RACGP

Royal Australian College *of* General Practitioners

Pre-budget submission

2021–22

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Pre-budget submission 2021–22

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Recommended citation

The Royal Australian College of General Practitioners. Pre-budget submission 2021–22. East Melbourne, Vic: RACGP, 2021.

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Published January 2021

We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

ID-350.8

Preface

Throughout the unprecedented events of 2020, general practitioners (GPs) and their teams were there for their patients. We provided advice about respiratory illness related to smoke inhalation, what to do if our patients thought they might have COVID-19, and how to manage their usual healthcare needs while in quarantine or isolation. We managed mental health care presentations among increased rates of anxiety and other psychological issues caused or exacerbated by the pandemic, and kept up to date with the constantly evolving messaging and emergence of new evidence around COVID-19 and the ongoing effects of the virus.

General practice has long been the most underfunded sector of the healthcare system in Australia, despite overwhelming evidence of the health benefits and economic savings that could be achieved by investing in primary healthcare.[1] If general practice does not receive a much-needed funding boost, recruitment to general practice training will continue to decline, and the future workforce will be jeopardised. Becoming a GP needs to be a sustainable and attractive career path for medical graduates. The number of eligible applications for the Australian General Practice Training (AGPT) Program has declined by 17% since 2015, while the number of Australian medical graduates has increased by 20% over the same period.[2]

Investment in the Medicare Benefits Schedule (MBS) is needed to ensure patient access to general practice services is not reduced and quality of care is not affected. Ensuring equitable access to healthcare in Australia requires adequate funding for general practice.

The federal government will this year work through reforms arising from the MBS Review, the Royal Commission into Aged Care Quality and Safety, and the Productivity Commission Inquiry into Mental Health. These reforms coincide with delivering the 10-year plan for primary healthcare and considering the future of Medicare-subsidised telehealth. Close collaboration with the medical profession is imperative for the government to achieve the best possible outcomes.

The outcomes of the current reform agenda will have long-term repercussions on the number of medical graduates who choose our specialty, and on engagement, retention and support for our GP workforce.

As the pandemic continues into 2021, presenting new complexities and challenges, the RACGP asks the federal government to work in partnership with us to support the continuation of the excellent care we provide.

This submission sets out practical steps to increase support for general practice immediately, and aligns with the spirit and intent of recommendations made by the aforementioned reform bodies: namely, to strengthen the stewardship role of general practice in the Australian healthcare system, and improve access to general practice care for all Australians.

The RACGP notes that negotiations around how voluntary patient enrolment (VPE) will proceed are ongoing and will form part of the 2021–22 federal budget. It is expected that the minimum $448 million spend set aside in the 2019–20 federal budget will remain available to support the rollout of VPE in 2021.

Dr Karen Price
RACGP President

Introduction

The Royal Australian College of General Practitioners (RACGP) thanks the federal government for the opportunity to contribute to discussions regarding the 2021–22 federal budget.

About the RACGP

The RACGP is Australia's largest general practice organisation, representing over 41,000 members working in or towards a career in general practice.

The RACGP is responsible for:

- defining the nature and scope of the discipline
- setting the standards, curriculum and training
- maintaining the standards for quality general practice
- supporting specialist GPs in their pursuit of excellence in patient and community service.

Recommendations

The RACGP calls on the federal government to commit funds to support the following recommendations.

1. Improve MBS funding

Improve patient access to general practice services through:

- increasing annual indexation of MBS rebates to support patient access to general practice care
- increasing the patient rebate for longer general practice consultations
- improving patient rebates to support mental health care, and coordination of mental and physical healthcare, by GPs.

2. Support MBS-subsidised telehealth consultations

Continue availability of adequately funded MBS-subsidised telephone and videoconferencing consultations for all Australians.

3. Introduce new funding models for general practice

Support the longer-term viability of general practice by introducing sustainable new models of funding patient access to general practice services, starting with the introduction of funding to support care coordination.

Recommendation 1 – Improve MBS funding

The RACGP calls on the federal government to improve patient access to general practice services through:

- **increasing annual indexation of MBS rebates to support patient access to general practice care**
- **increasing the patient rebate for longer general practice consultations**
- **improving patient rebates to support mental health care, and coordination of mental and physical healthcare, by GPs.**

The issues

The year 2020 was one like no other. It saw GPs and general practice staff across the nation hold the frontline in the fight against the COVID-19 pandemic and the 2019–20 summer bushfires.

GPs continue to work tirelessly to safeguard the health of Australians, but they report increasing pressure, after years of inadequate MBS support. If patient rebates do not significantly increase, patient access may be negatively affected by rising out-of-pocket costs.

