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AMA response to the Report from the General Practice and Primary Care Clinical Committee: Phase 2

The AMA Federal Council supports the principles for a new value and quality-based model of primary care as outlined in the General Practice and Primary Care Clinical Committee's (GPPCCC) reports, namely:

1. Targeted long-term investment in general practice, particularly in GP stewardship, will underpin value in the health system and realise beneficial downstream savings.
2. In the interim, an immediate and meaningful investment in general practice is required to deliver much needed support to the sector.
3. Longitudinal care, population health and non-face-to-face care are not directly supported by fee for service and will be rewarded by new and complementary funding.
4. By formalising the existing relationships between GPs and patients, and strengthening mutual obligations and responsibilities, GP nomination is one of the fundamental principles on which high value primary care is built. Recognising and rewarding the GP-patient relationship will facilitate and enhance data collection, sharing and reflection.

AMA Federal Council views the General Practice and Primary Care Clinical Committee's reports as a starting point for the further discussion of the reform of general practice, while maintaining the AMA's continued opposition to capitation.

Our GP members have expressed overwhelming concern that the GPPCCC's recommendations do nothing to address the inherent inequities that already exist within the MBS items. For example, the more time a GP spends with a patient in consultation, as per Level A to D attendance items, the less that time is valued. As fee for service items will remain the primary source of remuneration into the foreseeable future, it is vital to correct this. Perverse incentives that encourage poor practice and high patient throughput must be replaced by a fee structure that promotes, supports and rewards quality practice. The AMA therefore suggests that the GPPCCC support longer GP consultations by including the introduction of an extended Level B item as one of the recommendations to be delivered to the Minister for Health.

Furthermore, our GP members are concerned that a number of the recommendations seek to reduce existing rebates. What general practice has been crying out for is a significant

injection of funding, not just a redistribution of the existing funding pool, to help them manage the challenges of an ageing population, increasing chronic illness and successive governments who have starved their front line of health care providers for quick budgetary gains. This is evident in the most recent Productivity Report on Government Services which revealed that around 2.9 million presentations to public hospital emergency departments that could have been handled by GPs. More funding is needed to enhance patient access to their GP and to support the management of increasingly complex patients in primary care, where they can be cared for more cost effectively.

While the AMA in its Shared Vision for Australia's health system with the Australian government committed to encourage further use and uptake of the My Health Record, locking GPs into uploading GP Management Plans, Case Conference outcomes, Health Assessments and Medication Reviews is additional administrative work with limited clinical value for the treating practitioner. Practitioners time and cognitive input to the My Health Record needs to be valued and thus remunerated to ensure active engagement with the record. The AMA cannot support this requirement unless it is supported by adequate new remuneration. Anything less merely continues to undervalue the work performed by GPs.

Response to Key Recommendations

1. Move to a patient-centred primary care model supporting GP stewardship.

The AMA welcomes the recognition of the role that GPs play, in conjunction with their patients, and through appropriate clinical decision making, in providing relevant and appropriate health care to their patients. The AMA would emphasise that the trusted relationship between doctor and patient is vital to open discussion and understanding of what care is clinically appropriate, the risks and likely outcomes. Knowing and understanding patient's views and desires regarding their healthcare is important in guiding GPs in their clinical decision making, and providing advice to the patient about possible care options to assist them in making an informed choice regarding their health care.

The AMA is supportive of any model of care that bolsters the trusted relationship between GP and patient that enables and ensures patients are actively involved in the decision-making about their health care.

2. Introduce a new voluntary patient enrolment fee.

As a part of providing comprehensive and longitudinal care, and in order to fund that care through blended payments, the AMA understands the need for practices to be able to define their patient population. With this in mind, the AMA believes that patients should voluntarily nominate the GP and the practice they will attend for the majority of their care. The AMA is uncomfortable with the term 'enrolment' as this implies that practices will be actively seeking to enrol patients, whereas in a patient-centred model it should be the patient choosing who their GP, primary general practice or medical home will be.

Regarding whether there should be a payment attached to nomination, the AMA would expect that the value of care afforded through the process of having a nominated GP/practice should be unlocked across the continuum of the patient's care by enabling access to telehealth and chronic disease management items and a retrospective quarterly payment similar to the CVC payment that supports non-face-to-face care. If an up-front

payment is introduced, it should it be nominal so that it does not encourage gaming. The AMA would suggest that a $40 fee would be reasonable to cover the costs of discussing the purpose and benefits of nomination with the patient and in formalising the nomination. The primary purpose of the payment should be to compensate for the administrative cost of enrolling patients and maintaining a register and database.

