AMA

AMA SUBMISSION TO THE PRIMARY HEALTH CARE REVIEW

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Introduction

Primary health care has been demonstrated as the most effective way to deliver health services, with the Australian health system having a strong emphasis on this. Clearly, we must continue to embrace and strengthen this model. International studies show that the strength of a country's primary health care system is associated with improved population health outcomes for all-cause mortality, all-cause premature mortality, and cause-specific premature mortality from major respiratory and cardiovascular disease. Furthermore, increased availability of primary health care is associated with higher patient satisfaction and reduced aggregate health care spending. [1]

Australia has a health system to be proud of. It is one of the most efficient and highly performing health systems in the world. The OECD says it is one of the best in world.

In Australia, life expectancy at birth is 82 years – this is two years above the OECD average of 80 years. Life expectancy for women in Australia is 84 years compared to 80 for men. This difference in gender gap too is better than the OECD average of 6 years, with life expectancy for women 83 years and for men 77 years.

In line with this performance, death rates in Australia continue to decrease rapidly. According to a COAG Reform Council Report the death rate decreased by 8.4 per cent in the years between 2007 and 2012. The average OECD infant mortality rate is 4 deaths per 1000. Australia's rate is 3.3.

Furthermore, 85% of Australians say they are in good health whereas the OECD average is 69%. On this score Australia is ranked the fourth highest amongst OECD countries.

The strength of the Australian health system is its reliance on general practice and the pivotal role of the general practitioner (GP), a highly trained medical specialist. GPs are the first point of contact when most Australians feel unwell and the manage 90% of the problems they encounter. GPs apply their skills across the care continuum, from preventive care to managing a broad range of complex patients.

General practice is well positioned to play a more prominent role in the delivery of health care, particularly in tackling chronic disease and helping to keep people out of hospital. However, this will require additional investment and reforms that build on the GP coordinated model of care – which has proven very successful in the Australian context.

Team-based care is integral to high quality primary services and, while there is no doubt that there is scope to better utilise the skills of other health professionals, the Primary Health Care Advisory Group (PHCAG) must resist any reforms that potentially undermine the GP-led and coordinated model of care. This would only fragment care and lead to greater health care costs in the longer term.

Acknowledging the strong health outcomes that our primary care system is delivering for patients, the PHCAG also needs to take a very measured and evidenced-based approach to potential reforms and recognise that a one size fits all approach may not be appropriate,

[1] AMA (2010) Primary Health Care 2010 position statement. https://ama.com.au/position-statement/primary-health-care-2010

particularly in rural areas and Indigenous communities. We urge a focus on well-targeted reforms that improve on existing arrangements, particularly for those patients with chronic and complex disease who have higher levels of clinical need and are at greater risk of hospitalisation. Where appropriate, reforms must also be properly evaluated through pilot programs before being implemented more broadly.

Recommendations

In this submission, the AMA proposes that in the short to medium term, reforms should:

- recognise the need to increase funding for general practice, which will be an investment that delivers long term savings to the health system.

- immediately restore indexation of the Medicare Benefits Schedule (MBS), utilising a more appropriate indice to ensure indexation keeps pace with the growing costs of running a modern medical practice.

- simplify and streamline Medicare payment arrangements.

- focus on streamlining and reforming current MBS chronic disease items (while maintaining overall funding levels) so that:

    - red tape is reduced;

    - the role of the patient's usual GP is strengthened;

    - patients have better access to GP referred allied health services; and

    - the items are better structured to reward longitudinal care delivered by a patient's usual GP.

- for patients with higher levels of chronic disease, establish a Department of Veterans' (DVA) Coordinated Veterans' Care (CVC) style program that funds a proactive model of care coordination in general practice for patients at risk of hospitalisation.

- support quality improvement initiatives via the Practice Incentive Program (PIP), recognising the need to improve data collection to inform quality improvement.

- provide funding to support the utilisation of non-dispensing pharmacists in general practice to improve medication management, particularly for those patients with chronic disease.

- provide greater scope for private health insurers to fund targeted programs that support general practice in caring for patients with chronic disease.

- utilise Primary Health Networks (PHNs) to support GPs in caring for patients, including the development of care pathways to improve the connection between primary and hospital care.

- consider the evidence from the future evaluation of innovative models of integrated primary care, such as the Western Sydney Integrated Care project[2], recognising that it relies on a mixture of state and federal funding.

In the longer term, there may be scope to expand the use of blended payments. However, given the lack of evidence to demonstrate the impact of blended payments and other payment models in overseas health systems, these would need to be carefully designed and piloted as well as the subject of robust, peer review and evaluation. Where blended payments are used, they must be used to support equity in access to care for all Australians.

The AMA also acknowledges the current discussion about the potential benefits of the introduction of the medical home to Australia. This submission highlights the need to ensure that its potential introduction appropriately translates to the Australian context, focusing on those patients with the highest care needs and that it is designed in accordance with a number of core principles set out later.

General Practice: Efficient and Effective

General practice is the most efficient and cost-effective part of the Australia health system. Spending on general practice is just 7 per cent of total health spending, with the Commonwealth contributing 5.6 per cent of total health expenditure on general practice.

The Productivity Commission *Report on Government Services 2015* demonstrated that general practice remains a modest cost to the Commonwealth Government. The Australian Government contributed $7.3 billion in 2013-14 through MBS and DVA funding for general practice services[3]. The age-standardised expenditure on general practice per person was $299 in 2013-14, significantly cheaper than the real recurrent expenditure on public hospitals of Government of $1819 per person.

According to a National Health Performance Authority report, 84.7% of Australians visited a GP a least once in 2012-13. The above Productivity Commission Report shows that Australians have very affordable access to their GP, with only 4.9 % of people saying they had deferred or not visited a GP due to cost in 2013/14.

Data from Bettering the Evaluation and Care of Health (BEACH)[4] highlights that if GP services were performed in other areas of the health system they would cost considerably more than when provided in General Practice. For example, GP services provided in a hospital emergency department would cost between $396 and $599 each, compared to the average cost of a GP visit of around $50.

In addition the BEACH reports highlight that general practice over the last decade has been doing more than ever to keep Australians healthy. GPs have:

[2] NSW Department of Health. Integrated Care Demonstrators. http://www.health.nsw.gov.au/wohp/Pages/demonstrators.aspx

[3] SCRGSP (Steering Committee for the Review of Government Service Provision) 2015, Report on Government Services 2015, vol. E, Health, Productivity Commission, Canberra

[4] Britt H, Miller GC, Henderson J, Bayram C, Harrison C, Valenti L, Wong C, Gordon J, Pollack AJ, Pan Y, Charles J. General practice activity in Australia 2013–14. General practice series no. 36. Sydney: Sydney University Press, 2014.

- Managed 68 million extra problems of which 24 million were for chronic conditions such as diabetes and depression – up by 48%;
- 35 million extra GP-patient encounters – up by 36%, with 17 million of these with patients aged 65+ - up by 67%;
- 10 million extra hours of GP clinical time – up by 43%; and
- 10 million extra procedural treatments – up by 66%.

GPs are dealing with more problems per encounter and are providing patients with greater access to care.

Australians rely on general practice

Through general practice the Australian population access preventative health care, acute care, diagnostic services, treatment, disease management, referrals to specialist and access to a range of allied health services, often in-house, and at the end of life, palliative care.

General practice is not only the first point of contact for the majority of people seeking health care, it is also the first point of referral. Undifferentiated illness, such as that seen predominantly in the primary health care sector, requires appropriate assessment. The general practitioner is the only primary health care provider with the clinical skill and medical training for diagnosing undifferentiated disease. This training equips GPs to efficiently and effectively assess a patient's condition without subjecting them to unnecessary investigations, procedures or treatments.

As previously mentioned, 84.7% of Australians visited a GP a least once in 2012-13. According to a Menzies-Nous survey[5], 93% of patients return to the same practice and 66% of patients to the same GP. A recent National Health Performance Authority report on GP attendances shows that overall Australians see GPs 5.6 times per year on average. More than one-third of the population (35.3%) visited a GP six or more times in 2012–13, and more than one in 10 Australians (12.5%) went to a GP 12 or more times a year. Those who see a GP frequently are generally very unwell. When comparing Australia to other OECD countries, Australia's GP and medical specialist consultation rate is very close to the OECD average.

How should General Practice be funded?

The main funding mechanism for general practice is fee-for-service, with funding provided to support patients to access care through the MBS and DVA arrangements. This is supplemented by other funding streams including the PIP, infrastructure grants, and a number of other Government programs.

Funding arrangements and any proposed changes must have regard for context and, in this respect, fee-for-service has proven itself as an effective funding model over many years. Fee-for-service must remain the primary source of funding for general practice as this form of funding works effectively for the majority of patients, providing them with autonomy and choice, as well as access to care based on clinical need as opposed to the potential for rationed care that arise under some other funding models. It also supports the doctor/patient relationship. Nevertheless, the AMA acknowledges that where it can be demonstrated that fee-for-service is

[5] The Menzies-Nous Australian Health Survey 2012

not an effective model for supporting the delivering of care it should be complemented by other funding models.

