Post-election policy pointers

General practice: are we equipped for the future?

Flexible funding and evidence-based policy are needed

By global standards, Australia's health system has performed well. As a country, we spent 8.9% of gross domestic product (GDP) on health in 2011 — below the average for Organisation for Economic Co-operation and Development (OECD) countries (9.3% of GDP).[1] Conversely, we are in the top 10 OECD countries for life expectancy.[1] We have a system of universal health coverage for our entire population, something that the United States has been unable to achieve despite spending 17% of GDP on health.[1] Unlike the United Kingdom, our patients are free to choose their preferred doctors. In addition, Australians can access investigations and specialist referrals more easily than people in the UK.

General practice has played a key role delivering these outcomes. The Royal Australian College of General Practitioners (RACGP) defines general practice as the provision of person-centred, continuing, comprehensive and coordinated whole-person health care to individuals and families in their communities.[2] More and more, we are seeing general practice evolve to become team based, tapping into broader primary care expertise. Improvements in technology and communication mean that care can be delivered in ways not considered when Medicare was introduced in the 1970s. We now face the question of whether our current funding model can support high-quality general practice in the future.

Over the past 20 years, increases in the Medicare rebate for a standard general practice consultation have fallen well behind inflation.[3] Reliance on bulk-billing encourages shorter consultations and a high throughput of patients, while gap payments have resulted in 8% of patients delaying visits to their GP because of cost.[4] Anecdotally, numbers of general practices that offer home visits and after-hours care (including care for people living in residential aged care facilities) are decreasing, and increasing corporatisation of general practice can be seen as a sign that our system is under strain. From a workforce perspective, we have seen the proportion of doctors working in primary care drop from 41% in 1999 to 35% in 2009, with a corresponding increase in the number of specialists.[5] In areas where patients have the poorest health outcomes (rural and remote areas and socioeconomically disadvantaged areas), we see the worst shortages of doctors[6] and a heavy reliance on international medical graduates, many of whom have limited registration. With 36.6% of the general practice workforce aged over 55 years,[7] we are likely to see continuing pressure on general practice to meet the needs of the community.

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> "the funding dollar must follow patient need — this should be the template for assessing new policy"

So how should we move forward? Most importantly, the funding dollar must follow patient need — this should be the template for assessing new policy.

Recent proposals intended to address rising health care costs have included charging a copayment to discourage unnecessary general practice consultations.[8] Even if there were evidence to support this assertion, such a proposal is likely to discourage the poorest (who usually have the greatest health needs) while doing little to discourage wealthier patients from making unnecessary visits to the doctor.

Task substitution is also being explored by the government, with pharmacists and nurses taking on roles typically undertaken by medical practitioners, such as vaccination and prescribing. Again, while this proposal seems attractive on the surface, the lack of evidence supporting the safety of non-medical prescribing must be recognised.[9] Fragmentation of care is a real risk, with the potential for increased adverse events and errors.

Private health insurers have started to develop packages for their members based on contracts with GPs, corporations and other service providers. Conforming with relevant legislation, as well as engagement and dialogue between private health insurers and general practice, is needed to develop a set of principles on which to base investment in primary care. Supporting GPs to provide assistance with end-of-life care in hospitals is one example of how private insurers could substantially improve outcomes and reduce costs. Enhancing capacity and quality in general practice depends on policy that has been shown to improve outcomes, support continuity of care with the GP and the practice, and uphold clinical autonomy in decision making.

Now is the time to plan for maintaining high-quality general practice in Australia. While fee for service is still important for acute care and face-to-face consultations, other, more flexible, forms of funding are needed. The RACGP's federal budget submission for the 2014–15 financial year recommends: practice payments for infrastructure and administrative costs; practitioner payments for care of enrolled patients with complex health care needs, for educating and training students and doctors in training, and for general practice research; and a population complexity loading that recognises the additional resource implications associated with Indigenous, rural, low socioeconomic and ageing populations.[10] Benefits are likely to accrue through reduced hospital costs, but the challenge will be dealing with two tiers of government to use these savings to pay for the scheme. In moving forward, we need to address the goals of equity, access and quality while preserving the most important part of our practice: the doctor–patient relationship. General practice must aim to achieve its full potential.

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1 Organisation for Economic Co-operation and Development. OECD health statistics 2013 — country notes. http://www.oecd.org/australia/oecd-health-statistics-2013-country-notes.htm (accessed Jan 2014).
2 Royal Australian College of General Practitioners. What is general practice? http://www.racgp.org.au/becomingagp/what-is-a-gp/what-is-general-practice (accessed Jan 2014).
3 Productivity Commission. Report on government services 2013. Canberra: PC, 2013. http://www.pc.gov.au/gsp/rogs/2013 (accessed Jan 2014).
4 Australian Bureau of Statistics. Patient experiences in Australia: summary of findings, 2010–2011. General practitioners, medical specialists and dental professionals. Canberra: ABS, 2011. (ABS Cat. No. 4839.0.)
5 Australian Institute of Health and Welfare. Medical labour force 2009. Canberra: AIHW, 2011. (AIHW Cat. No. AUS 138.) https://www.aihw.gov.au/publication-detail/?id=10737419680 (accessed Jan 2014).
6 Australian Institute of Health and Welfare. Australia's health 2012. Canberra: AIHW, 2012. (AIHW Cat. No. AUS 156.) http://www.aihw.gov.au/publication-detail/?id=10737422172 (accessed Jan 2014).
7 Australian Institute of Health and Welfare. Medical workforce 2011. Canberra: AIHW, 2013. (AIHW Cat. No. HWL 49.) http://www.aihw.gov.au/publication-detail/?id=60129542627 (accessed Jan 2014).
8 Australian Centre for Health Research. A proposal for affordable cost sharing for GP services funded by Medicare. Melbourne: ACHR, 2013. http://www.cormorant.net.au/images/18%20oct%202013%20achr%20gp%20copayment%20paper%20final.pdf (accessed Jan 2014).
9 Bhanbhro S, Drennan VM, Grant R, Harris R. Assessing the contribution of prescribing in primary care by nurses and professionals allied to medicine: a systematic review of literature. *BMC Health Serv Res* 2011; 11: 330.
10 Royal Australian College of General Practitioners. RACGP submission to the Minister for Health, federal budget 2014–2015. http://www.racgp.org.au/yourracgp/news/reports/20140203prebudget (accessed Jan 2014). ❑