Despite the vast majority of patient care being provided in the highly efficient primary care sector, year after year most government expenditure on health is dedicated to the hospital system. The percentage of total government health expenditure on hospitals continues to increase each year, while the percentage spent on primary care has gradually declined.[3]

Expenditure per person on general practice was $391 in 2018–19, a decrease in real terms from $395 per person in 2017–18.[4] Total government (state/territory and federal) expenditure on general practice services is around 7.4% of health expenditure.[4]

As the effects of the COVID-19 pandemic continue to be felt by the Australian population over the short and long term, it is vital that patients are adequately supported to spend time with their GP, to discuss their healthcare needs for chronic conditions and multimorbidities, their mental health needs and preventive healthcare.

Patient out-of-pocket contributions to access health services continue to increase each year. The average patient out-of-pocket cost to see a GP is now higher than the Medicare rebate for the most commonly used general practice item (standard GP consultation less than 20 minutes – item 23).

To support patient access to affordable general practice care, the federal government must increase investment in MBS patient rebates. This support is needed now more than ever, to help GPs manage the ongoing physical and mental health impacts of the pandemic, and future natural disasters caused by climate change.

Actions required

Investing in primary care is a highly effective way of improving the health of the population, as it targets preventive healthcare to keep people healthy and out of the more costly hospital system.[5] The RACGP recommends the following target areas for government investment.

Increasing annual indexation of MBS rebates to support patient access to general practice care

The RACGP proposes to increase annual indexation from 1.5% to 1.99%.

Indexation at a rate of 1.99% per annum for MBS items used in general practice would require an investment of $46.4 million in the first year (Table 1).

Table 1. The cost of increasing indexation of MBS rebates to 1.99%		
Measure	**Additional cost, year 1 ($m)**	**Additional cost, years 1–4 ($m)**
Indexation at 1.99%	$46.4	$523.7

Increasing patient rebates for longer general practice consultations

The MBS Review Taskforce recommended that the Minister for Health '[u]ndertake additional research regarding the appropriateness of the current length, content and minimum quality metrics for GP MBS consultation items (Level A–D)'.[6]

The RACGP notes there are considerable issues with the current time-tiered MBS rebates in general practice. Due to poor weighting of rebate values and overly long time intervals, the patient's rebate reduces dramatically per minute if they need to spend more time with their GP. This creates significant disadvantages for patients with chronic and complex health needs. The RACGP expects that the review will address some of these disadvantages, and strongly encourages the Minister for Health to support this work in the federal budget.

However, swift action is required to better support patients to spend time with their GP now. The RACGP proposes that longer consultation items (Level C and Level D) be increased by 18.5% (Table 2).*

Table 2. The cost of increasing patient rebates for longer consultations		
Measure	**Additional cost, year 1 ($m)**	**Additional cost, years 1–4 ($m)**
Level C +18.5%	$334.7	$1522.7
Level D +18.5%	$48.1	$222.5
Level C +18.5% + indexation at 1.99%	$382.6	$2065.7
Level D +18.5% + indexation at 1.99%	$94.7	$749.0

The MBS Review Taskforce also recommended the Minister for Health '[i]ntroduce a new Level E consultation item for consultations of 60 minutes or more by a GP'.[6]

An adequately funded Level E consultation item would support the provision of care for people with chronic and complex conditions, allowing patients time to discuss their care needs and further develop trusted relationships. This allows patients and GPs to work in partnership and fosters patient-centred care.

The RACGP recommends the rebate value for a Level E attendance be at least $192.49.†

The costs as a result of introducing a Level E consultation (Table 3) will be partly offset by a corresponding decrease in billings for Level D consultations.‡

Table 3. The cost of introducing a Level E consultation item		
Measure	**Additional cost, year 1 ($m)**	**Additional cost, years 1–4 ($m)**
Level E	$65.7	$274.8

* Refer to calculations in Appendix 1, *RACGP recommendations on professional attendances items used in general practice*. Note: This loading value is applied wherever a new item number is recommended in this submission.

† Calculation: Level D ($110.50) + equivalent increase from Level C to Level D (47%) + 18.5% loading.

‡ Services have been estimated at 20% of current Level D services, and increasing at a rate of 3% each year, based on the 10-year average increase in out-of-hospital non-referred GP/vocationally registered services.

Improving patient rebates to support mental health care, and coordination of mental and physical healthcare, by GPs

The Productivity Commission recommended in its final report from the Mental Health Inquiry that governments should '[i]mprove outcomes for people with comorbidities' and '[a]gree to an explicit target to reduce the gap in life expectancy between people with severe mental illness and the general population, and develop a clear implementation plan with annual reporting against the agreed target'.[7]

The RACGP notes that GPs, as generalists and the first point of contact for patients seeking care, are best suited to provide ongoing care coordination for patients with mental and physical healthcare needs. However, the MBS needs to be modernised to support this care.

