Australian Divisions of General Practice

Submission to the Senate Select Committee on Medicare

December 2003

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SUBMISSION TO MEDICARE SELECT COMMITTEE

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The Australian Divisions of General Practice Ltd. (ADGP) is pleased to provide this submission to the Senate Select Committee on Medicare regarding the Government's proposed *"MedicarePlus*" package of reforms.

ADGP is the peak national body for the Divisions of General Practice network, comprising 121 local Divisions and 8 State Based Organisations. Over 90% of GPs are members of a Division, making the Divisions Network the largest GP representative group in the country.

Executive Summary

The response by the profession to *MedicarePlus* has been generally more positive than that to the initial "Fairer Medicare" proposal. GPs overwhelmingly opposed the compulsion inherent in the original proposal, and whilst the $5 incentive in MedicarePlus to bulk bill HCC holders and children under 16 will be welcomed by those GPs who choose this style of billing for the majority of their patients, ADGP believes it unlikely that the incentive will cause a substantial number of doctors to change their billing behaviour, particularly when the gap being charged to these groups of patients is more than the incentive being offered.

We are concerned, too, that a flat rate incentive across all items will further encourage rapid throughput of patients, when in fact longer consultations have been demonstrated to provide better health outcomes, particularly for patients with chronic and complex care needs. Ultimately, the incentives provide a stop gap measure that may assist access for some disadvantaged patients and children, however we believe that major ongoing reform involving all sectors within the health system, with a focus on increased investment in primary care, health promotion and prevention, is necessary to achieve substantially better health outcomes in Australia.

The severe and endemic medical workforce shortages mean it is paramount that ongoing strategies are put in place to increase the size of the workforce. These include increased opportunities to encourage non-practising GPs back into the workforce or to relocate, or the provision of incentives for graduates to choose a career in general practice. ADGP welcomes the *MedicarePlus* initiatives to increase the number of medical students and GP registrars and the streamlining of processes to allow overseas trained doctors (OTDs) to enter the workforce; however, there are ongoing concerns with the proposed process for introducing these initiatives.

ADGP, as one of the four major GP organisations comprising the General Practice Representative Group (GPRG), regards the Overseas Trained Doctor initiative announced as part of *MedicarePlus* as only an initial step to sustainable reform to resolve the workforce crisis.[1] The Divisions of General Practice are the facilitators of change in primary health care in Australia, and provide an avenue to explore and

[1] GPRG Statement on *MedicarePlus,* 27 November 2003 (accessible at http://www.adgp.com.au/site/index.cfm?PageMode=indiv&module=NEWS&page_id=2045)

implement innovative programs to improve and enhance the availability of health services in their local communities.

ADGP supports the initiative to have MBS items available for services provided by a nurse in general practice. Practice nurses are highly skilled health professionals who can complement the work of GP in providing high quality care and have a substantial impact on practice capacity. In the current situation of chronic workforce shortages, this has profound implications for improving access to general practice services. However, the scope of tasks provided by nurses for which the practice can attract a fee should not be limited to wound care and immunisations.

ADGP has also previously argued for expansion of the practice nurse subsidy to be extended to all practices in Australia. There is strong evidence of the effectiveness of structured multidisciplinary approaches to health service delivery in producing better outcomes for patients, and such initiatives should be accessible to patients of all general practices.

The HIC Online initiative has the potential to produce substantial savings for Government. The administrative cost of approximately 3% for every Medicare transaction performed in the practice will now be transferred to the GP. These savings should be reinvested in general practice to support the ongoing infrastructure and administrative costs of this measure to general practices, or there is a risk that these costs will be passed on to patients.

Further, it will be critical that the process to interact with HIC Online be fully automated and integrated into GPs' desktop software packages. Work with the software providers to integrate this function into their accounting modules must be pursued urgently. Broadband access may assist connectivity, but without seamless integration with standard software used by general practices, the initiative will struggle to succeed.

The lack of adequate infrastructure and funding for general practice services in aged care facilities has been a major issue for general practice. ADGP looks forward to working with Government on the detail of this initiative, to ensure appropriate support mechanisms are put in place.

Divisions of General Practice have been instrumental in many areas in supporting stronger links between general practitioners and the aged care sector. It is encouraging that Divisions have been highlighted in this initiative as playing a key supporting role to general practice in improving health care for residents of aged care homes, however there are substantial implementation issues arising from this proposal that will need to be worked through in consultation with the Divisions Network.