In addition, the administrative arrangements for Medicare paying patient rebates are cumbersome and should be simplified so that where patients are charged a fee over and above the Medicare Scheduled fee, practices should only be required to collect the gap from the patient as opposed to the full up-front fee. This would cut red tape, reduce up-front costs for some patients and support GPs in having more discretion in charging modest out of pocket costs for those patients who can afford to contribute towards the cost of their care. With strong safety nets in place for patients, this would help strike a better balance that would support the ongoing sustainability of general practice, give greater recognition to the value of the services that GPs provide and help to engage patients more in their care.

Before there can be any sensible discussion of new funding models in general practice, there must be an examination of the level of funding that it requires to effectively deliver high quality services into the future. Despite being acknowledged as the key to the future sustainability of the health system, general practice has been the target of funding cuts in successive budgets and it is now suffering under the impact of the freeze on MBS rebates. There is an expectation on the part of Government that general practice needs to play a bigger role in the health system, but there is a demonstrated lack of willingness to deliver the extra funding required to support this policy objective.

The lessons from the UK in this regard are stark. There has been a strong emphasis on moving the provision of care out of hospitals and into the community. This has put a significant strain on general practice, which has also been the target of funding cuts. The GP workforce in the UK is reported as being demoralised and suffering from severe shortages. Standard consultations are ten minutes, which is significantly lower than the average consultation time spent with a GP in Australia.

The UK also has in place many of the funding models that are outlined in the PHCAG Discussion Paper and, to that extent, the PHCAG should be very wary of the blind assumption that they are working or indeed that they can translate to the Australian context. More than anything else, what general practice needs is a serious injection of funds to help equip it to meet the health challenges of the future with ongoing funding certainty, including the restoration of MBS indexation based on an appropriate indice to ensure that indexation keeps pace with growing input costs and ensures that patients are not faced with growing out of pocket costs.

The benefits of improved management of chronic disease

The AMA recognises that care for people with chronic disease is a major challenge confronting the Australian health system. The increasing incidence of chronic diseases such as diabetes, cardiovascular disease, and respiratory disorders mean more people in Australia are living with debilitating illness, unable to work or participate in their communities, and facing poor mental health, disability and premature death. Addressing and managing the health needs and escalating costs associated with the growing incidence of chronic diseases requires further policy emphasis on supporting the role of primary health care, particularly general practice.

Patients whose care is well managed and coordinated by their usual GP are likely to have a much better quality of life and make a positive contribution to the economy through improved workforce participation. More expensive downstream costs can be avoided. Chronic

conditions, if treated early and/or effectively managed, are less likely to result in the patient requiring hospital care for the condition or its complications. With chronic conditions accounting for 85% of the total burden of disease in Australia[6] and for a large share of potentially avoidable hospitalisations, greater investment is required now by Government in general practice and primary health care[7].

Increasingly, people with chronic disease are being treated by primary care teams. This team based approach allows patients access to a broad range of professional expertise and has helped improve access to care for patients as well as the quality of care that they receive. Therefore, it is important to recognise that for this approach to be both clinically and cost effective, patients require a medical diagnosis and properly coordinated care, avoiding inappropriate or delayed treatment, fragmentation of care, unnecessary duplication of services and wastage of health care resources.

In this regard, GPs are the highest trained general health care professional. They bring experience and training in whole-patient, multi system continuous care, and have been traditionally recognised as the most appropriate primary care professional to manage a patient's care. It is important that this fundamental role is preserved, otherwise Australia risks creating a more fragmented health system that will deliver poorer outcomes for patients and cost the community more.

Better care for people with complex and chronic illness

Reforming CDM items

Through effective care planning and chronic disease management the usual GP/general practice provides care aimed at preventing the escalation of an established disease and the development of multiple co-morbidities which increase the complexity of patient care. Current MBS arrangements for Chronic Disease Management (CDM) items are administratively burdensome, do not accord with accepted clinic practice and do not effectively reward or encourage longitudinal care.

Provided overall funding is maintained, CDM items could be more effective if restructured to:

- Strengthen the role and definition of a patient's usual GP;
- Tackle the complex requirements specified in the items so that they reflect modern clinical practice and involve less red tape;
- Streamline requirements for referral to allied health services; and
- Ensure that the structure of the relevant MBS items encourage longitudinal high quality and appropriate care.

This approach ensures that patients with low to moderate levels of chronic and complex disease would continue to be supported with access to structured care as well as allied health services.

Risk stratification

Current MBS CDM items do not differentiate for those patients with more serious chronic and complex disease and for this group a more proactive approach is required. This philosophy was

[6] Australian Institute of Health and Welfare. *Australia's health 2014*. Canberra: AIHW, 2014. (AIHW Cat. no. AUS 178; Australia's Health Series No. 14.)
[7] NHPA (2015) *Healthy Communities: GP care for patients with chronic conditions in 2009-2013.*

proposed in the AMA's Chronic Disease Plan (**Attachment 1**), which recommended enhanced support for patients in these circumstances.

DVA has established the CVC program, which funds a planned and coordinated health care model for eligible Gold Card holders with one or more chronic conditions, complex care needs and who are at risk of unplanned hospitalisation. CVC targets patients with:

- Congestive Heart Failure
- Coronary Artery Disease
- Pneumonia
- Chronic Obstructive Pulmonary Disease
- Diabetes

CVC involves the preparation of comprehensive care plan by the patient's usual GP, supports a multidisciplinary approach and provides funding for enhanced care coordination, often delivered by the practice nurse. CVC is a serious attempt to keep patients out of hospital and to save downstream health care costs. There is great potential for the development of a similar style program, provided it is well targeted. Twenty percent of hospital patients account for seventy percent of hospital costs, so the patients that would benefit the most from a CVC style program would most likely have one or more of the following conditions:

- Chronic Obstructive Pulmonary Disease
- Congestive Cardiac Failure
- Ischemic Heart Disease
- Diabetes Mellitus
- Renal Disease

Special consideration, in this regard, should also be given to patients who are disadvantaged in accessing mainstream health services, in residential aged care facilities, requiring palliative care, or who have a mental health condition.

The Western Sydney Integrated Care Pilot (WSICP) is another example of an innovative model of care that targets today's high needs patients while providing the extended services to minimise tomorrow's patients. The WSICP is proactive, providing access to additional services for high needs patients, GP-led coordinated team care, and the funding and resources to support and enable longitudinal care and improved patient outcomes. This pilot is yet to be fully evaluated and goes further than a CVC style model.

It looks at establishing better connections between different health services (including hospitals) and closer partnerships with other primary care organisations such as PHNs and enhanced IT tools. Patients are risk stratified and supported with access to care according to their clinical needs. PHNs also assist those practices involved with funding to engage the additional allied health resources they need in caring for patients with chronic conditions, eg an in-house pharmacist, or diabetes educator etc.

IT systems

Effective care coordination and shared care can only be achieved with reliable and interoperable mechanisms for communication between health care providers. The AMA has welcomed the Government's commitment to improving the Personally Controlled e-Health Record (PCEHR) (to be known as MyHealth Record) and looks forward to the outcomes of the

opt-out trials. The AMA sees opt-out as a critical change to increase the uptake and usefulness of the PCEHR to clinicians. It is essential for the efficiency and quality of clinical care that there is a reliable, seamless and trustworthy source of key clinical information about the care and treatment provided to patients in other healthcare settings that is readily accessible to the treating practitioner.

In addition, mechanisms for secure communications between treating practitioner must be expanded. Funding through the PIP has helped equip general practices with the capacity to use this technology. Unfortunately, the other health care providers who GPs would send clinical messages to have not been. Secure messaging capability must be expanded to facilitate continuity of care.

Medical Home

In Australia, the concept of the medical home is well established with the majority of patients returning to the same GP and the same practice. Quality general practice provides safe, clinically necessary, comprehensive, coordinated multidisciplinary, team based and longitudinal care to patients.

While the AMA recognises the potential for the medical home model of primary care to deliver improved outcomes for patients and supports the principles on which the concept is based, its adoption in Australia would require very careful design if it is to be appropriately translated into the Australian context.

Certainly the model has been beneficial overseas, with reported improvements in quality measures, performance and service use, and significant reductions in avoidable hospital admissions, emergency department use and overall care costs.[8] Given the differences in health systems, it is not clear as to the extent to which these results could be replicated in the Australian context. If the PHCAG is to recommend a formal medical home model in Australia:

- It must be appropriately funded, including funding to support administration, additional care coordination, non-face-to-face work;
- Funding should complement existing fee-for-service arrangements, paid on a longitudinal basis;
- It must utilise the patient's usual general practice/GP as the medical home;
- It must be voluntary, allowing patients or GPs to opt out, or reverse their decision;
- It must target patients with chronic disease, with independent evaluation undertaken;
- It must impose minimal administrative burden on practices; and
- It must be based on a GP led team.

Rural Australia

With people in rural areas having poorer access to health care and higher rates of morbidity and mortality as a result, it is vital that GPs in these areas are supported to deliver comprehensive care. Health care in rural areas heavily depends on a strong and multi-skilled

[8] Jackson, C. L. (2012) Australian general practice: primed for the "patient-centred medical home"? Med. J. Aust. 2012, 197(7): 365-366

GP workforce which must be supported in accessing and connecting with specialists, allied health providers and community services.

The AMA has previously proposed the establishment of the Community Residency Program (**Attachment 2**) to provide junior doctors with well supported community-based terms in rural areas, which would provide a strong training experience that is associated with improved retention rates. The Rural Workforce Rescue Package (**Attachment 3**) developed by the AMA and the Rural Doctors Association of Australia also outlines a plan for sustaining the regional and rural workforce through targeted financial incentives so that patients in rural communities have improved access to GPs with the right skills.