As a first step, patient rebates for mental health care and physical healthcare should be aligned (Table 4). For example, unlike general consultation items, there is currently no unrestricted item for patients to spend more than 40 minutes with their GP discussing their mental health.

The cost of implementing this measure will be offset by a reduction in billing for the corresponding professional attendance item.

Table 4. Proposed mental health MBS item numbers

General consultation	Proposed rebate value
Level D mental health item number 40–60 minutes	$130.94
Level E mental health item number >60 minutes	$192.49

Recommendation 2 – Support MBS-subsidised telehealth consultations

The RACGP calls on the federal government to continue availability of adequately funded MBS-subsidised telephone and videoconferencing consultations for all Australians.

The issues

The RACGP welcomed the federal government's announcement that MBS-subsidised telehealth consultations will remain available for all Australians to consult with their usual GP. The benefits of flexible access to care for many groups has been demonstrated, with significant acceptance and uptake by patients, and strong demand for this continued flexibility from providers and patients.

The RACGP supports a model of healthcare that enables high-quality, comprehensive and coordinated services to be delivered across a range of settings, including telehealth where clinically appropriate.

Telehealth facilitates patient access to their usual GP, meaning patients can more easily receive high-quality and personalised services when and where it suits them. This will guarantee that patient access goes hand in hand with high-quality and appropriate care, including face-to-face consultations when required, delivered with respect to a patient's history, circumstances and needs.

GPs have embraced change during 2020 and rapidly adapted their models of care to ensure the safety of patients, ongoing accessibility of high-quality general practice care, and safety of practice staff. Overall use of telehealth increased significantly as a result of the pandemic, with 97% of GPs surveyed reporting they were providing care remotely. Of these GPs, 96% indicated they were consulting via phone and 30% via video. Just 15% of GPs were using telehealth in their practice before the pandemic.[2]

Despite the high uptake of telehealth, about 65% of GP consultations in April and May 2020 were provided face-to-face.[8] This shows that telehealth is complementing face-to-face care, with GPs deciding how best to meet their patients' needs.

Actions required

The RACGP calls on the federal government to consider the following points (a–d) when developing ongoing funding mechanisms for telehealth services in general practice. Patient rebates for all consultation types (phone, video and face-to-face) must remain available to all Australians, be set at equal values, and all consultation types must be adequately rebated and financially supported by the federal government.

(a) Equality of access

The introduction of telehealth has had a marked impact on creating better avenues of access for all patients. For example, in the Aboriginal and Torres Strait Islander health sector, telehealth helped remove a cultural barrier of attending a practice for a face-to-face appointment.

The federal government has indicated a preference for telehealth consultations to be provided via video wherever possible. However, not all patients and practices have access to the necessary skills and technology to allow for this.

It is important that the gains achieved in improving patient access are not compromised.

Patient rebates for all consultation types (phone, video and face-to-face) must be equal. A patient's access to phone, video or face-to-face consultations with their GP must not be impeded by any variation in rebate value. Choice of consultation type takes into account the patient's preferences and life circumstances, including where

they live, their level of comfort with technology, their access to technological devices and their socioeconomic status. It is important that financial support for all consultation types remains available and of equal value to avoid discrimination against any patient group.

The RACGP proposes nil additional spending to achieve this priority. Telehealth item numbers represent a shift from other general consultation item numbers.

(b) Policy considerations around telehealth and access

The RACGP is supportive of the government's existing relationship requirement implemented on 20 July 2020, which ensures continuity of care between patient and GP.

The RACGP will continue to work with the government to fine-tune this policy to ensure no patients are disadvantaged by this rule. There are situations where it is appropriate for a GP to provide care to an unknown patient via telehealth. Some GPs provide specialised care for women's health, eating disorders, mental health, obesity or LGBTIQ services. There are often considerable barriers for patients to access these services locally, and patients may not have had a prior face-to-face attendance.

The RACGP recommends patients should have access to MBS-subsidised telehealth services from these GPs if they have not had a face-to-face attendance in the past year, with a referral from a patient's regular GP serving as the linking mechanism (as with non-GP medical specialists).

Further, patients in rural and remote areas are less likely to see their GP frequently due to geographic barriers. The RACGP recommends that the 12-month rule be progressively relaxed (to 24–48 months), based on the patient's level of geographic isolation.

(c) Patient rebates must recognise the time and expertise of the GP

The same level of GP expertise is used to provide patient assessment and advice, regardless of the consultation media used (phone, video or face-to-face). A patient's rebate must reflect that they are receiving the same level of expertise, and be valued equally.

Some consultation formats require additional time in administrative tasks; for example, establishing the patient's identity virtually, or obtaining consent regarding access to medical records.