Dr Rob Walters,

Chair

Australian Divisions of General Practice Ltd.

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Workforce

The severe and endemic medical workforce shortages mean it is paramount that ongoing strategies are put in place to increase the size of the workforce. ADGP welcomes the *MedicarePlus* initiatives to increase the number of medical students and GP registrars and the streamlining of processes to allow overseas trained doctors (OTDs) to enter the workforce. The increased opportunities to encourage non-practising GPs back into the workforce are also welcomed.

Funding should also be made available to Divisions to provide professional and peer support to GP Registrars and to assist with integration of undergraduate, pre-vocational and vocational training, and continuing professional development and research, including support for doctors re-entering the GP workforce.

However, there are some ongoing concerns with the proposed process for introducing these initiatives, which are outlined below.

1. Additional medical school places

1.1. The increase in medical places by 234 per year is generally supported; however, bonding students to areas of workforce shortage for a minimum of six years and the lack of financial incentive for students to take up the bonded places, will not guarantee that more students will opt for general practice training unless this vocation is made more attractive. ADGP would prefer to see general practice promoted as a positive, attractive career pathway, and this can only occur if general practice is adequately funded and supported.

1.2. ADGP believes there should be HECS reimbursement for the bonded places, or an incremental reduction in the HECS debt for each year worked in an area of need, as currently offered under the *Regional Health Strategy: More Doctors, Better Services* measure. Consideration should also be given to making scholarships available should all the new places not be filled.

2. Additional GP Registrar places

2.1. The additional 150 GP registrar places per year are also welcome, however as recent experience in some areas has shown, there is no guarantee that all positions will be filled. There are many factors that influence the career decisions of newly trained doctors, including compulsory training placement terms, and any additional requirements may impact adversely on a newly trained doctor's decision to choose general practice as a career.

3. Overseas Trained Doctors

3.1. The *MedicarePlus* workforce initiative also seeks to increase doctor numbers by drawing from the pool of temporary and permanent resident overseas trained doctors (OTDs), through expediting and streamlining processes for

registration, approval and provider number allocation to OTDs. ADGP understands that the Red Tape Taskforce will be making recommendations in this area, and we look forward to working with the Government to progress this initiative. The Rural Workforce Agencies (RWAs) have been excellent in navigating the existing process, and along with Divisions, can provide valuable advice in the implementation of more efficient processes.

3.2. While many OTDs will elect to work in a rural or remote area of need and undertake an alternate pathway to vocational recognition (VR); there are others who, due to family constraints, language difficulties, cultural sensitivities and confusion about how to enter the system, will not re-enter medicine at all, including the public hospital system.

3.3. Ongoing workforce shortages mean that hospitals and State health departments will be competing with general practice for the same pool of overseas trained medical practitioners, as evidenced by the Commonwealth Government's willingness to allow State and local governments, hospitals and private providers to recruit OTDs to areas of medical workforce shortage.[2]

3.4. Australia also has an obligation to observe the tenets of the Melbourne Manifesto endorsed by WONCA 2002. The Melbourne Manifesto presents a code of practice for the international recruitment of health care professions, and has put the onus on every country to train enough health professionals to meet its own needs.[3]

3.5. Standards assessment

3.5.1. The GP workforce shortage crisis should not expose communities to underqualified or inexperienced doctors; suitable mentoring and supervision mechanisms must be in place to support OTDs who have trained in different environments and whose qualifications may vary to those achieved through Australian medical schools.

3.5.2. It is essential that OTDs should pass the FRACGP examination, within two years, to ensure medical standards and access to quality medical care is the same across all Australian communities. It should be noted that many permanent resident OTDs have migrated from the UK, Canada, South Africa and New Zealand, and have similar medical training to Australian graduates, therefore the level of support needed to up-skill and/or refresh their skills to attain VR status would be minimal.

3.5.3. OTDs could be supported via the Divisions Network to undertake their studies and maintain and enhance their skills base. Divisions already support GP educational activities, and many are now involved in the regionalised General Practice Training Program, which makes them ideally placed to support OTDs to attain and maintain VR status, i.e. Fellowship of the RACGP.

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[2] L Hawthorne and Bob Birrell, *Doctor Shortage and their impact on the quality of medical care in Australia,* People and Place, vol.10, no.3, 2002, pp 56 and 58.

[3] World Rural Health, 1-3 May 2002, *Melbourne Manifesto*.