With many rural patients having to travel considerable distances to access services it is vitally important that effective e-health solutions are available and supported to facilitate the continuity of the patient care.

Aboriginal and Torres Strait Islander peoples

Despite modest gains in the life expectancy for Aboriginal and Torres Strait Islander people in recent years, progress is slow and much more needs to be done to close the unacceptable gap in health outcomes between Indigenous and non-Indigenous Australians. Recent data has identified stubbornly high levels of treatable and preventable conditions, high levels of chronic conditions at comparatively young ages, high levels of undetected and untreated chronic conditions, and higher rates of co-morbidity in chronic disease. With Indigenous populations experiencing a higher prevalence of risk factors for chronic disease - diabetes, mental health conditions, smoking, being overweight or obese and harmful drinking, ongoing funding via the Closing the Gap Initiative is vital to ensure a network of adequately resourced and responsive primary health care services for Indigenous people.

Innovative care and funding models

The proposed introduction of a Quality Improvement Incentive (QII) under the PIP would be a way for the Government in the short to medium term to better reward and encourage quality care, including preventive and longitudinal care. The QII could provide quarterly payments to practices for achieving a defined level of improvement in the provision of targeted services and/or specified patient outcomes, and for maintaining that level of care. Practices would be able to choose from a suite of improvement areas, those that would best suit the practice's improvement goals, patient and community needs.

Data collection at the practice level would be essential for practices in identifying their goals, measuring their progress and reporting their outcomes. The AMA would argue that in the short to medium term enhancing practices collection and use of data should be a key component of the QII. A longer term objective should be to consider how this practice data can be safely and effectively de-identified and aggregated in order to be shared to inform National health outcome objectives.

The AMA also believes that there are significant benefits to be gained from bringing non-dispensing pharmacists into general practice as part of the GP-led multi-disciplinary team. We have already seen how funding to support the employment of practice nurses has enhanced the breadth of care that general practices can provide. Now there is growing evidence that where pharmacists are part of the general practice team patient medications can be better managed, leading to better prescribing, improved medication compliance, and reductions in medication

misuse, adverse drug events and preventable hospital admissions. The AMA, in conjunction with the Pharmaceutical Society of Australia, has developed a funding model, the Pharmacist in General Practice Incentive Program (**Attachment 4**), to support integrating pharmacists into the general practice team. The introduction of this program would not only better support patient care but would deliver significant savings on health care expenditure.

The AMA has also referenced innovative funding models earlier in this submission including DVA CVC as well as the WSICP.

Better recognition and treatment of mental health condition

It is estimated that 2-3% of Australians have severe mental health disorders, another 4-6% have a moderate disorder, and a further 9-12% have a mild disorder[9]. Australians living in regional, rural and remote areas are 10% more likely to have mental disorder at some point in their lifetime and the suicide rate in these areas is 10-20% higher than in metropolitan areas[10]. Comorbidity is common in people who have a mental disorder, increasing the complexity of their care needs.

General practice plays a key role in mental health care in Australia, as patients often first present to their GP. GPs play a vital role in assessing and coordinating the patient's care with other health professionals and support services. However, with funding in this sector scarce, ready access to mental health services continues to be problematic. For those patients in rural and remote areas, the tyrannies of distance to care and workforce shortages mean many fail to access support services until their conditions deteriorate.

General practice needs to be supported in caring for those with mental health conditions with the establishment of well-defined referral pathways, effective funding arrangements that support team care and its coordination, support for innovative models of care that respond to community needs, make use of available technology to increase patient access to care, i.e. telehealth services, enhance access to crisis care and ongoing support services.

Greater connection between primary health care and hospital care

Continuity is a key tenet of quality care. Continuity of care is associated with improved preventative and chronic care, greater patient and clinician experience, and lower costs.[11]

General practice, is the central point from which patients are referred for clinical necessary services fundamental to their care. Supporting general practice to coordinate the care of patients with chronic and complex health conditions should be a key outcome from the primary health care review. This support should come, not only in the form, of funding to provide for care coordination, communication of transfer of care arrangements, and follow-up services provided on behalf of patient outside of a face-to-face consultation, but also in the form of IT systems that facilitate the timely sharing of clinically relevant patient information. A well-developed

[9] Australian Institute of Health and Welfare. *Australia's health 2014*. Canberra: AIHW, 2014. (AIHW Cat. no. AUS 178; Australia's Health Series No. 14.)
[10] Kõlves, K. et al. *Suicide in Rural and Remote Areas of Australia*, Australian Institute for Suicide Research and Prevention, 2012.
[11] Bodenheimer et al (2014) The 10 Building Blocks of High-Performing Primary Care. Annals of Fam. Med., Vol. 12, No. 2.

and clinician-friendly e-health system would go a long way to improving communications between various parts of the health system and ensuring the continuity of patient care.

The establishment of the PHNs provides an environment to support integrated health care including good transfer of care arrangements in the health system to ensure continuity of care. PHNs and Local Hospital Networks (LHNs) should have formal engagement protocols and some common membership in governance structures, and work together where possible in areas such as assisting with patients' transitions out of hospital back in to the community or, where relevant, into supported home care or aged care.

In this regard, PHNs and LHNs could fund appropriately skilled GPs and hospital specialists to devise collaborative pathways for transfer of care ensuring that best practices are implemented.[12] While the AMA acknowledges that the previous Medicare Locals/LHNs have commenced work on improving care pathways across various part of the health system in their areas, this is not happening consistently across Australia and there is scope for this to be applied across the country.

Questions from the Discussion Paper

What aspects of the primary health system work well for people with chronic and complex health conditions?

General practice is the cornerstone of the Australian health system. It supports patients with chronic and complex health conditions with holistic care, treating their acute and undifferentiated presentations, while providing structured health care with action plans for managing their condition, access to multidisciplinary services where required, and ongoing review.

Without a usual GP/general practice, patient care can easily become fragmented, delaying effective treatment and management, resulting in wasteful use of resources, more expensive treatment requirements and, in some cases, preventable admissions to hospital. Where a patient's care is led by the usual GP that care is coordinated, with appropriate referrals and reporting mechanisms in place to the monitor the patients progress in line with their treatment and management plan. General practice is an efficient and effective gatekeeper and referral point for other health services. The outcomes of the Primary Health Care Review should support the provision of this level of care and strengthen general practices capacity to provide it.

Increasingly, general practices are enhancing the range of services they offer and the comprehensiveness of the care they can provide by expanding their general practice teams with multi-disciplined health professionals. Practice nurses, dieticians, diabetic educators, psychologists, physiotherapists, and pharmacists are just some of the health professionals practices are utilising in the quest to provide quality preventative and comprehensive health care. Practices such as these should be recognised and supported to continue providing this level of care. Practices yet to do so should be encouraged and supported to develop along this pathway.

Government incentives have helped ensure that most practices now have a practice nurse. As previously mentioned, the AMA is currently calling on the Government to support practices to

[12] AMA (2013) General practice/hospitals transfer of care arrangements 2013 https://ama.com.au/position-statement/general-practicehospitals-transfer-care-arrangements-2013

engage the services of a non-dispensing pharmacists because evidence suggests that where pharmacists are integrated within general practices there is greater capacity for interdisciplinary teamwork and the improvement of patient care through the quality use of medicines and improved management of patient medications.[13] General practice is the obvious and proven hub for comprehensive health care.

Government should be mindful of the success of programs such as the Practice Infrastructure Grants, the Practice Nurse Incentive Practice (PNIP), and the Mental Health Nurse Incentive Program (MHNIP), as a models for sensible investment in general practice capacity.

What is the most serious gap in the primary health care system currently provided to people with chronic and complex health conditions?

The lack of an effective, secure, interoperable and streamlined system with which health care providers can communicate regarding patient care is the most serious failing within the current primary health care system. With no reliable access to relevant patient information treating practitioners are restricted in their ability to efficiently optimise patient care. When vital clinical information is unavailable to the treating practitioner patient care is jeopardised and limited resources are wasted. Ineffective systems of communication negatively impact on the coordination of care, which again can jeopardise patient outcomes. Addressing this gap would go a long way to improving the coordination of patient care.

Another serious gap, is the disparity in access to and utilisation of medical and allied health services across the country. Workforce shortages and maldistribution, particularly outside of metropolitan areas, restrict patient access to care, delay timely interventions, and lead to poorer patient outcomes. According to the Australian Institute of Health and Welfare (AIHW) rural people generally do worse than people who live in major cities on a wide range of health status measures.

For example, death rates in regional, rural and remote areas are significantly higher than urban areas. Australian governments must do more to ensure the availability of the medical and allied workforce required to meet community needs. This is one area where innovative programs to build, strengthen and retain GPs and their multidisciplinary teams should be supported and appropriately funded.

How might the technology described in Theme 2 improve the way patients engage in and manage their own health care?

The availability and use of an electronic health record, telehealth, point of care testing, self-monitoring devices etc. have significant potential in increasing patient access to care and in supporting them to manage their condition and share their progress with their GP.

