and regional medical workforce needs, based on local conditions and patient demand.

Risks and implementation

Reforms must not be done in a piecemeal way, however the current approach with state/territory and federal initiatives is uncoordinated. A comprehensive solution is required that deals with pay as well as the continuity of leave entitlements. Critical to the success of any scheme is the need to ensure that support and funding for training practices and general practitioner supervisors is not diminished in any way and, indeed, strengthened over time. We also need support for GP supervisors and training practices as a priority.

Risks of not taking action

The accessibility of general practice should be one of the key priorities for governments, as general practitioners play an integral role in preventing, diagnosing, and managing diverse medical conditions. The predicted shortages of general practitioners is a significant issue that will take years to address if nothing is done now to stem the crisis. If nothing is done now, patients will increasingly find it challenging to access care through their general practice, which will have an impact on health outcomes and increase the burden on emergency departments which are more expensive and are already operating at capacity.

Timeframe and costing

The AMA has estimated the cost of reforming employment conditions for general practitioner trainees to match their hospital-based counterparts. This costing covers rates of pay as well as parental, long service leave, and study/examination leave entitlements. Additionally, this costing is based on the number of Australian General Practice Training (AGPT) program trainees as an indicative estimate, noting that there are other pathways to fellowship and trainees on these pathways would also benefit from such reforms.

Table 2: Estimated cost of reforming employment conditions for general practitioner trainees

		2024–25	2025–26	2026–27	2027–28	Total
Salary boost ($m)		14.4	22.3	31.3	39.1	107.2
Parental, long-service leave, study/examination leave ($m)		18.6	19.2	19.8	20.4	78.0
Total cost to governments ($m)		**33.0**	**41.5**	**51.1**	**59.5**	**185.2**

Policy proposals

Improving access to general practice by encouraging more doctors to become general practitioners - More GP training places and more GP rotations

There has been greater focus by all levels of government on the need to recruit more GPs. In order to achieve this, we need to boost the number of GP trainees to enable the GP workforce to grow, otherwise there will be a shortfall as the population grows and our GP workforce ages. The range of shortfall projected varies between an estimate of 5,560 FTE by 2033 by the Department of Health, reinforcing the independent modelling by the AMA which projected a range of 3,600 up to a shocking 10,600 by 2031. To address this in the first instance, the AMA proposes an expansion into more areas of workforce shortage of the John Flynn Placement Program and the addition of 500 more training rotations, along with a phased progression of a further 500 funded AGPT places.

Risks and implementation

Additional training places must start soon and build to the level required to meet demand for GPs in the longer term. This must include addressing capacity constraints and ensure a consistent and well-developed pipeline of trainees into general practice.

The number of graduates from medical school willing to undertake GP training, those medical interns and registrars that have exposure to GP practices and the number of GP places available from GPs able to deliver Australian General Practice Training (AGPT) places.

Work must be done to improve the attractiveness of General Practice to improve the flow of medical graduates into GP training places.

Risks of not taking action

This chart shows the implications of the Department's own labour modelling of GP supply shortfall. Even under the Department's conservative assumptions, the demand-supply gap will continue to widen into the future. The AMA's proposal of an additional 500 rotations will not close the supply gap, but it will slow the growth, and hopefully stabilise it until further investment and action can be taken.

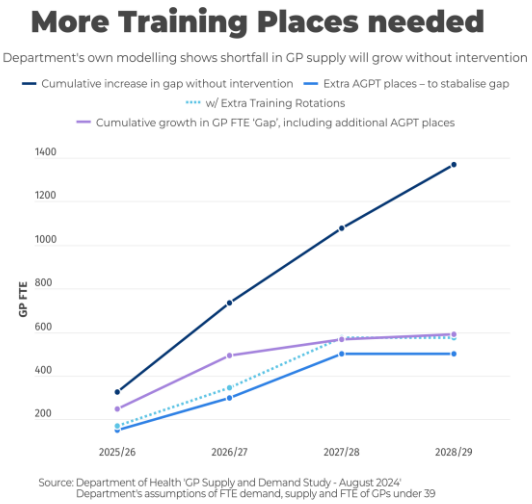


Figure 1.1: GP Full Time Equivalent 'shortfall' and additional GP Places (number)

Timeframe and costing

The AMA has estimated the cost of increasing the number of AGPT training places by 500 trainees as well as increase the number of rotations by 500, phased in over the 4 years. This costing covers rates of pay as well as parental, long service leave, and study/examination leave entitlements. Additionally, this costing is based on the number of AGPT program trainees as an indicative estimate, noting that there are other pathways to fellowship and trainees on these pathways would also benefit from such reforms. The benefit for patients would be immediate, with the additional trainees working in general practice providing increased capacity and supporting improved access to care within a well supervised environment.