3.6. Orientation

3.6.1. Lack of knowledge of the Australian health care environment was cited as a major issue with OTDs seeking to participate in the Rural Other Medical Practitioners (ROMP) Program. Doctors are placed in rural locations with little or no understanding of the Australian health system and how it operates. Specifically, GPs have highlighted issues surrounding prescribing procedures as well as other agencies in the health system, including the Health Insurance Commission, Department of Veterans' Affairs, Work Cover and Centrelink. A structured induction program for new doctors would be beneficial and provide adequate preparation for working in the Australian health system. Divisions of General Practice should be resourced appropriately to provide this crucial support role.

3.6.2. The occupational English examination that OTDs from non-English speaking backgrounds are required to take as a condition to be able to work in Australia is not necessarily a true indication of the communication skills of the doctor. Many OTDs require support to improve their English and communications skills, and this should be part of an orientation course for OTDs before being assessed eligible to practise in a rural community (i.e. eligible to participate in the ROMP or other similar programs) where culture support networks do not exist.

3.6.3. Further, OTDs who are actively engaged in a pathway to VR should have some reasonable guarantee of permanent or at least long-term Australian residency. It is not likely that our workforce shortages will be resolved soon, so it is unreasonable to string so many OTDs along if we expect them to commit to becoming highly qualified to participate in the Australian medical environment over many years.

3.7. Reducing RRMA inequities

3.7.1. The current Rural, Remote and Metropolitan Areas (RRMA) classification for rurality continues to disadvantage certain communities. In the 2002 Federal Budget, the Government introduced the *More Doctors for Outer Metropolitan Areas* measure that offers access to A1 MBS items and relocation grants of up to $30,000 as incentives to non-VR GPs working in inner metropolitan areas to relocate to a district of workforce shortage in designated locations of the six capital cities in Australia, excluding Darwin, i.e. RRMA1 areas.

3.7.2. Darwin is even further disadvantaged because it is excluded from the outer metropolitan program, plus its status as a RRMA1 population centre does not reflect its real level of remoteness, and precludes its participation in the ROMP and other recruitment and retention programs. An improvement to the ROMP Program would be to grant Darwin an exemption to the restriction on eligibility to RRMA4-7 classifications.

3.7.3. In addition, communities in RRMA3 regional centres are frustrated that outer metropolitan areas with workforce shortages are now given

preference to workforce incentives. This has accentuated the inequities for regional centres, making it even more difficult to attract doctors to RRMA3 areas such as Shepparton/Mooroopna, Albury/Wodonga, Bendigo, Wagga Wagga, Tamworth and Toowoomba. These communities could potentially face an exodus of doctors to areas where incentives are available.

3.7.4. There is a lack of recognition of the GP workforce shortage in RRMA3 communities where, in many instances, the GP to population ratio is much worse than in surrounding smaller rural centres. As an example, in March 2003 the GP to population ratio in Wagga Wagga was 1:2,172.

3.7.5. Similarly, a recent workforce survey clearly demonstrates the difficulties that Bendigo is having in maintaining its GP population; this is both due to the loss of GPs and the growth of Bendigo and the surrounding area. At the end of 2002, the GP to patient ratio was 1:1,727[4]. Since the survey was conducted three full-time GPs have either moved from Bendigo or stopped practising.

3.7.6. Even when workforce need is declared in these regions, the inability to access a reasonable rebate for recruits under the two-year OTD scheme renders the costs of recruitment prohibitive. On top of providing a reasonable income for the GP, an average recruit costs in excess of $8,000, and the costs of accommodation and travel (estimated at $10,000 p.a.) and practice overheads of the order of 30% need to be met, making such schemes virtually unworkable.

3.7.7. Although the population is growing fast in a number of RRMA3 regional centres, and the GP population is ageing rapidly; non-VR GPs who may be seeking to practise in RRMA3 communities are ineligible for incentives under the ROMP Program.

3.7.8. The lack of access to the ROMP Program in these areas provides a distinct disincentive to the recruitment of non-VR GPs and doctors employed under the Rural Locum Relief Program (RLRP) because these doctors potentially earn 25-30% less than their RRMA4-7 counterparts.

3.7.9. The demand for new services often occurs in low socio-economic areas, where the capacity for the community to pay is lower. Lack of access to the ROMP Program in RRMA3 communities is thus a substantial disadvantage to establishing new practice or practice locations in these areas, and hence disadvantages the community.