The AMA considers that technology-based patient consultations are an appropriate alternative to consulting with a patient in the same physical room when they are used:

- as an adjunct to normal medical practice;
- for regular patients of the practice;
- for patients who have been referred by another medical practitioner; and

[13] Tan E.C., Stewart K., Elliott R.A., George J. (2014) Pharmacist services provided in general practice clinics: a systematic review and meta-analysis. *Research in Social & Administrative Pharmacy* 2014; 10(4):608-22

- when it is clinically appropriate for the patient's circumstances.

Used in this way, technology-based patient consultations can improve patient access to care and can enhance efficiency in medical practice. They complement but do not replace face-to-face consultations, which enable a physical examination of the patient as part of the therapeutic process. Technology-based patient consultations should only be used in a way that enhances and enables the ongoing care and management of a patient, and should in no way fragment patient care.

As a medical service, it is appropriate that Medicare Benefits arrangements assist patients with the costs of medical care provided using technology-based patient consultations.

Regarding Point of Care Testing (PoCT), the Government funded trial demonstrated that PoCT enables GPs to better manage their patients with established diabetes, established hyperlipidaemia or on anticoagulant therapy. PoCT testing provides GPs with reliable and timely information that enables them to optimise patient therapy. PoCT also assists general practice in engaging patients in their self-management and enables ongoing monitoring and regular follow-up.

Despite the findings of the trials, PoCT continues to receive no funding via the MBS, failing patients and their GPs alike. Greater attention needs to be given to what funding mechanisms could support the evaluation and adoption of new technology which streamlines health care and enhances the proactive management of disease. The QII is perhaps one option. Investing in general practice to support the provision of PoCT is another.

We have already seen the Department of Veterans' Affairs making greater use of health analytics in determining patients who would benefit from a more proactive model of care. In addition, they are taking advantage of emerging technology to monitor and consult with their at risk patients from the comfort of their homes.

Emerging technology provides significant opportunities for patients with chronic conditions and complex health care needs to actively participate in managing their condition with the benefit of enhanced access to medical supervision and intervention, when required. Patients and providers need to be supported in embracing these new modalities of care with education and incentives to participate. There will need to be investment in effective systems, perhaps such as the myHealth Record, for recording or storing patient progress data, and the monitoring and review of patient data will need to be appropriately remunerated.

<u>What enablers are needed to support an increased use of the technology described in Theme 2 to improve team based care for people with chronic and complex health conditions?</u>

Universal take-up of a secure interoperable electronic patient record containing useful and meaningful information and which is easy to use would be a fundamental enabler of improved patient care. Not only would it provide treating practitioners with the information they need to minimise adverse patient outcomes, it would enable patients to keep track of their own health and health events.

In addition, secure modalities for treating practitioners and health care providers to communicate with one another on patient care is also required. While incentives have supported general practices to be equipped with secure messaging capability, this capacity will be wasted until specialists and allied health providers have the same capability. The

Government needs to invest in the technology and support access to it that will facilitate and support team-based care.

Reflecting on Theme 3, is it important to measure and report patient health outcomes?

The AMA encourages and supports practices to not only meet a minimum set of standards in the provision of safe and quality care, but also to continuously pursue improvement. If the health outcomes for patients with chronic and complex health conditions are to be improved then it will be important to define, measure and report on them, provided such activity is based on robust and sensible methodology.

The health outcomes to be measured should be defined as the end result of a medical service or a quantifiable change in the patient's health status that is meaningful, valid and measurable, and recognisable as a single outcome to the patient, carers, or a population.

Health interventions can result in positive or negative health outcomes. These benefits and harms are the result of a complex interplay of many interacting factors. These include the specific medical treatment provided and the environment it is provided in, the patient's pre-existing health status, their ability to understand their needs and the care provided (their health literacy), support systems and social connectedness, the patient's adherence to treatment, ongoing management of their condition, and the effects of treatment or disease complications.

Adherence to treatment makes an important contribution to achieving positive health outcomes. Patient understanding, education and supports can improve adherence to the clinician's advice contributing significantly to health outcomes. These interventions to improve adherence have their own costs and potential downsides and also need to be assessed for effectiveness and sustainability.

When assessing and reporting on the achievement of health outcomes, the ability of patients to adhere to clinical advice in normal circumstances must be assessed and factored in. Current levels of patient adherence, and how to improve them effectively, should be considered as part of any broader work to improve health outcomes.

To be valid for measurement and use, health outcomes must be evidence-based, use verifiable and reproducible data, and be relevant to the purpose and context for which they are being measured and reported.

Measuring outcomes should not be about assigning blame for failure to meet an outcome, but instead should be about identifying what does and does not work, and what alternative strategies may be needed to facilitate improvement.

To what extent should patients be responsible for their own health outcomes?

The vast majority of Australians enjoy very good access to health care as well as nutritious food. Despite this, there is growing prevalence of lifestyle diseases. This may be due in part to low levels of health literacy. Poor health literacy affects the capacity of health care consumers to make decisions and take action to manage their health and health care. With evidence showing that only 40% of adults have a level of health literacy that enables them to assess the safety of product, to understand health messages, and to be able to make good choices health

care choices[14]. Improving Australians' health literacy will be fundamental to enabling Australians to take more responsibility for their health.

How should primary health care payment models support a connected care system?

The best opportunity for connecting care is by recognising and supporting general practice by ensuring GPs can help their patients to navigate a complex health care system and access the care they need from the right health professional. This would include care coordination, streamlined pathways of referral for their patients for specialist care, for clinically relevant allied health services, to community health services, and to specialised programs of care with additional health care needs. General practices must be supported with information about service availability in their local areas and with funding to support and recognise care coordination and longitudinal care.

In addition, an improved shared electronic health record is an essential and logical conduit to a more connected health care system. Such a record must be ubiquitous across the patient population, must contain the core clinical information required for patient care by medical practitioners and other health care professionals involved in their care. There is extra and new work for general practitioners to contribute (probably the largest component of the) core clinical information to the shared electronic health record for their patients and it is only reasonable that this be recognised in the fee for their service. However, given the downstream savings arising from continuity of patient care and avoidable hospitalisations that are expected from a shared electronic record, it is appropriate that the Federal Government meet the costs of this activity in general practice.

What role could Private Health Insurance have in managing people with chronic and complex health conditions in primary health care?

The AMA supports a limited role for PHIs in general practice/primary care. In 2014, the AMA released its position statement Private Health Insurance and Primary Care Services 2014 (**Attachment 5**) that recognises the potential for targeted reforms to improve patient care and save the health system money.

GPs provide holistic and well-coordinated care for patients, including preventative health, yet this largely goes unrecognised in current private health insurance arrangements. PHIs have introduced a number of programs that provide their members with access to services such as telephone coaching, exercise physiologists, dieticians, and physiotherapists to better manage their chronic conditions. While these programs can potentially benefit patients, they generally work in isolation to the usual GP/general practice who understands their patients care needs. This is a significant problem and fragments patient care.

In this context, there is certainly scope for PHIs to explore the potential for greater engagement with general practice to improve the coordination of patient care, ensure care is provided in the most appropriate clinical settings, and avoid unnecessary hospital admissions.

The attached position statement outlines the areas that the AMA believes could be explored including wellness programs, maintenance of shared electronic records, hospital in the home, palliative care, minor procedures, and GP directed hospital avoidance programs.

[14] Australian Commission on Safety and Quality in Health Care. August 2014. *National Statement on Health Literacy: Taking action to improve safety and quality*.

However, it is important to stress that patient choice and clinical autonomy are among the great strengths of our health system and must be protected. We do not want in any way to proceed down the managed care route adopted in countries such as the United States. Some PHIs seem to be taking a more interventionist approach to the funding of the provision of care for their members and, to this extent, any model implemented would need to satisfy a number of criteria including:

- Recognition and support for the usual GP as the central coordinator of patient care;
- A collaborative approach to care, with the usual GP retaining overall responsibility for the care of the patient;
- Appropriate access to care based on a patient's clinical needs;
- Preservation of patient choice; and
- Protection of clinical autonomy.

Prepared by the Australian Medical Association September 2015

List of Attachments:

Attachment 1:	AMA's Chronic Disease Plan: Improving the care for patients with chronic and complex care needs
Attachment 2:	Community Residency Program for Junior Medical Officers
Attachment 3:	AMA/RDAA Rural Workforce Rescue Package
Attachment 4:	Pharmacist in General Practice Incentive Program
Attachment 4a:	Deloitte Access Economics: Analysis of non-dispensing pharmacists in general practice clinics
Attachment 5:	AMA Position Statement: Private Health Insurance and Primary Care Services 2014

Improving care for patients with chronic and complex care needs

Revised 2012

1. Introduction

The AMA recognises the need for more efficient arrangements to support the provision of well-coordinated multidisciplinary care to patients with chronic and complex disease. If access to coordinated multidisciplinary care is improved then patients will benefit, the number of avoidable hospital admissions can be reduced, and long-term savings to the health system will be generated.

The AMA supports a comprehensive approach to the management of chronic and complex disease based on arrangements that:

- Provide GP-coordinated access for patients to services based on clinical need;
- Provide a patient's usual GP with the support they need to improve the care they can provide/organise for patients with chronic and complex disease;
- Support GPs to facilitate access for their patients to other members of a multi-disciplinary primary care team;
- Continue to ensure that funding follows the patient;
- Lead to better collaboration with existing service providers; and
- Simplify and enhance the existing MBS chronic disease arrangements.