AMA members have expressed concerns around the ambiguous nature of terms such as (from page 30 of the Report from the General Practice and Primary Care Clinical Committee, 2018: Phase 2):

- Providing non-face-to-face access to enrolled patients
- Providing some after hours or emergency services for enrolled patients

Qualification around the non-face-to-face access and the after-hours or emergency services that GPs/practices will be expected to provide to the patients' needs to be provided. Patients who have voluntarily nominated a GP/practice should certainly have reasonable access but that should never be construed to mean immediate or 24/7 access – except where defined circumstances warrant it and it has been pre-arranged by the GP with the patient. There is a risk that the payment will not properly cover the true cost of providing these additional services, particularly if the payments are not indexed.

3. Introduce flexible access linked to voluntary patient enrolment.

The AMA supports the proposal that patients formally nominate their usual GP and general practice where they expect to receive the majority of their health care. This will help direct funding to the GP and practice for the services they provide to and on the patient's behalf outside of a consultation. This proposal also supports longitudinal care, without the restricting patients from seeking acute care elsewhere if necessary, such as when travelling.

The AMA has always advocated that telehealth services should be available:

- as an adjunct to normal medical practice;
- for regular patients of the practice;
- when it is clinically appropriate for the patient's circumstances.

However, it is important that there is an appropriate mix of payments and incentives so that the payment structure encourages provision of the best care for the patient and not provide perverse incentives to provide telehealth consultations when it is not clinically appropriate.

It is also important that flexible access is clearly defined, as noted in the response to Recommendation 2.

Applied correctly, this recommendation will align with aspects of the Bodenheimer's Quadruple Aim (i.e. patient experience and cost-effective health care) and the 10 building blocks for high performing primary care (i.e. empanelment, patient-team partnership, and continuity of care).

4. Combine GP Management Plans (GPMPs) and Team Care Arrangements (TCAs) and strengthen GPMPs.

The recommendation to combine GPMPs and TCAs aligns with AMA advocacy around the simplifying and streamlining of chronic disease management items to better support longitudinal care, effective chronic disease management, access to allied health services where clinically appropriate, while reducing the administrative burden imposed by requirements which are either repetitive or do not align with clinical workflows. The AMA would like to see requirements modified to enable greater support from the health care team in meeting the requirements of the item. For example, a member of the team should at the request of the GP be able to assist in explaining to the patient the steps involved in the review and obtaining and recording the patient's consent.

While the AMA supports the strengthening of GPMPs, members have raised concerns with the proposed inclusions for the explanatory note for Item 721. The phrase "all the patient's known health care needs, health problems and other relevant conditions" is open to misinterpretation. For plans to be effective, they must be focused on conditions that require coordinated care. We support comprehensive, coordinated care that focuses on the key health issues. The phrases "beyond the scope of existing chronic diseases" will also not be relevant for many elderly patients with multiple chronic conditions.

The AMA also cannot support the changes to the descriptor that sets a minimum time requirement of 40 minutes for the patient to spend in total with the GP and other health professionals in the GP's practice. The use of time as a measure of effort or quality is incongruous with the stated principles of the GPPCCC recommendations. This is especially so in the light of the move to equalise payments over a time period, leading to a significant reduction in the payment for the first 40 minutes. This also fails to recognise the dynamic nature of chronic disease management, where time spent will vary according to the needs of each at any given point in time.

When it comes to uploading the chronic disease management plan to My Health Record the AMA appreciates the flexibility proposed and the acknowledgement that it may not always be reasonably achievable to do so.

The AMA supports that patients will not be denied access to chronic disease management items where they choose not to nominate their GP and practice.

The AMA also supports that GPPCCC in its recommendations seeks to build on and enhance existing MBS items, in a manner which will not see patient's MBS benefits cashed out, ensuring MBS funding follows the patient.

5. Link allied health items to GPMPs.

This change is in line with recommendations of AMA Chronic Disease Plan and is therefore supported by the AMA.

6. Equalise the rebate for GPMPs and GPMP reviews.

This change is in line with AMA recommendations around removing front-loading to better facilitate and reward longitudinal care. However, the AMA would not be supportive of any

equalisation of the MBS fees where the total amount available to practitioners is less than current items would provide for, i.e. $690.85 per 12 months, as per below.

Description	*Item No*	*Minimum claiming period**	*MBS fee*
Preparation of a GP Management Plan (GPMP)	721	12 months	$144.25
Coordination of Team Care Arrangements (TCA)	723	12 months	$114.30
Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements	732	3 months	$72.05

The AMA also believes that clinical circumstances should determine when a patient review occurs, not the minimum claiming periods. The time periods listed should be used as guides only.

