Australian Divisions of General Practice

Federal Budget Submission 2003-04

Investing in the future through primary health care

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1. Executive Summary

ADGP's Federal Budget Submission 2003-04 focuses on increasing Australia's investment in primary health care to achieve a high quality and efficient health system that meets the needs of all Australians.

Australia's primary health care sector is ailing. GPs are struggling to meet the demands of their communities with inadequate resources. The value of the Medicare rebate has declined in real terms to the point where many GPs find it financially unviable to bulk bill. Workforce shortages, endemic in rural and regional areas for many years, have now moved into the outer metropolitan regions of capital cities.

ADGP's Budget Submission calls for a significant additional investment in Australia's primary health care sector and a re-orienting of our health system towards primary care. This must include an increase in the number of GP training places and medical school intakes and increased resources enabling GPs to work in primary care teams with practice nurses and allied health professionals.

Investing in the primary health care sector will pay significant health and efficiency dividends, both in the short and long term. International research across 14 OECD countries has shown that a health system oriented toward the primary health care sector achieves more effective care, lower levels of mortality, less hospitalisation, lower costs and a more equitable distribution of good health throughout the community.

The Divisions of General Practice Network links 94% of GPs in Australia in a national structure to support general practice and improve community access to primary care. The Divisions of General Practice Network is the key to integrating general practice with other sectors of the health system, both government and non-government, to deliver high quality care to the Australian community.

ADGP's Budget Submission focuses on a number of strategies to support general practice and Divisions to improve access and quality of care. Specific examples include: an expansion of the Practice Nurse Program; increased linkages between GPs and aged care homes; support for a primary care early childhood agenda; a national allied health program run through Divisions; increased resourcing for Divisions to build capacity and engage in research; a national GP-hospital liaison program to link general practice with hospitals, including facilitating electronic data transfer; and funding for the restructure of the Medicare Benefits Schedule to support more complex, longer GP consultations.

ADGP is also advocating for better coordination of health policy and funding across Commonwealth/State programs, including quarantined primary care funding through the Australian Health Care Agreements. ADGP strongly believes that all levels of government need to articulate a commitment to reducing cost-shifting and increasing their investment in primary health care.

ADGP's Federal Budget Submission 2003-04 articulates our vision for a health system that delivers high quality primary care to all Australians.

Dr Rob Walters
Chair

2. ***Background***

Australian Divisions of General Practice (ADGP) is the peak national body representing 121 Divisions of General Practice across Australia. About 94 per cent of GPs are members of a local Division of General Practice.

Divisions are funded by the Commonwealth to support general practice to deliver high quality care to the Australian community. General practice is the core of Australia's health system. Around 90 per cent of Australians visit their GP each year, and these visits are the gateway to the country's hospital, specialist and diagnostic services.

General practice plays a major role in childhood immunisation, management of chronic diseases such as asthma and diabetes, identifying and treating mental illness, and working with indigenous communities in remote parts of Australia.

Within the community, Divisions are central to the integration of general practice with other health sectors – pharmacy, hospitals, and community and area health services.

Through linking GPs in local areas, Divisions are the voice of general practice in the community, with the concerns and views of GPs in day-to-day practice being passed through local divisions to the ADGP, which in turn presents those views to Federal and State Governments.

ADGP is one of Australia's largest representative voices for general practitioners. As part of ADGP's representation program, grass roots GPs sit on approximately 60 key decision-making bodies in the health sector, having direct input into general practice financing, GP workforce and training, clinical practice and practice management and other key areas influencing the future of general practice.

ADGP also coordinates a number of National Programs through Divisions of General Practice to improve the health of all Australians. ADGP's programs cover a broad range of primary care issues, including immunisation, youth health and practice nursing. These programs aim to strengthen primary health care to better meet the needs of the Australian community.

ADGP often works collaboratively with other organisations, both government and non-government, to develop and coordinate national population health programs. Many of these programs are overseen by committees made up of GPs from Divisions and other stakeholders such as academics, allied health professionals and consumers. ADGP also works closely with the State-Based Offices of the Divisions Network and individual Divisions to ensure that national programs meet the local needs of their communities.

Through supporting GPs and advocating on behalf of general practice, the Australian Divisions of General Practice has become a vital part of Australia's primary health care system.

3. ***Investing in the Primary Care Workforce***

3.1. Current workforce initiatives, both for rural and remote, and now outer metropolitan communities, are seeking to increase doctor numbers by drawing from the same inadequate pool of GPs. Strategies to encourage non-practising GPs back into the workforce, and others to re-locate, or provide incentives for graduates to choose a career in general practice must be combined with an overall increase in the size of the general practice workforce.

3.2. ADGP, and other peak medical organisations, have long argued that Australia is not training enough doctors to meet community needs. This view has been confirmed by research undertaken by Access Economics and the Australian Bureau of Statistics that highlights the decline in the number of GPs providing primary care in Australia.