The AMA believes that significant gains can be made in improving care for patients with chronic and complex care needs by improving existing systems and processes so that they provide GPs and their patients with the support they need.

In considering this issue, it is important to recognise that current MBS arrangements are meeting the needs of most patients. The Government's own draft Primary Care Strategy said in this regard that *supported by the Medicare Benefits Schedule (MBS), most Australians have good access to affordable services provided through general practice, have a choice of provider, and have been supported in their access to many specialist and diagnostic services*.

2. Background

2.1 Care for patients with chronic and complex needs

The care needs of Australians are becoming more complex with the ageing population and increasing incidence of chronic disease. Increasingly patients are suffering from multiple chronic conditions, which complicate their care needs. These patients need the services of a range of medical and allied health services in managing their conditions. Care in this environment can easily become fragmented unless that care is coordinated and appropriate referral and reporting mechanisms are in place to monitor the patient's progress in line with their treatment and management plan.

The increasing burden of chronic disease has a significant cost impact on Australia's health system. Fifty percent of GP consultations involve patients with a chronic disease, such as heart disease, cancer or diabetes[1]. This cost of chronic disease is further added to with at least 10% of hospitals stays for patients with chronic conditions potentially preventable had timely and adequate non-hospital health care been provided[2]. The Australian Institute of Health and Welfare reported that in 2007-08 there were 33.6 potentially preventable admissions per 1,000 people and that more than half of those were due to chronic conditions[3]. With preventable admissions costing over $1.3 billion a year[4] there is an incentive for Government to support more coordinated care in order to keep people out of hospital by better caring for them in the community.

Coordinated care ensures the patient receives the care and services they need to better manage their health in a community setting and prevents avoidable hospital admissions.

2.2 Evidence from the research

The benefits of coordinated care are recognised around the world. In 2011 the World Medical Association issued a statement on the Global Burden of Chronic Disease[5]. In this statement the WMA advocates for the promotion of prevention health strategies, team based chronic disease management, and continuity of care for patients with chronic disease and this was backed by findings from a number of studies.

The Coordinated Care Trials in Queensland in 2008 for example, demonstrated that coordinated care reduced hospital admissions by up to 25%, reduced inpatient costs by 26%, reduced patients rate of depression and improved their quality of life[6]. The trial demonstrated that when all costs are included (MBS, PBS, hospital etc), service provision costs can be reduced by 8%. In addition, the trial found that when patients were connected to community models rather than acute models of care that they were more active in their own health maintenance.

In 2005 SA HealthPlus successfully implemented a generic model of coordinated care with improved health and wellbeing outcomes[7]. Evidence gathered suggested that the key components of the model were the programs and goal approach, the care plan, and service coordinators working with general practitioners and patients. It was determined that costs savings in the short

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[1] Australian Institute of Health and Welfare (2006), Chronic diseases and associated risk factors in Australia 2006, (Australian Institute of Health and Welfare: Canberra)

[2] National Health and Hospital Reform Commission, A Healthier Future for all Australians Final Report June 2009, p56

[3] Australian Institute of Health and Welfare (2010), Australia's Health 2010, p486 (Australian Institute of Health and Welfare: Canberra).

[4] Estimated from data presented by Wilcox S, Making Prevention the Priority, 10th Annual Health Congress 2008, Health Policy Solutions.

[5] World Medical Association (2011) Global Burden of Chronic Disease, the 62nd WMA General Assembly, Montevideo, Oct 2011.

[6] GP Partners, Coordinated Care (2008) Team Care Health II Perspectives, http://www.gppartners.com.au/content/Document/report_teamcare.pdf.

[7] Battersby, Malcom W and the SA HealthPlus Team, Health reform through coordinated care: SA Health Plus. BMJ, Vol 330, 19 March 2005.

term were best achieved by better targeting those patients who would benefit the most from coordinated care. Those patients most likely to benefit are those who:

- are not already linked with services,
- lack knowledge of their condition,
- are depressed,
- lack motivation to change behaviour,
- have lifestyle risk factors, and
- conditions are poorly controlled.

Further, the study concluded that better targeting of coordination activities should be based on patients who have had a prior admission to hospital and a potential to improve self-management.

A systematic review[8] of various care coordination strategies has found that in more than 50% of studies all were associated with improved health and/or patient satisfaction. The strategies identified for the review were classified into two groups: i) communication and support for providers and patients, and (ii) structural arrangements to support coordination. Those interventions that used multiple strategies were found to be more successful than those using single strategies.

Another study, an analysis of community care models in North Carolina, USA, has demonstrated that the potential health system cost savings models of comprehensive and proactive primary care should generate are between 7% to 15%[9]. The study concluded that cost savings were associated with reduced costs for emergency room visits, inpatient hospital admissions, and other services as patients receive improved access to primary care, prescription drugs, and other appropriate treatments for chronic conditions. These were the expected cost savings from future medical services that would have but were avoided by earlier intervention.

Overall the evidence suggests that coordinated care is: beneficial for patients; improving their health and wellbeing; and is beneficial to the health system (because it reduces the costs that would eventuate through poorer health outcomes and avoidable hospital admissions).

2.3 Effective care coordination

The AMA believes effective care coordination involves:

- Care that is led by the patient's usual GP and based on clinical need.
- Actively involving the patient in goal setting and decision-making.
- Enabling patients to better understand and manage their condition.
- Funding that follows the patient, i.e. through the existing Medicare Benefits System (MBS), and supports the provision by GPs of initial and ongoing care.
- Funding that supports the coordination and transition of patient care between health care providers and across health care and community sectors.

[8] Powell Davies, Gwaine, et. al. (2008) Coordinating primary health care: an analysis of the outcomes of a systematic review. MJA 2008; 188 (8 Suppl): S65-S68.

[9] Cosway, Robert et al. (2011) Analysis of Community Care of North Carolina Cost Savings, Millman Report for the North Carolina Division of Medical Assistance, 15 December 2011.

2.4 Current MBS arrangements for funding chronic and complex care needs

Current Medicare arrangements provide support to patients so that they can see a GP when they need to. MBS funding follows the patient and the rebate is directly linked to the provision of a service by a GP. Patients with chronic and complex disease can also access some allied health on referral from a GP in defined clinical circumstances. The Government only pays for the services that are delivered.

Where patients face significant out-of-pocket costs for out-of-hospital services, the Medicare Safety Net will pick up 80% of these costs once certain thresholds are reached.

In addition, patients with total net (out of pocket) medical expenses of over $1,500 in certain categories (including Medicare payable items) can claim through the income tax system a 20% rebate on those expenses.

3. GP-coordinated care for patients with chronic and complex diseases

GPs are highly trained professionals who are accountable to their patients and work within established codes of professional conduct. GPs are the highest trained general health professional assessing and managing patient care according to their individual overall health needs. The AMA considers GPs are the best placed health professional to lead coordinated care for patients with chronic and complex disease.

GPs are the most visited health professional, with about 85% of the population seeing a GP at least once a year[10]. The National Health and Hospital Reform Commission (NHHRC) recognised this (GPs being the most visited health professional), proposing to build on it by improving access to a more comprehensive and multidisciplinary range of primary health care and specialist services in the community. The NHHRC also recognised the value that a 'medical home' provided to patients in ensuring coordinated care[11]. AMA research shows that 88% of people have a usual family doctor[12] and therefore a 'medical home'. Having a trusted family doctor is good for your health, with research showing that people who have an ongoing relationship with a family doctor have better health outcomes and lower death rates.

GPs manage a vast array of conditions with over one-third of the problems they manage chronic in nature. The chronic problems most often managed by GPs being hypertension, depressive disorder, diabetes, lipid (cholesterol-related) disorders, chronic arthritis, oesophageal disease and asthma[13]. Since 1998-99 there has been statistically significant increases in the management rate of each of these conditions, except asthma, which has been declining.

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[10] Australian Institute of Health and Welfare (2008), Australia's Health 2008, (Australian Institute of Health and Welfare: Canberra).

[11] National Health and Hospital Reform Commission, A Healthier Future for all Australians Final Report June 2009 Chapter 4, 4.2.1 Primary health care as the cornerstone of our future health system

[12] Essential Research. National Patient Poll, Commissioned by AMA, 2010.

[13] Australian Institute of Health and Welfare (2010), Australia's health 2010, (Australian Institute of Health and Welfare: Canberra).

The Government has acknowledged the value in GP-coordinated care for patients with chronic and complex diseases by funding the Department of Veterans' Affairs (DVAs) Coordinated Veterans Care (CVC) program. The AMA was involved throughout the program's design and as such it upholds and supports the GPs role in providing clinical leadership and oversight to the coordination of patient care. Building on existing funding mechanisms, the program sets a benchmark for the management of chronic and complex diseases. With a few changes to expand current funding arrangements this benchmark could be extended throughout the rest of the community in order to proactively manage and care for patients, preventing avoidable hospital admissions and saving scarce health resources in the process.

4. AMA model for improving care of patients with complex and chronic disease

Australia's high-quality primary health care system is built on the solid foundation of the role of the GP. GPs could do more to provide access to multidisciplinary care and support services for patients with chronic and complex disease. However, existing chronic disease management arrangements are too limited, cumbersome, difficult for patients to access, unreflective of established referral practices and are wrapped up in red tape and bureaucracy.

To deliver real benefits for patients and maximise the impact of available funding, new arrangements need to be put in place that better support GPs to provide patients with chronic and complex disease with access to multidisciplinary care and essential support services.