3.7.10. A non-VR GP employed under the RLRP in a district of workforce shortage, but not in an eligible ROMP Program location, is obliged to take into account the lower Medicare rebate when determining his/her billing structure. This creates a differential in fees within a practice for patients, particularly in relation to the Medicare rebate. Practices advise

[4] It should be noted that the population figures used in the survey did not take into account people who use medical services in Bendigo, but come from outside the local government area (LGA).

that there is concern that patients will also perceive the differentials in fees as a reflection of the quality of services provided.

3.7.11. In addition, the predominantly overseas trained RLRP doctors often require more support, supervision and mentorship and therefore can have lower levels of throughput of patients. The additional support combined with lower levels of income generated from these doctors mean that practices are very reluctant to take on non-VR RLRP doctors.

3.8. Divisions of General Practice – Future Role

3.8.1. ADGP, as one of the four major GP organisations comprising the General Practice Representative Group (GPRG), regards the Overseas Trained Doctor initiative announced as part of *MedicarePlus* as only an initial step to sustainable reform to resolve the workforce crisis.[5]

3.8.2. The Divisions of General Practice are the facilitators of change in primary health care in Australia, and provide an avenue to explore and implement innovative programs to improve and enhance the availability of health services in their local communities. Such programs could include:

3.8.2.1. As a means of supporting and retaining GPs in their communities, consideration should be given to subsidising Divisions to establish and manage a local GP locum service to ensure doctors can plan quality leave with their families, as well as provide some certainty about availability of locums so they can attend CME sessions, conferences and other educational programs;

3.8.2.2. In communities where GPs are looking to retire or relocate but are having difficulty in attracting a purchaser for their practice, Divisions could negotiate the purchase of the existing practice. This would ensure practices retain a resale value and that the profession, through the Board of Directors of the Division, maintains control of general practice service delivery environment within the community;

3.8.2.3. In areas where there are no existing general practices or access to services within a reasonable proximity, Divisions could be funded to establish and manage best practice multidisciplinary centres that provide general practice services, supported by practice nurses and allied health professionals, as well as access to specialist services that meet the needs of the practice population, thereby enhancing the total health system for their community.

3.8.3. ADGP, through its consultation with grass-roots GPs and practice staff, Divisions of General Practice, SBOs and other professional organisations, is confident that the potential exists within the profession

[5] GPRG Statement on *MedicarePlus,* 27 November 2003 (accessible at http://www.adgp.com.au/site/index.cfm?PageMode=indiv&module=NEWS&page_id=2045)

and the community to work towards a solution to the medical workforce crisis facing Australia.

MedicarePlus and the Implications for Practice Nursing

4. New Item numbers for practice nurses

4.1. ADGP supports the initiative to have MBS items available for services provided by a nurse in general practice. Practice nurses are highly skilled health professionals who can complement the work of GP in providing high quality care and have a substantial impact on practice capacity. In the current situation of chronic workforce shortages, this has profound implications for improving access to general practice services.

4.2. In the Aboriginal Community Controlled Health sector, this initiative could also encompass work undertaken by Aboriginal health workers.

4.3. However, rather than limiting the scope of tasks provided by nurses for which the practice can attract a fee to wound care and immunisations, this initiative should be expanded to include such things as:

- Monitoring and clinical management (eg. simple review of blood pressure after the GP has altered treatment);
- Providing early disease detection services (eg. diabetes screening in high risk groups);
- Input to chronic disease management (eg. providing asthma education for patients, spirometry etc.);
- Home visits, including protocol-driven health assessments under the supervision of a GP;
- Conducting PAP smears.

4.4. *MedicarePlus* introduces item numbers for specified services provided by a practice nurse working in general practice, however there is no definition of what type of nurse is defined as a practice nurse. Both registered and enrolled nurses work in general practice. The types of procedures that registered and enrolled nurses perform vary from practice to practice depending on the competence and experience of the nurse. The scope of practice also varies from State to State depending on the guidelines set by the State registering authority (i.e. Nurses Registration Board). The Schedule for *MedicarePlus* will need comprehensive explanatory notes defining the term ‘practice nurse’, which should be developed in conjunction with the chief nursing bodies.

4.5. The *MedicarePlus* information sheets state that practice nurses can provide the service (new item numbers) under the 'broad supervision’ of the doctor but without the GP needing to be present. This term needs to be clearly defined. For example, does broad supervision require that the GP needs to be physically present in the same room; in the practice, or perhaps providing

indirect supervision so that the GP is easily contactable but not actually present?