7. Increase access to care facilitation services for patients.

The AMA supports the option of block funding for care facilitation outside of the MBS. This would be provided to practices with enrolled patients to support staff capacity in providing care facilitation. However, this funding must cover the true cost of providing services, including administrative costs, and must not include a cap for how many GPs in one practice it will cover.

8. Activate and engage patients in their own care planning.

The AMA welcomes the recommendation to develop advice and support mechanisms to activate and engage patients in their own care planning, including assessment and support of patient health literacy. Not only will this empower patients in understanding their condition, treatment and management options, but will help to objectively inform their outcome expectations and drive their actions in obtaining the best health outcomes for them.

9. Rebate participation in case conferencing for non-GP health professionals.

The AMA has no objection to AHPRA registered allied health professionals privately practicing and who are a member of the patient's health care team being granted access to a rebate for participation in multi-disciplinary case conferencing.

The AMA is concerned however that the proposed new explanatory note as per Recommendation 9 on pages 45-47 of the GPPCCC Phase 2 Report requires each provider participating in case conference to seek the permission of the patient. This is an impractical requirement for both the providers and on the patient, and it should only be the responsibility of the coordinating practitioner to obtain the patient's, or the consent of the carer authorised to make health decision on the patient's behalf (if appropriate) for them to participate. We are also concerned that requiring every participant to make a recording of the meeting is unnecessary. This may make the process too onerous and promote administrative compliance over patient care.

The AMA supports patients having the opportunity to be involved (unless there is a valid clinical reason for them not to attend, which must be documented) in a multi-disciplinary case conference. Being involved empowers patients as a partner in their health care, provides assurance that their views and goals contribute to decision making process, and may strengthen the relationship between the patient, their doctor and the rest of the health care team. However, there is no mention of patients who are unable to participate in their care planning, for example patients with dementia. This must be acknowledged and guidance on how to proceed provided.

10. Build the evidence base for Health Assessments and ensure that the content of Health Assessments conforms to appropriate clinical practice guidelines.

The AMA supports evidence-based medicine and has no further comment.

11. Delete Health Assessments less than 30 minutes and expand the at-risk groups who are eligible for Health Assessments.

The AMA has no objection to the deletion of MBS item 701. The data signalling its declining use and indicating that the work involved in undertaking a health care assessment takes longer than 30 minutes.

The AMA supports the expansion of the remaining health assessment items to include new at-risk populations. However, the AMA is concerned that no rationale has been presented for why assessments for diabetes and chronic disease should be consolidated. The MBS currently allows for this assessment to be conducted every 3 years, yet the proposed change seems to have bundled diabetes and the chronic disease assessment item restricting its usage to once only (as per the current chronic disease risk assessment for people aged 45-49). This change would minimise the opportunity for assessing a patient's risk factor for diabetes or some other chronic condition and to make a plan to reduce that risk.

AMA advocacy ensured that nurse time was counted in the conducting of Health Assessments. With the expansion of the Workforce Incentive Program to include other allied health professionals, there is support for practices to expand their multi-disciplinary health care team to deliver cost effective and comprehensive care that best meets patients health care needs. The AMA therefore encourages the GPPCCC to recommend the wording of the explanatory notes for the Health Assessment items and the associated Fact Sheets be updated to make it clear that the time for any assistance provided by "any member of the practice team according to accepted medical standards who is an NRAS registered health professional", counts towards the time requirement for the item claimed.

By way of example, the explanatory notes for Health Assessments should include the following words as per the Health Assessment Fact Sheet:

> "Any member of the practice team who is an NRAS registered health professional may assist GPs in performing a health assessment, in accordance with accepted medical practice and under the supervision of the GP. This may include activities associated with:
>
> - information collection, including gathering of patient information for the medical practitioner and the taking and recording of routine measurements; and
> - providing patients with information about recommended interventions at the direction of the GP.

All other components of the health assessment must include personal attendance by the GP.

The time needed to undertake the aspects above of the health assessment by the practice nurse, allied health professional or Aboriginal and Torres Strait Islander health practitioner may be added to the time taken by the GP to complete the assessment."

12. Link Medication Management Reviews (MMRs) to GPMPs and reduce the schedule fee.

The AMA has no objection to the better targeting of MMRs and certainly agrees that if the fee is reduced that any savings should be reinvested back into general practice. However, the AMA will not support any reduction in the MMRs items for GPs. These items support pro-active care and better medication management and their use should facilitate savings where medications can be reduced and potentially preventable hospitalisations can be avoided by reducing the risk of adverse drug event. The GP has a number of responsibilities under this item and that should not be devalued.