The NHHRC suggested "An enhanced Medicare in the future"[14] that:

- Supplements medical services with a broad package of health services (allied health, nursing and other health professionals) to support complex and continuing care;
- In addition to personal individual consultations, encourages and supports team-based and multidisciplinary care;
- Adds to current benefits as it pays for a mix of private and publicly delivered services (expanded to cover state-funded primary health care services, public hospital outpatient specialist services and selected allied health and other health professional services);
- Adds greater scope to support stronger focus on prevention, health promotion, early intervention and wellbeing, including supporting people in self-management;
- Supports a broader range of specified services by health professionals providing care within their defined scope of practice (and provided it is safe and cost-effective) and for innovative, collaborative care models within services;
- Supports the development of more integrated safety net arrangements that protect people from unaffordable costs; and
- Also pays for different types of services – email, telephone, telehealth (e.g. video conferencing) – that do not involve the physical presence of the patient. Payment for these services may be part of episodic payment or grant payments.

[14] Excerpts from National Health and Hospital Reform Commission Final Report June 2009 Table 4.1 An evolving Medicare.

The AMA plan provides a comprehensive and coordinated care for patients with complex and chronic disease, which satisfies the intentions of the NHHRC goals as detailed above.

4.1 Level 1 - GP Management Plans

GP Management Plan (GPMP) arrangements in the MBS provide a structured approach to caring for patients with chronic and complex disease, although presently they do not provide patients with access to allied health and other support services. To provide access to allied health services GPs must also prepare a team care arrangement, which involves additional red tape.

We know that early intervention helps to improve health outcomes and in this regard initial access to a limited number of multidisciplinary and other support services through GPMPs could yield significant benefits for patients. The GPMP pathway could also provide access to medically appropriate preventive health services for individuals at high risk, e.g. developmental delay in children.

The AMA believes that GPMP arrangements should be simplified and reformed so that they provide "automatic" access to a predetermined number of GP referred services. On referral from a patient's usual GP, GPMP arrangements should provide patients with access to:

- Five funded visits to allied health services per annum[15];
- Parenting programs for children at risk; and
- Selected home aids including home safety, mobility aids, vital call, diabetes equipment, continence aids and therapeutic appliances.

This arrangement is similar to that in place with the Department of Veterans' Affairs (DVA), which enables access to allied health providers upon referral from a medical practitioner, typically the patient's usual GP.

Unlike the existing Team Care Arrangement (TCA) item that provides patient access to allied health services, the requirement for the GP to consult with other care providers prior to referral would be removed under this revised arrangement for the GPMP. Prior consultation with allied providers is burdensome and does not accord with accepted medical practice. When patients are referred by GPs for services from other health care providers, such as other specialists, they are not subject to the same level of prescription and red tape that the current TCAs impose.

In relation to home aids, we believe that it would be possible for Medicare Australia to contract with relevant suppliers for the provision of these services, much like the DVA does for veterans needing extra support to continue living at home.

4.2 GP Management Plan Review

The existing GP Management Plan Review item in the MBS should be retained in order to check patients progress against the plan and to make amendments to the plan if clinically required. If in the GPs opinion, extra clinically relevant allied health services are required, the review item should enable access to additional referred services.

[15] Noting that private providers, community health centres or public hospitals could provide these services

Where the GP determines upon subsequent review that a patient's likely health outcomes are not improving, there is a significant risk of hospitalisation or rehospitalisation due to their condition/s, and that they would benefit from a more coordinated approach to their care, the GP may consider the patient eligible for access to a coordinated care program.

4.3 Level 2 - Coordinated Care for patients that need more support

The Coordinated Care program, administered through Medicare Australia, would provide those patients with chronic and complex disease that need greater support than can be provided through a GPMP, particularly those at risk of a preventable hospital admission, with streamlined and coordinated access to a range of services relevant to their clinical needs.

Similar to the DVA's Coordinated Veterans' Care (CVC) program, access to the program would be determined by the GP upon the completion of an eligibility assessment. If the patient is assessed as eligible and is willing to participate in the program the GP (with the assistance of a Practice Nurse or Aboriginal Health Worker) will conduct a needs assessment and develop a Comprehensive Plan for Coordinated Care, which is shared with the patient. The needs assessment and resulting Comprehensive Plan for Coordinated Care will essentially be a revised and simplified version of the current TCA item.

The AMA accepts that strict eligibility guidelines would need to be developed to govern access to the program, including the requirement for the patient to already have a current GPMP in place. Patients would only be eligible to access the program where they were assessed by their usual GP as requiring and likely to benefit from additional support beyond that which is available through a GPMP.

Under a Comprehensive Care Plan for Coordinated Care, the GP funded access should be available to the following:

- GP-referred allied health and nursing services;
- A broader range of home aids, ramps for disability, home safety, mobility aids, wheel chairs and vital call;
- Transport services to assist with access to medical or allied health care;
- An enhanced safety net for medications;
- Dressings; and
- Education programs.

The program would retain a review mechanism similar to existing MBS review items in order to assess a patient's progress and ongoing eligibility for this extra support.

GPs may enlist the assistance of a Practice Nurse or Aboriginal Health Worker to act as a Care Coordinator for the patient. The Care Coordinator:

- coordinates patient access to referred services, liaising where required with providers to identify available services, facilitating access (applications etc) and arranging appointments and transport if required;

- monitors patient health and wellbeing, and progress against the plan – via phone, home visit or videoconference – providing regular feedback to the GP;
- provides patient advice and education, where appropriate, on better managing their health and well being;
- liaises with the patient's carer as to patient's progress against the plan or of any changes to the plan;
- liaises with emergency and/or hospital discharge departments; and
- maintains patient records as to monitored action and coordination activities.

Under the program, GPs in addition to the relevant MBS items, would be supported with funding to prepare their practices for coordinated care with an additional payment per patient with a Comprehensive Care Plan for Coordinated Care and ongoing quarterly payments to support the additional services (e.g. monitoring, liaising, educating, coordinating etc.) provided on behalf of the patient.

This Care Coordination Model is line with the DVA's CVC program to which the AMA was a key contributor.

5. How does the AMA plan addresses the needs of patients with chronic and complex disease?

The AMA proposal is a comprehensive plan to address the needs of patients with chronic and complex disease. The AMA's proposal:

- Ensures that patients do not lose their entitlement to a Medicare rebate;
- Ensures services are funded on an as needs basis and under arrangements that do not compromise the doctor/patient relationship;
- Means patients would have more choice and greater control over decisions about their health care;
- Provides patients with multiple chronic conditions and related complex care needs with improved access to GP coordinated care services ensuring continuity of care;
- Seeks to enhance proven existing arrangements so that they work better for patients;
- Provides access to a broad range of allied health and other support services;
- Supports proactive care and preventive medicine;
- Respects the professionalism of GPs and the comprehensive care that they provide to patients;
- Reduces the red tape burden on GPs; and
- Is both clinically and cost effective.

6. The role of Primary Health Care Organisations in Coordinated Care

The AMA acknowledges the potential reach of Primary Health Care Organisation (PHCOs), also known as Medicare Locals, in supporting and in coordinating services for people with chronic and complex disease. However, Medicare Locals need to be introduced in a way that is respectful of the existing role of GPs and other community based Specialists and in a fashion that seeks to maximise positive relationships and partnerships at all levels.

The AMA believes that the activities of Medicare Locals, should be to support and complement general practice. In this context, Medicare Locals will be of assistance to general practice by:

- improving population health planning at the local level so as to help reduce the risk factors that lead to the development of chronic conditions; and
- organising allied health services in areas of unmet need so that GPs can provide patients with access to such services.

Prepared by the Australian Medical Association
April 2010 - Revised February 2012

COMMUNITY RESIDENCY PROGRAM FOR JUNIOR MEDICAL OFFICERS

Summary

A proposal from the Australian Medical Association for the Commonwealth Government to establish and fund a system to support high quality prevocational placements in general practice for junior medical officers

Community Residency Program for Junior Medical Officers

Background

The 2014/15 Federal Budget saw the abolition of the Prevocational General Practice Placements Program (PGPPP), effective from the end of 2014. The PGPPP was the successor to the Rural and Remote Area Placement Program. The PGPPP commenced in 2004, initially funding 280 twelve-week placements per annum from 2005 onwards. By the time of its conclusion, the PGPPP funded 900 placements annually.

The decision to end the PGPPP has left general practice in the position where it is the only major specialty area where junior medical officers (JMOS) are unable to access (in a structured way) some experience before making a career choice. This has implications for recruitment into general practice and makes it very difficult for doctors working in other specialties to have a proper understanding and appreciation of general practice, how it functions, and the role it plays in the health system.

Why is it important for junior medical officers to experience general practice?

The Government's decision to cease the PGPPP from 31 December 2014 has effectively seen the Commonwealth withdraw from any role in providing support for JMOs to work in general practice before they choose a vocational training pathway.

The PGPPP was a valuable program for many reasons. It supported efforts to deliver more training and care in the community, supplementing the traditional hospital-based approach to medical training. Through careful targeting, it also boosted access to GP services in rural and remote communities.

The PGPPP gave JMOs a valuable insight into life as a GP, and informed their career choice. While it encouraged some participants to enter GP training, it also helped others to decide that general practice was not for them. Both are equally valid objectives, with the latter helping to avoid the investment of Commonwealth resources in people who enter and then later drop out of the GP training program.