Table 3: Estimated cost of increasing places for general practitioner trainees

	2025–26	2026–27	2027–28	2028–29	Total
Additional Rotations	160	300	500	500	
Additional AGPT Places	150	300	500	500	
John Flynn ($m)	1.6	3.2	5.4	5.5	15.7
AGPT Training Places ($m)	12.6	26.8	46.5	48.4	134.4
Total cost to government ($m)	**14.5**	**29.9**	**51.8**	**53.9**	**150.1**

Policy proposals

Improving access to care in general practice by supporting more nurses and allied health professionals to work in general practice

After years of AMA advocacy, the Commonwealth Government agreed to index the amount of the benefit paid under the Workforce Incentive Program (WIP) for nurses and allied health professionals (AHPs). Effectively lifting the maximum amount available under the program from $25,000 per subsidy to a maximum of $32,500, in the first year. This recognised the significant contributions being made by registered nurses and other allied health professionals within practices as well as the reality of the significant cost of their salaries.

Nurses' salaries are some of the fastest growing costs faced by a General Practice and this increase in funding made some contribution to keeping these vital workers part of the practice. Unfortunately, funding arrangements continue to constrain the number of nurses and AHPs are supported to engage.

Risks and implementation

This past reform, while an increase, needs further investment to recognise how modern GP practices operate. Many more practices today are much larger, with many containing 10 or more GPs. Removing the cap on WIP payments for nurses or AHPs will increase the capacity of practices to modernise to reflect the growing number of patients with chronic conditions.

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.[13] 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,[14] with 5.7 per cent or 660,000, of all hospitalisations in 2021–22 due to 22 preventable conditions that could be managed by general practice. It will also result in poorer health outcomes for patients, which in turn is associated with absenteeism, presenteeism, lower productivity, and lower workforce participation. [15,16]

Timeframe and costing

The AMA has estimated the cost of reforming with WIP for General Practices, based on the assumption that practices uptake will increase to the equivalent of 7000 SWPE compared to the current 4000 SWPE limit.

This costing assumes the base rate remains the same and continues to be indexed.

Table 4: Estimated cost of increasing the WIP payment to support more nurses or AHPs in general practice

	2025–26	2026–27	2027–28	2028–29	Total
Remove limits on WIP ($m)	93.1	97.8	102.7	107.8	401.4
Total cost to government ($m)	**93.1**	**97.8**	**102.7**	**107.8**	**401.4**

Policy proposals

Funding for better general practice information collection and research

High-quality general practice data plays a pivotal role in advancing both clinical care and service delivery, while also serving as a critical foundation for shaping primary care policy. Accurate and comprehensive general practice data assists in making informed decisions about patient treatment, diagnosis, and preventative care, particularly with the establishment of MyMedicare. It can also inform operational processes, enhance resource allocation, optimise appointment scheduling, and allow policymakers to identify trends, allocate resources effectively, and design evidence-based strategies for healthcare.

The Bettering the Evaluation and Care of Health (BEACH) dataset analysed general practitioner and patient interactions and patient management. It supported numerous academic publications, grant applications, provided data to various sectors, including industry, government, and non-profit organisations. It aided health system planning, policy development, educational material creation, and pricing decisions.[17]

Despite its effectiveness, the Commonwealth Government ceased funding for BEACH in 2016, and the commitment to "develop a more contemporary means of accessing general practice and primary health care research and data, to guide decision making and policy development," never materialised.[18] To this day, any serious policy proposal in General Practice still utilises BEACH data. The pressing need for more contemporaneous data is becoming dire as reforms are desperately needed.

Risks and implementation

Financial and structural support will need to be provided to general practices and general practitioners to support the translation of data into improved service delivery. Collection of data must leverage existing clinical management systems to ensure that general practitioners involved in the project are not burdened with additional administration. Additionally, analysis of the strengths and weaknesses of the BEACH data project should be performed so learnings can be applied to this new research and data project. There should also be adequate and long-term funding and resource allocation, along with a strong commitment to data privacy and ethics.

Risks of not taking action

The BEACH dataset is outdated, however many studies still rely on this dataset as there is no alternative. The Australian Government Department of Health and Aged Care: *Supply and Demand Study of General Practitioners in Australia* released in August of 2024 stated that there are still 'gaps' in the data available.[19] Researchers, policymakers, and industry stakeholders are therefore lacking contemporary insights into general practice, patient-based risk factors, and the effects of health service activity. This has a significant impact on policy development, program design, and ultimately the delivery of evidence-based healthcare services.

Timeframe and costing

The BEACH total budget was reported to be $1.3 million in 2007, of which 23 per cent was funded by the Commonwealth Government. Additionally, the original BEACH dataset was on a sample of 1,000 general practitioners, around 3.5 per cent of general practitioners in 2007.[20] Using this as a baseline, the AMA estimates that establishing a similar research and data collection project today would cost $17.5 million over the forward estimates. It should be noted that BEACH was able to secure funding from other sources, a model that could again be replicated, potentially bringing down the Commonwealth's contribution.

Table 5: Estimated cost of funding for general practice research and data

	2025–26	2026–27	2027–28	2028–29	Total
Total GPs	42,100	43,000	43,800	44,600	
Sample size	1,750	1,750	1,750	1,750	
Total cost ($m)	4.2	4.3	4.4	4.6	17.5
Total cost to government ($m)	**4.2**	**4.3**	**4.4**	**4.6**	**17.5**

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