The RACGP proposes nil additional spending to achieve this priority. Telehealth item numbers represent a shift from other general consultation item numbers.

(d) Practices must be supported to meet infrastructure costs of telehealth

Video consultations can incur additional infrastructure costs (eg new software, licensing, hardware). General practices are not able to absorb these additional costs. The RACGP calls on the federal government to invest in the future of telehealth, and support practices to meet these additional costs through the introduction of a time-limited grant program for telehealth infrastructure and IT requirements.

Recommendation 3 – Introduce new funding models for general practice

The RACGP calls on the federal government to support the longer-term viability of general practice by introducing sustainable new models of funding patient access to general practice services, starting with the introduction of funding to support care coordination.

The issues

The COVID-19 pandemic is an opportunity for innovation and a prompt for long-overdue health funding reform. The RACGP's *Vision for general practice and a sustainable healthcare system* (the Vision) outlines the urgent need to restructure the healthcare system into one that provides the right care for patients at the right time and in the right place, and that is sustainably funded into the future.

In 2020, the MBS Review Taskforce noted that the MBS fee-for-service model is adequate for treating patients with short-term ailments or singular interventions. However, where multiple interventions or team-based care are needed for ongoing or complex care, alternative funding models should be considered to complement the MBS and support patients to achieve the best possible health outcomes.[9]

Actions required

The RACGP endorses the MBS Review Taskforce's recommendation to the Minister for Health to '[e]valuate and implement alternative funding models that complement the MBS'.[6]

The RACGP supports blended payment models and welcomes more flexible approaches to funding general practice services. It is important that stakeholders be included in the design of any new payment models. The RACGP counsels the government against using this exercise to find efficiencies through alternative funding solutions.

The MBS Review Taskforce's recommendations demonstrate the current deficiencies in funding preventive and coordinated primary healthcare services. These deficiencies would be worsened should overall funding be reduced through the guise of reform.

The RACGP's Vision presents a way forward. PwC Australia estimates that implementing the Vision will bring about economic benefits by reducing the need for more expensive hospital care, and by improving the productivity of the nation through a healthier workforce. It is expected these benefits will promote health equity for Aboriginal and Torres Strait Islander people, people living in remote areas, and people living in low socioeconomic areas, who currently use disproportionately more hospital care than other groups.

In total, estimated minimum benefits of implementing the Vision to the Australian healthcare system is $1 billion in 2021 and $5.6 billion over the next five years, as well as 98,000 quality-adjusted life years (QALYs) gained in 2021 and 520,000 QALYs gained over the next five years.[10]

These benefits could extend to as much as $4.5 billion in 2021 and $24.8 billion over the next five years.[10] A further breakdown of estimated benefits is provided at Table 5.

Many non-monetary benefits would also follow from implementation of the Vision, including improved patient satisfaction with care and improved health provider satisfaction.

Table 5. Annual estimated economic and non-economic benefits of the RACGP's Vision ($m)[10]					
Metric	**2021**	**2022**	**2023**	**2024**	**2025**
Preventable hospitalisations for ambulatory care sensitive conditions	$152.4	$160.6	$169.2	$178.1	$187.5
Emergency department presentations	$552.0	$579.8	$608.4	$638.0	$668.8
Unplanned hospital readmissions	$68.8	$72.8	$77.0	$81.5	$86.1
Workforce productivity	$250.4	$258.4	$266.5	$274.7	$282.9
Total economic benefit*	**$1024**	**$1072**	**$1121**	**$1172**	**$1225**
QALYs gained	**98,000**	**101,000**	**103,900**	**106,800**	**109,800**
**Amounts have been rounded.*					

The MBS Review Taskforce has recognised that GPs play a pivotal role in supporting an effective and efficient healthcare system through responsible stewardship of healthcare resources, and that a strong relationship between the patient and their GP is at the heart of the Australian health system, and must continue to be supported.[9]

The RACGP recommends as a first step towards achieving these savings and acting on the MBS Review Taskforce's recommendations, the federal government should introduce funding to support coordination of care by a patient's regular GP (Table 6). Care coordination is a patient-centred activity, which delivers on the stewardship and relationship-based role of GPs and their teams. It can help people living in the community to remain well and reduce demand for more intensive healthcare services, while having the potential to increase provider, patient and carer satisfaction

This would include creating additional funding for GPs and their teams to manage patient transitions between their general practice and other parts of the health system, to complement the limited funding available via chronic disease management MBS items, and to support multidisciplinary team care in general practices.

Table 6. Cost of introducing health service coordination payment		
Measure	**Cost 2021 ($m)**	**Cost 2021–24 ($m)**
Introduction of health service coordination payment for most complex patients*	$258	$1057

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