The program also helped build an understanding of how general practice works, informing future practice in other specialty areas. With a deeper appreciation of the role of GPs, other specialists can make better decisions about patient care and work more closely with their GP colleagues.

An alternative model – Community Residency Program

Recognising the importance of prevocational experience in general practice, the AMA has developed a proposal for a Community Residency Program for JMOs. This is designed to provide the same high quality general practice experience, but delivered more cost effectively than the former PGPPP.

The proposed Community Residency Program will also provide patients with much-needed medical services, particularly in regional and rural Australia, and ease pressure on access to prevocational training places for JMOs in the hospital sector.

Community Residency Program - Design Principles

- Participation in the program will be available to JMOs from PGY1 onwards.

- Participation in the program by any individual JMO will be upon application to a GP training provider accredited by the State/Territory-based postgraduate medical education council (PMEC), as part of the doctor's pre-vocational medical education and training.

- JMOs undertaking a placement will remain employees of the local health authority, effectively working on 'secondment'.

- JMOs in the program will work under the supervision of a specialist general practitioner recognised by the Medical Board of Australia (MBA).

- Design and supervision of the placement will be in accordance with criteria established by the two GP Colleges, with PMECs to assess and accredit practices.

- Rotations will be of 10 to 13 weeks in duration (FTE), with part time placements available.

- Placements in the program will be available in a range of outer urban, regional, and rural areas, based on a practice's suitability and capacity to provide supervision and support, as well as community need. In relation to inner metropolitan areas, there should be the capacity to place JMOs in demonstrated areas of need (e.g. Aboriginal Medical Service).

- The program will be implemented as an "Approved Placement Program" under Section 3GA of the Health Insurance Act (1973), enabling patients to access Medicare rebates.

- The Medicare rebate available to patients treated by a JMO (PGY2+) under the program should be at the rates in Group A1 of the Medicare Benefits Schedule (MBS).

- The new GP Training Governance Committee being established by the Commonwealth would be responsible for general oversight of the program, including the development of appropriate policies about the operation of the program.

Community Residency Program - Funding

The following costs, aside from costs attributable to the MBS, should be encompassed in any new funding model:

- Practice support to provide supervision for JMOs, recognising that this should include compensation for supervisors seeing fewer patients;

- GP training provider (i.e. fund holder) administration costs;

- General practice infrastructure and support to cover the use of practice resources, licences, software, minor equipment, and the like;

- Briefing, orientation, provision of educational resources;

- Travel costs to a placement, applying only where a JMO is required to relocate;

- Accommodation costs, applying only where a JMO is required to relocate for a placement; and

- Costs incurred by the GP Colleges and PMECs in relation to accreditation arrangements.

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RURAL DOCTORS ASSOCIATION OF AUSTRALIA

Caring for the Country

AMA/RDAA Rural Workforce Rescue Package

Background

There are significant concerns over the sustainability of the rural medical workforce with obvious adverse implications for the health of rural Australians. The AMA and RDAA believe that a rural medical workforce crisis now exists and that an urgent intervention is required to attract Australian trained doctors to rural Australia.

According to the Australian Institute of Health and Welfare (AIHW) rural people generally do worse than people who live in major cities on a wide range of health status measures. For example, death rates in regional, rural and remote areas are significantly higher than urban areas.

Health services in rural areas are also being rationalised, which is making access to health care more difficult for rural patients. Since 1995 around 50% of maternity units alone have been closed across the country. Funding levels are lower with the under-spend for Medicare funded GP services being estimated at $157m in 2004/05. Private health services are more widely available in urban areas so the benefit of the private health insurance rebate is not as significant in rural Australia. This short changes rural Australia by around $100m per annum.

Rural communities are finding it harder and harder to recruit and retain doctors. According to the latest AIHW statistics overall medical practitioner supply has increased in metropolitan regions and decreased in non-metropolitan regions. The decreases in the rates of supply in the three non-metropolitan regions were: (per 100,000 population) from 147 to 143 FTE in Outer regional areas, from 152 to 133 FTE in Remote areas and from 138 to 95 FTE in Very remote areas.

The influx of overseas trained doctors is the only reason that medical workforce numbers in rural areas are not in complete free fall. Up to 50% of doctors in some parts of rural Australia are now overseas trained - well above the 25% average across the country. Even

with the contribution of overseas trained doctors at least 1000 additional doctors are needed to fill current vacancies.

It is a grim statistic that in the last 15 years less than 5% of graduates from Qld and NSW universities have taken on rural practice and there is no sign that this percentage is increasing.

How can we turn this situation around and restore health services in rural Australia?

The AMA and RDAA have proposed a range of policy initiatives that will directly benefit rural patients. These include more funding for rural hospitals, a rural health obligation, more support for patient transport schemes, expanded specialist outreach services, and training strategies. These are important, but they are not enough to fix the problems in rural Australia once and for all.

The Government needs to commit to a significant initiative that is simple to understand and implement. It must give a clear signal that doctors currently working in the bush are valued and that moving to the bush is an attractive option.

The RDAA and AMA are proposing that a two tier incentive package be introduced for rural doctors. The first tier is designed to encourage more doctors to work in rural areas including GPs, other specialists and registrars. It takes into account the greater isolation involved with rural practice.

The second tier is aimed at boosting the number of doctors in rural areas with essential obstetrics, surgical, anaesthetic or emergency skills. Rural areas need doctors with strong skills in these areas to ensure that communities have access to appropriate local services including on call emergency services.

The proposed loadings would be based on the existing rurality loadings in the Practice Incentives Program - split into two tiers. It is envisaged that the program would be implemented via the existing Service Incentive Program (SIP) and incentives would be calculated as a loading on rural doctors' Medicare billings or as a special payment for salaried rural doctors. The loading would increase with the rurality - based on the Rural, Remote and Metropolitan Areas (RRMA) classification system.

The RDAA/AMA model can be summarised as follows:

Tier One - Rural Isolation payment

- This would be available to all rural doctors including GPs, locums, other specialists, salaried doctors and registrars.
- Incentive payment based on isolation. Support increases with rurality.
- Activity based - calculated on a percentage of Medicare billings.
- Special payment arrangements for salaried doctors.

Tier Two - Rural procedural and emergency/on call loading

- This would be targeted at procedural and emergency skills and would include specialists.
- To be eligible a doctor would need to be credentialed by their hospital to undertake obstetrics, surgery, anaesthetics or primary on-call emergency services.
- Eligible doctors must be providing meaningful on-call services for the local hospital.
- Special criteria to be established for small population centres for doctors that provide regular emergency on-call services where no hospital exists.
- Activity based - calculated on a percentage of Medicare billings.

The final incentive structure is subject to further discussion and agreement, with one possible loadings structure* outlined below.

RRMA	**3**	**4**	**5**	**6**	**7**
Tier One	7.5%	10%	20%	12.5%	25%
Tier Two	7.5%	10%	20%	12.5%	25%

** Incentives paid through SIP would be calculated by the above percentage loadings to Medicare billings*

These incentives would be promoted through a variety of available mechanisms including a special section in the Medicare Benefits Schedule. To ensure take up of the package, payments would need to be regular – at least quarterly.

How much will this rescue package cost?

It is estimated that this investment in rural health care would be of the order of $300m to $400m annually. Given the extent of rural workforce shortages, this is not an unrealistic or excessive amount.

Summary

The RDAA and AMA believe that unless immediate action is taken to address the rural workforce crisis that access to health services in the bush will be further reduced and that many rural communities will be significantly disadvantaged. A key part of addressing rural workforce shortages must include appropriate rural specific incentives to attract and retain doctors along with other measures outlined in the AMA and RDAA Election documents. The cost of implementing the rural specific incentives will be significantly outweighed by the cost of not implementing them as rural communities are unable to access health services and as a consequence will be unable to retain and attract families to their communities.

AMA

GENERAL PRACTICE PHARMACISTS – IMPROVING PATIENT CARE

Summary

A proposal from the Australian Medical Association for the Commonwealth Government to establish a funding program to integrate non-dispensing pharmacists within general practices.

Pharmacist in General Practice Incentive Program (PGPIP)

Summary

The costs to the health system associated with overprescribing, medication misuse, adverse drug events (ADEs), and preventable hospital admissions are significant.

A study by Picton and Wright (2013)[i] estimated that rates of patient non-compliance with their medications are as high as 33%, and the Australian Commission on Safety and Quality in Health Care (ACSQHC) estimates there are 230,000 medication related admissions to hospitals annually, costing an estimated $1.2 billion (Roughead et al, 2013).[ii]

The Australian Medical Association (AMA) believes that there are significant benefits to be gained from integrating non-dispensing pharmacists within general practices as part of a GP-led multi-disciplinary team. While there has been a strong trend to have allied health professionals and nurses working in GP-led multi-disciplinary teams this, to a large extent, has not included pharmacists.

Independent analysis undertaken for the AMA by Deloitte Access Economics also shows that the integration of pharmacists within general practices will deliver net savings to the health system of the order of $545m over four years, primarily through fewer avoidable hospital admissions and a reduction in the utilisation of medications.