4.6. It is understood that the new item numbers will attract a rebate of $8.50, regardless of the length of time taken for the nurse to deliver the service, or the complexity of the task (see 9.4). This small fee demeans the level of knowledge and expertise required by the nurse to demonstrate competence in immunisation and wound care, and would not even cover the overhead costs associated with the delivery of the service – wages, consumables etc.

4.7. Wound Care: the types of dressings undertaken in general practice for wounds varies significantly from simple dressings to complex wound care, which is resource intensive and time consuming. A single item number for wound care will not take into account the time and human resource cost of these procedures.

4.8. Immunisation: there are a number of issues regarding immunisation that require clarification, including:

4.8.1. In order for a practice nurse to administer an immunisation, is that nurse required to be an accredited nurse immuniser? At present the guidelines for immunisation vary from State to State with some States requiring that any nurse who administers immunisation must undertake an accredited immuniser course. It is strongly recommended that the new item number require the nurse immuniser to be formally accredited in order to ensure a high level of safety and quality service to patients. This would require that all practice nurses are easily able to access training, ongoing reaccreditation and support, which indicates a strong role for Divisions of General Practice;

4.8.2. GPs currently receive a service incentive payment of $18.50 on the completion of each schedule as per the National Health Medical Research Council (NHMRC) standards for childhood immunisation. If a practice nurse undertakes this task on behalf of the GP, will the GP still be eligible for this payment?

5. An additional 457 practice nurses and/or allied health workers funded to work with GPs in urban areas of workforce need

5.1. ADGP has previously argued for expansion of the practice nurse subsidy to be extended to all practices in Australia. There is strong evidence of the effectiveness of structured multidisciplinary approaches to health service delivery in producing better outcomes for patients, and such initiatives should be accessible to patients of all general practices.

5.2. The issues that need to be dealt regarding these additional places include:

5.2.1. How will 'urban areas of workforce need' be defined in order to ensure equity of access to a quality service to all people living in urban areas?;

5.2.2. In the 2001-2002 Practice Incentive Program for Practice Nurses, eligible practices were able to receive an incentive payment to employ

either a practice nurse or an aboriginal health worker depending on the needs of the practice. Will this same principal apply under *MedicarePlus*?

5.2.3. Where will the nursing workforce come from? There is evidence of an ongoing shortage of nurses throughout the system that will impact on the implementation of this initiative.

HIC Online

The HIC Online initiative has the potential to produce substantial savings for Government. The administrative cost of approximately 3% for every Medicare transaction performed at the practice will now be transferred to GPs. These savings should be reinvested in general practice to support the ongoing infrastructure and administrative costs of this measure to general practices, or there is a risk that these costs will be passed on to patients.

A related concern is the need for practices to collect and store patients' bank account information, which has implications for privacy procedures in the practice as well as the additional administrative burden. The previous proposal, where patients paid only the gap and the rebate was issued to GPs, would have avoided these problems.

6. Support for general practices to adapt to new billing system

6.1. The subsidies provided for general practices to prepare for the HIC Online initiative in MedicarePlus are relatively small. If the Government wishes to maximise the impact and realise the full efficiencies possible through the HIC Online initiative, it is imperative that Divisions of General Practice are funded to support its implementation. Such support will entail:

6.1.1. providing general practices with support for upgrading/making compatible their existing IMIT systems;

6.1.2. providing advice in business systems alignment resulting from the adoption of a new billing mechanism;

6.1.3. providing advice, training and information sharing to maximise the patient outcomes and clinical benefits possible from the concomitant availability of broadband internet resources.

7. Software integration

7.1. Further, it will be critical that the process to interact with HIC Online be fully automated and integrated into GPs' desktop software packages. Work must be undertaken as a matter of urgency with the software providers to integrate this function into their accounting modules. Broadband access may assist connectivity, but without seamless integration with standard software used by general practices, the initiative will struggle to succeed.

Aged Care

The lack of adequate infrastructure and funding for general practice services in aged care facilities has been a major issue for general practice. ADGP looks forward to

working with Government on the detail of this initiative, to ensure appropriate support mechanisms are put in place.

Divisions of General Practice have been instrumental in many areas in supporting stronger links between general practitioners and the aged care sector, as a 2002 survey conducted by the ADGP showed.[6] It is encouraging that Divisions have been highlighted in this initiative as playing a key supporting role to general practice in improving health care for residents of aged care homes, however there are substantial implementation issues arising from this proposal that will need to be worked through in consultation with the Divisions Network.