While the AMA supports the use of an appropriately trained proxy in gathering information for these items as it aligns with better use of the multidisciplinary health care team, that should not be viewed as substitution of the claiming GPs overarching responsibilities. The fee should reflect the work involved, not who does it.

The AMA believes that if linking MMRs to GPMPs is to be successful, the pharmacist agreement must be linked to the MBS so that pharmacists can perform reviews annually if required (they are currently restricted to every 2 years), and that pharmacists must not be individually limited in how many reviews they can perform per month (they are currently limited to 20 per month). This will help achieve the stated rationale of improving access for patients in rural and remote areas.

13. Increase the rebate for home visits for patients with a GPMP.

The AMA welcomes this change as it will better support GPs to provide care to patients out of rooms. All home visits should have increased rebates as there are many patients not on GPMPs who are sick and may require home visits.

14. Introduce a 6-minute minimum time for a Level B consultation item.

AMA members are uncomfortable with the proposal to put a minimum time limit of 6 minutes on a Level B consultation. Not only does this effectively formalise 6-minute medicine, it disregards the breadth and quality of care that an experienced GP can provide in a short period of time for a patient they have long provided cared for. As noted in the response to Recommendation 4, the purpose of these changes to funding is to move from volume to value. To use a time base as a measure of effort is a backwards step.

Furthermore, the GPPCCC has provided no evidence to support the need for this additional administrative barrier. The AMA also queries what measures the Department of Health will require of GPs to prove compliance with the item. Are practitioners and their patients going to be made to feel like they on the clock? This would be contrary to the goals of the patient and provider satisfaction aspects of the Quadruple Aim.

15. Introduce a new Level E consultation item at 60 minutes or more.

The AMA has no objection to this recommendation, given it supports GPs being appropriately funded to spend additional time with the patient when clinically necessary. The fee for this new item would need to be an appropriate extension up from the fee for a Level D consultation to be acceptable to the AMA. The AMA notes the recommendation that the new schedule fee should have the same per-minute rate as a Level D consultation, which would make the minimum acceptable fee of $160.72.

16. Increase access to primary health care in Residential Aged Care Facilities.

The AMA supports the replacement of the derived fee with the introduction of a flag fall fee that goes to recognising travel and time away from consulting rooms when attending a residential aged care facility.

More, however, must be done to recognise the complexities of caring for aged care residents and to acknowledge the time that doctors spend with patients assessing and diagnosing their condition and providing medical care. A recent AMA aged care survey indicating that RACF attendance items need to be increase by at least 50% to compensate for the currently unpaid non-contact time in coordinating patients care.

Simply introducing a flag fall fee that compensates (partially) for travel does not adequately compensate for the complexity of aged care medicine and extensive non-consultation time spent with staff and families. Consultation item numbers must be increased to make quality medical care available to RACFs into the future. The AMA recommends including a telehealth item for providing after hours support and medical advice to staff and residents of RACFs will reduce after hours home visits and reduce overall MBS costs.

17. Update language across the MBS to better reflect the role of registered and enrolled nurses.

Broadly speaking the AMA supports updating the language across the MBS to ensure it is respectful and reflects the role of nurses within the general practice as part of the health care team.

18. Amend the specialist consultation telehealth items to enable GPs to claim the items.

The AMA welcomes this proposal to enable GPs to claim telehealth items. Additionally, the AMA strongly believes the descriptors should also be amended to reflect that those patients with mobility issues for whom attending a practice is problematic should have access to telehealth services. The recommendations mention this on page 10 as part of the rationale for extending access to telehealth items to GPs but then fails to confirm that at Recommendation 18.

The AMA also recommends the addition of a dedicated after-hours telehealth item for RACFs. As noted in the response to recommendation 16, a telehealth item for providing after hours support and medical advice to staff and residents of RACFs will reduce after hours home visits, reduce inappropriate and preventable hospital presentations, and reduce overall MBS costs.

Additional Comments

The AMA is grateful for the opportunity to comment on the Phase 2 recommendations. While we continue to support the principles for a new value and quality-based model of primary care, there is significant concern from our GP members that there is a lack of adequate funding. Without real funding to drive these changes, GPs will continue to perform hours of unpaid work each day.

The AMA believes that the aim of the changes must be to alter the balance from poorly coordinated, reactive care to high-quality care based on the fundamental principles of:

- Improved continuity of care;
- Improved co-ordination of care;
- Improved comprehensiveness of care;
- Enhanced modalities of accessing care;
- Patient Centredness; and
- Embedding a culture of continuous quality improvement through data evaluation.

Should you require any further information or clarification on the AMA's response to the Recommendations, please contact Michelle Grybaitis at mgrybaitis@ama.com.au.

Yours sincerely

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