3.3. Australia has an obligation to observe the tenets of the Melbourne Manifesto endorsed by WONCA (World Organisation of Family Doctors) 2002 and not actively recruit doctors from developing countries or regions where they may be needed more than in Australia. The Melbourne Manifesto presents a code of practice for the international recruitment of health care professions, and has put the onus of responsibility on every country to train enough health professionals to meet their own needs.

3.4. ADGP supports an increase in the number of training places available to registrars in the General Practice Training Program as a long-term solution to the workforce shortage.

3.5. Increasing the number of GP training places is vital. It is also important that the requirements of the training program for registrars to work in areas of need will not continue to change as more areas of Australia experience workforce shortages. More registrars seeking to train in general practice will in turn provide communities with greater access to quality general practice services and improve continuity of patient care.

3.6. ADGP also supports an increase in medical school student numbers. Sustainability of the medical workforce in the long-term must begin with an increase in medical school intakes.

3.7. For Australia to become more self-reliant, universities must be able to offer more Australian students the opportunity to pursue a career in medicine. Given restricted entry into medical school, many secondary school students do not even consider applying. Methods of selecting students for medical school also need to be reviewed to ensure the selection process targets students likely to seek a career as general practitioners.

3.8. An increase in medical school placements would need to be supported with a boost in assistance programs/scholarship schemes as a means of easing the financial burden on the family so that potential students are encouraged to

study medicine. Such schemes could include incentives for recipients to work in general practice

4. ***Expanding the Practice Nurse Initiative***

4.1. It is proposed that the current Practice Incentive Payment (PIP) funding arrangements to assist the employment of practice nurses to work with GPs in rural and remote areas and other areas of workforce pressure, be extended to all Australian general practices, particularly those in outer-urban areas.

4.2. Outer metropolitan areas have been recognized as areas of significant doctor shortage and workforce pressure.

4.3. Rationale

4.3.1. The Practice Nurse initiative supports a multidisciplinary team approach to the provision of primary care services. The practice nurse can play a key role in facilitating integrated service delivery to meet the needs of patients with complex needs. The practice nurse is able to complement the role of the GP, thus enhancing health care outcomes.

4.3.2. The introduction of the Practice Nursing initiative to rural and remote practices has been well received, and is recognised as a key strategy to reducing the workforce pressures experienced by GPs in rural and remote communities.

4.3.3. Health Insurance Commission data to May 2002 indicates that 60 per cent of eligible PIP practices have registered for the initiative. Early data also indicates that nearly one in three participants did not previously employ a practice nurse.[1] Anecdotal information received from Divisions of General Practice indicates a high level of GP support and interest in the program.

4.3.4. Extension of the Practice Nurse initiative to eligible practices in outer metropolitan areas should provide similar relief to workforce pressures and result in greater patient access to their GP, as well as providing a practical incentive for other doctors to re-locate.

4.4. Medicare items for Practice Nurse procedures

4.4.1. The real value of employing a practice nurse would be realised if changes were made to Medicare Benefits Schedule (MBS) that enabled GPs to claim for:

- an agreed group of procedures for which the GP does not need to see the patient unless requested by the practice nurse; and
- a longer consultation that covers the time taken for both the GP and the practice nurse to provide care to the patient, eg. immunisations, complex dressings etc.

[1] *National Networks*, Issue 36 October 2002, Department of Health and Ageing, Pg 9.

4.4.2. Establishment of such MBS items would significantly increase community access to primary health care by freeing-up GP time, and would contribute to the wellness of the general practice workforce by taking the pressure off GPs who care for patient populations that may be two to three times the recommended size.

4.5. Training and support for nurses working in general practice

4.5.1. Funding should be directed to extending training and support for nurses seeking to work in general practice in outer metropolitan areas, such as the Practice Nurse Re-entry and Up-skilling Scholarship Scheme.

5. ***Investing in Integration through Divisions of General Practice***

5.1. It is proposed that appropriate funding be made available to enable the Divisions Network, including local Divisions, State Based Organisations and their peak national body, ADGP, to provide a bridge between Commonwealth/State systems and primary care/hospital care. The Divisions Network can deliver increased efficiencies and reduced duplication in health service funding and delivery.

5.2. Coinciding with the Commonwealth Review of the Role of Divisions of General Practice, the Divisions Network has undertaken several months of extensive consultation to develop a vision for the future role of the Network in supporting general practice as the cornerstone of primary care in Australia. The Network has developed a policy paper entitled *A Vision for Divisions of General Practice to 2007,* which outlines new roles for the Divisions over the next five years in a context of self-determination, accountability and quality improvement.