8. GP Panels

8.1. Some of the key factors in the decline of GPs providing services in aged care homes have been: inadequate remuneration for the complexity of care needed by residents; lack of suitable facilities within aged care homes to conduct suitable (and private) consultations with patients; lack of appropriate record keeping and information sharing among the multiple providers involved in residents' care, including nurses and pharmacists; lack of incompatibility of computerised information systems to allow accurate and timely transfer of patient data. Simply having more GPs available to provide services in aged care homes will not solve these issues.

8.2. It is critical for the quality and safety of patient care that funding be made available to support the provision of suitable consulting facilities and information systems within aged care homes.

8.3. There is some doubt that in the current climate of severe workforce shortage, there will be sufficient numbers of GPs even to make up the Panels. GPs are generally aligned to one or two aged care homes, and there may be some reticence to attend others with which they are not familiar. The number of Panels per Division will also need to reflect the number of homes and beds to be serviced in the area.

8.4. Further, patients' and GPs' freedom of choice should not compromised in the establishment of such panels. This is in line with the Aged Care Act and RACGP criterion 2.1.6 that acknowledge the right of patients to transfer their care and the right of GPs to discontinue treatment of a patient.

8.5. Another key concern for GPs in providing such services is that it involves a substantial time commitment away from their practice, including travel to and from the aged care facility. The chronic GP workforce shortage means that GPs are finding it increasingly difficult to manage patient demand during regular practice hours. The $8,000 *MedicarePlus* incentive for GPs to join a Panel breaks down to a little more than $150 per week (based on an average of 48 weeks worked per year) and it is difficult to see how this will encourage large numbers of GPs to make up the shortfall in aged are homes.

[6] Report on Responses to the ADGP Aged Care Taskforce *Aged Care Questionnaire for Divisions of General Practice,* ADGP, February 2002.

8.6. Further, those GPs who currently provide care to their patients in aged care homes, but do not join a panel due to workload pressures or other factors, will be disadvantaged as they will not be eligible for the incentive payment. The incentive may in fact have the unintended effect of prompting such GPs to withdraw their services from facilities.

8.7. There are other matters that have raised concerns among Divisions. For example, to establish panels of GPs to provide services to residents of aged care homes who do not have an identified GP, will Divisions become responsible for credentialing these GPs, with the associated medicolegal liabilities? Many see this as an inappropriate role for member-based organisations.

8.8. The inclusion of any GP on the 'local panel' should be based on his/her stated availability and not on any additional criteria that relate to professional qualifications and/or competence. Registration through the various State Medical Boards and the RACGP is a valid indicator of a GPs qualifications and expertise to treat all patients. Any further registration/qualification process will add another dimension of administrative burden (for GPs and Divisions) and may potentially act as a deterrent for GPs to become involved on the 'local panels'.

8.9. ADGP is also aware that in many areas it is the After Hours Deputising Service that provides the majority of care to residents of aged care facilities. How these services will interact with the Division-led panels will need to be carefully considered.

9. Comprehensive Medical Assessments and Residential Medication Management Reviews

9.1. ADGP and other GP groups have lobbied for several years for the introduction of a comprehensive medical assessment (CMA) item that can be accessed by GPs providing this service to residents of aged care homes and we are pleased to see this included in the *MedicarePlus* initiative.

9.2. We have also been part of recent work at the Medical Benefits Consultative Committee (MBCC) to incorporate a CMA for residents on admission as part of a collaborative medication management review framework. The current Home Medicines Review (HMR) item, involving collaboration between GPs and pharmacists, has been an important development in team-based primary care delivery. It has not been available to residents of aged care homes.

9.3. The medical assessment and the medication management review have separate and distinct functions in caring for aged care residents, and ADGP believes that quality care will be achieved by the addition of both items to the MBS schedule. Clarity is needed on how the current Pharmacy Guild HMR facilitators based in Divisions will interact with the proposed arrangements.

9.4. ADGP also welcomes the initiative flagged in *MedicarePlus* to develop formal links between Divisions of General Practice and residential aged care homes to facilitate GP input into such things as facility Medication Advisory

Committees and quality assurance processes to support a team based approach to aged care, involving nurses, pharmacists, geriatricians, allied health professionals and carers.