5.3. The Divisions Network provides a well-developed structure for health policy development, integration and service delivery at national, State/Territory and local levels. The Divisions have been a powerful tool in assisting general practice to deal with the pressures of a continually changing health care environment. The future vision includes enhanced support for practice staff, business systems, information management and technology and an extended community service role, to ensure effective support of general practice.

5.4. Key elements include:

- Supporting the development of capacity and infrastructure in General Practice for Chronic Disease Management and multidisciplinary healthcare teams within general practice, to help prevent unnecessary and expensive hospitalisations and expand the capacity of community-based providers to reduce the need for acute or sub-acute care.

- Building capacity for population health data collection and analysis by Divisions to enable local and regional needs analyses and health planning that spans the continuum of care (AHCA working group recommendation 4.14);

- Building formalised primary care partnerships at the state and regional level across the spectrum of care, that supports integrated planning, resourcing and service delivery (AHCA working group recommendation 2.7);
- Establishing research and evaluation expertise within Divisions and partnerships with appropriate research bodies to participate in research relevant to general practice and primary care service delivery, and feed into policy development through Divisions Network channels;

5.5. The Divisions Network offers Government diversity, local responsiveness, capacity to coordinate primary care and the ability to provide constructive grassroots input to national policy development. No other structure in the Australian health care system does this. Investing in the Divisions Network can assist in achieving increased efficiency and integration of the entire health system.

6. *Investing in Aged Care*

6.1. Increasing linkages between general practice and aged care homes is the key to improving the care of older Australians and reducing unnecessary hospitalisations.

6.2. GPs are currently under-resourced to care for people in aged care homes and there are few systematic links between general practice and the aged care sector. Funding is needed for Divisions to work with aged care providers to improve facilities for GP care in aged care homes. This must include increased involvement by GPs in clinical governance in aged care homes and support for GPs as part of an aged care team. It must also include support for aged care homes to provide space for GPs to examine patients privately and safely.

6.3. Funding must also be provided to improve the quality use of medicines in aged care facilities, including support for medication reviews.

6.4. A Medicare item number for Comprehensive Medical Assessments (CMA) should also be considered to support GPs to undertake an initial medical assessment on entry into an aged care home.

7. *Investing in Early Childhood – A National Primary Care Platform*

7.1. The Government has announced its commitment to introducing a National Early Childhood Agenda.

7.2. Children and young people are our future and yet measures of their developmental health and well being demonstrate a significant deterioration in a number of key indicators. The cost burden of these adverse outcomes is enormous and increases with time. Reversal of these trends is essential for the continued cohesion of our social fabric and the wealth of the nation. As many others advocate, the only effective means to do this is prevention.

7.3. General practice has a key role in giving kids a healthy start in life and facilitating their emotional and social wellbeing. General practice also has a key role to play in providing advice and referral pathways to parents experiencing difficulties with their children, be it behavioural problems in younger children or risk-taking behaviour in the teenage years such as drug and alcohol problems.

7.4. If we are serious about building healthier children, families and communities, we must support general practice to assist with promotion and prevention targeting the health of children and young people. We must also support general practice in the early detection and management of child and adolescent health problems, including mental health problems which represent over half the disease burden in young people.

7.5. The following key initiatives should be funded to underpin a robust contribution by general practice to the National Early Childhood Agenda and help the government meet many of its health and social policy targets:

7.6. *Every Family* [$4 million]

7.6.1. The GP is the first stop parents make when faced with 'problem children'. *Every Family* would be a national program rolled out at the local level through Divisions. *Every Family* would strengthen the resourcefulness and resilience of families through enhancing the competence and confidence of parents in dealing with common behavioural, emotional and developmental problems of children.

7.6.2. *Every Family* would be based on the Triple P program, an impressive Australian (University of Queensland) implementation of a multilevel family intervention for the parents of younger children, which illustrates a comprehensive approach to establishing a family intervention program. The range of interventions varies from provision of information in community and primary care settings to more intensive face to face preventive interventions in specialised clinical settings.

7.6.3. *Every Family* would have the following elements:

7.6.3.1. Training for GPs in responding to behavioural and emotional problems in children. This would assist in improving the ability of GPs to identify parents who experience adverse effects of dealing with children and teenagers and to provide training in the transfer of parenting skills and appropriate referral pathways to aid in the management of children and teenagers with behavioural problems

7.6.3.2. Integration with the Better Outcomes in Mental Health Care Initiative by providing GPs with:

- a user-friendly 3-step mental health assessment tool, tailored specifically to the assessment of mental health need in children and young people

- access to allied health support in managing child and adolescent mental health through an extension of the current mental health allied health projects in Divisions

7.6.3.3. Parenting seminars to reinforce and link with GP advice

7.6.3.4. A Positive Parenting Newsletter containing tips and fact sheets on common childhood health problems and strategies to overcome them at home

7.6.3.5. Telephone counselling support through a Parent Line

8. ***Expansion of the More Allied Health Services Program***

8.1. ADGP supports funding for a comprehensive and integrated ancillary health program that meets the identified needs of the population and links with other Commonwealth and State/Territory funded health services.

8.2. This program would be based on the Commonwealth-funded More Allied Health Services (MAHS) program based in rural areas. The MAHS program has been successful in increasing access to allied health services to rural communities. It provides a flexible and locally-responsive model that involves the community in setting priorities for funding and service delivery.

8.3. The program would be run through Divisions of General Practice, coordinated nationally by the Australian Divisions of General Practice. The Divisions of General Practice Network is the only primary health care infrastructure that is able to deliver a national community-based health program integrating general practice with other sectors of the health system.

8.4. Funding would be delivered on the basis of a needs assessment of the community, undertaken by local Divisions with GP, allied health worker and consumer input. Divisions would be required to meet minimum standards of service provision, set by the Commonwealth (such as basic dental care) and have to demonstrate that their proposed program would contribute to achieving Commonwealth health policy objectives. The State-Based Organisations of the Divisions Network would liaise between Divisions and State Governments to link with State-funded programs.

8.5. Divisions would be required to provide data to the Commonwealth on the allied health services provided under the program to enable better planning of primary health care policies and programs. The program could be comprehensively evaluated to assess health outcomes, consumer support, increase in access to allied health services and efficiency of resource use.

8.6. The program would provide an integrated approach to health care through coordination through Divisions of General Practice, linking general practice, allied health and other Commonwealth and State/Territory funded health initiatives and services. It would also facilitate linkages between allied health and relevant Commonwealth funded general practice programs, such as Enhanced Primary Care. It would provide rural communities with increased access to ancillary services and ensure a more equitable funding of services

between rural and urban Australia. The program would also allow for more flexibility in the way health services are delivered and encourage the development of more innovative funding and service delivery models.

8.7. One option for funding this program is to divert funding from the ancillary services component of the Private Health Insurance Rebate Scheme.

9. ***General Practice Attendance Item Restructure – investing in General Practice capacity***

9.1. ADGP supports a collaborative approach between peak GP groups and Government to increasing the value of the GP rebate to support GPs to deliver quality care.

9.2. The Attendance Item Restructure Working Group (AIRWG) is due to present its final report to the Commonwealth. The GP groups represented on the Working Group (ADGP, AMA, RACGP and RDAA) have unanimously called for any reform of the structure to include commitment of significant additional funding for GP attendance items.

9.3. AIRWG was formed in February 2002 to develop proposals for reform of the Medicare Benefits Schedule (MBS) attendance item structure for in-surgery general practice consultations (unreferred attendances) to improve incentives for the provision of quality care.

9.4. AIRWG has recognised that the current item structure provides significantly different financial incentives (in terms of rebate dollars per minute) within individual items and between the different consultation items. Financial incentives under the current structure favour short consultations. These were also the findings of the *Relative Value Study*. In order to support the delivery of quality primary care, the structure must reduce the perverse incentives for short consultations and more appropriately remunerate GPs for quality practice.

10. ***Investing in GP-Hospital Integration through a National General Practice Liaison Officer Network***

10.1. It is proposed that $400,000 be made available over two years to fund a national GP Liaison Officer (GPLO) Network through the Divisions of General Practice program infrastructure, to consolidate the GPLO network that has been developed through Divisions and build best practice in GP-hospital communication and integration. (AHCA working group recommendation 4.17).

10.2. Rationale

10.2.1. Over the last ten years GPLOs have been employed by local health services, hospitals and Divisions of General Practice to facilitate improving the GP-Hospital interface. The two evaluations of the GPLO role by the University of NSW (CGPIS 2000, 2002) show that the role is seen as useful by hospital and Division stakeholders, and is associated

with sites where there are more complex interfaces between GPs and hospitals.

10.2.2. GPLOs are instrumental in:

- extending the range of areas in which GPs and hospitals collaborate to provide effective care (including better communication);
- extending the reach of effective programs, both in terms of the uptake of programs across hospitals and the extent to which they are taken up by GPs and hospital staff within local areas.

10.2.3. This initiative has contributed to the more efficient use of resources as it reduces the number of hospital re-admissions, and reduces the doubling-up on prescriptions as GPs are more aware of the medications prescribed by the hospital for their patient.

10.2.4. Through the initiative of several of the GP liaison officers, an informal GPLO e-mail network has been established, a website developed and two national GPLO conferences organised. Formalising the network will enhance the capacity for GPLOs to facilitate the development of ongoing systems to link GPs and hospitals and improve GP-hospital integration as well as provide opportunities for GPLO contribution to and implementation of Commonwealth and State policy and program initiatives.