This paper outlines a proposal for the Commonwealth Government to establish a funding program to integrate non-dispensing pharmacists within general practices. Under the model outlined in this paper, pharmacists will assist GPs with medication management to deliver:

- Better coordination of patient care;
- Improved prescribing;
- Improved medication use;
- Reduced medication-related problems;
- Fewer ADEs;
- Fewer hospital admissions (from reduced ADEs);
- Improved health outcomes for patients, including a better quality of life.

Integrating pharmacists within general practices

Rationale

Funding provided under the Fifth Community Pharmacy Agreement provides for approximately 52,000 Home Medicines Reviews (HMRs) in each year of the agreement, but there are about 700,000 patients with co-morbidities who would benefit from a review of their medications. This is a significant gap. In addition, there are more than 7 million patients with chronic diseases (based on Australian Institute of Health and Welfare (AIHW) estimates)[iii] in Australia who could potentially benefit from having their medications reviewed.

A systematic review (2014) [iv] of pharmacists working in collaboration with GPs concluded that "*Pharmacists co-located in general practice clinics delivered a range of interventions with favourable results in various areas of chronic disease management and quality use of medicines*."

Evidence suggests that where pharmacists are integrated within general practices there is greater capacity for interdisciplinary teamwork and the improvement of patient care.[v] Working in collaboration

with GPs in a general practice provides the ideal setting for pharmacists to utilise their complementary skills to ensure the quality use of medicines and the reduction of ADEs in patients.[vi] It has also been shown that where there is an integrated pharmacist conducting HMRs the timeliness, uptake and completion of HMRs is increased.[vii]

Further, the PINCER trial, conducted in England in 2010, found that pharmacists play a critical role in reducing medication errors in general practice. Study findings demonstrated that pharmacist input and collaboration with GPs reduced the frequency of prescription errors and medicine monitoring errors.[viii]

Proposed role for pharmacists in general practice

The role of the general practice pharmacist would not include dispensing or prescribing medication or issuing repeat prescriptions. The AMA proposes that non-dispensing pharmacists in general practice will focus on medication management, in particular:

- medication management reviews conducted in the practice, an Aboriginal Health Service, the home or a Residential Aged Care Facility (RACF),
- patient medication advice to facilitate increased medication compliance and medication optimisation;
- supporting GP prescribing;
- liaising with outreach services and hospitals when patients with complex medication regimes are discharged from hospital;
- updating GPs on new drugs;
- quality or medication safety audits; and
- developing and managing drug safety monitoring systems.

Supplementary activities, depending on the needs of individual practices, could include activities such as patient education sessions, mentoring new prescribers and teaching GP registrars on pharmacy issues.[ix]

Proposed funding model

The most feasible approach to funding pharmacists in general practice is to adapt existing models that have been accepted and shown to work in general practice. The AMA proposes the introduction of a PGPIP that is structured in the same way as the existing incentive payments provided for nurses working in general practice. Introduced during 2012, the Practice Nurse Incentive Program (PNIP) supports an expanded role for practice nurses. Similar to the PNIP, the AMA proposes that PGPIP adopt the following payment structure:

- $25,000 per year, per 1000 Standardised Whole Patient Equivalent (SWPE) where a pharmacist works at least 12 hours 40 minutes per week.
- Incentives will be capped at five per practice, meaning that practices will be eligible to receive up to $125,000 per year to support their pharmacist workforce.
- A rural loading of up to 50% for rural and remote practices.
- To be eligible to receive the pharmacist incentive payment, a practice must:
    - meet the Royal Australian College of General Practitioners (RACGP) definition of a general practice;
    - be accredited or registered for accreditation against the RACGP Standards for general practice and be fully accredited within 12 months of joining the PGPIP;
    - maintain practice accreditation;
    - have current public liability insurance;
    - ensure all practice GPs have current professional indemnity cover;

- employ or otherwise retain the services of a qualified pharmacist;
- employ or retain the services of a GP (including less than one full-time GP); and
- make sure all pharmacists are covered by the appropriate professional indemnity insurance arrangements required by the Australian Health Practitioner Regulation Agency (AHPRA) or by the professional's registration body.

The economic case to integrate pharmacists within general practice

An AMA commissioned independent analysis by Deloitte Access Economics of the AMA's proposed initiative and funding model demonstrates that it would result in significant savings to the Australian health system - totalling $544.87m over four years.

The analysis considers the current costs (base case) of ADEs, overprescribing and medication non-compliance and compares this to the costs of the AMA's proposed initiative. The projections cover the four years from 2015-16 to 2018-19 and take into account costs including the Pharmaceutical Benefits Scheme (PBS), Medicare Benefits Schedule (MBS), hospital and individual expenditures, as well as the cost of the PGPIP.

The analysis shows that the AMA's proposal delivers a benefit-cost ratio of 1.56, which means that for every $1 invested in the program it generates $1.56 in savings to the health system.

The study estimated that around 3,100 general practices would take up the PGPIP and although it would cost the Federal Government $969.5 million over four years, this would be more than offset through broader savings to the health system in the following areas:

- Hospital savings of $1.266 billion – due to reduced number of hospital admissions following a severe ADE;
- PBS savings of $180.6 million – due to the reduced number of prescriptions from better prescribing and medication compliance;
- Individual savings of $49.8 million – reduced co-payments for medical consultations and medicines; and.
- MBS savings of $18.1 million – due to reduced number of GP attendances following a moderate or severe ADE.

A copy of the Deloitte Access Economics paper is attached.

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[i] Picton, A. and Wright, H. (2013) Medicines optimisation: helping patients to make the most of medicines, Royal Pharmaceutical Society, London.

[ii] Roughead, L., Semple, S., and Rosenfeld, E. (2013) Literature review: medication safety in Australia, Australian Commission on Safety and Quality in Health Care, Sydney.

[iii] AIHW (2014) Australia's health series no. 14, Ct. No. AUS 178, Canberra. http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129547726

[iv] Tan E.C., Stewart K., Elliott R.A., George J. (2014) Pharmacist services provided in general practice clinics: a systematic review and meta-analysis. *Research in Social & Administrative Pharmacy* 2014; 10(4):608-22

[v] Ibid.

[vi] Freeman C.R., Cottrell W.N., Kyle, G., Williams, I.D., Nissen L (2012) An evaluation of medication review reports across different settings. International Journal of Clinical Pharmacy.

[vii] Ibid

[viii] Smith, J., Picton, C. and Dayan, M. (2013) Now or Never: Shaping Pharmacy for the future. The Report of the Commission on future models of care delivered through pharmacy. Royal Pharmaceutical Society. http://www.rpharms.com/promoting-pharmacy-pdfs/moc-report-full.pdf

[ix] The PSA has recently been commissioned by Coast City Country GP Training in southern NSW and the ACT to produce a resource for pharmacists teaching GP registrars about pharmacy-related matters.

Deloitte Access Economics

Analysis of non-dispensing pharmacists in general practice clinics

Australian Medical Association

9 April 2015

Deloitte.

Contents

Tables

Glossary

ABS	Australian Bureau of Statistics
ADE	adverse drug event
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
BCR	benefit cost ratio
BEACH	Bettering the Evaluation and Care of Health
CPI	consumer price index
GP	general practitioner
MBS	Medicare Benefits Schedule
NHPA	National Health Performance Authority
NPV	net present value
PBS	Pharmaceutical Benefits Scheme
PNIP	Practice Nurse Incentive Program
PPB	Pharmaceutical Policy Branch
PSA	Pharmaceutical Society of Australia
SWPE	standardised whole patient equivalent

Executive Summary

Deloitte Access Economics was commissioned by the Australian Medical Association to analyse the financial impact of a proposed policy to integrate non-dispensing pharmacists into general practice clinics.

The policy will provide financial incentives to general practice clinics to hire a non-dispensing pharmacist, who will share current drug information with doctors and practice staff, respond to medicine queries, increase practice efficiency and free up general practitioners' time, deliver patient-directed services, and perform practice based quality assurance activities.

The aim of the policy is to improve the quality of primary healthcare by increasing compliance and persistence with medication regimens, reduce the level and severity of adverse drug events, optimise the management of long-term conditions, and reduce the burden on the Pharmaceutical Benefits Scheme that arises from overprescribing of medicines.

The analysis by Deloitte Access Economics estimated the financial costs associated with the base case (that is, the current situation), and estimated the financial costs associated with the intervention (that is, the policy as proposed by the Australian Medical Association). This allowed for a comparison to be made between the two states (base case and intervention), which provided an estimate of cost savings that may be achieved from the policy. Data for the analysis was sourced from a variety of publicly-available databases, as well as from peer-reviewed journal articles.

The costs under the base case and intervention were limited to:

- **Medications that are prescribed to patients**: there is a lower cost of medications in the intervention as the policy reduces the rate of overprescribing of medications.
- **Visits to general practitioners that arise when a patient has a moderate or severe adverse drug event**: there is a lower rate of visits in the intervention as the policy reduces the risk of adverse drug events.
- **Hospital admissions due to severe adverse drug events**: as with visits to general practitioners, these are lower in the intervention.
- **Incentive payments to general practice clinics to hire non-dispensing pharmacists** (these costs are only incurred in the intervention, and not the base case).
- **The costs of individuals' co-payments for prescribed medications and for consultations with general practitioners that are not bulkbilled**: these costs are lower in the intervention due to consultations avoided and medicines being deprescribed.

The results of the analysis demonstrated that the policy results in financial savings of $544.87 million over the four years from 2015-16 to 2018-19 ($440.23 million in net present value terms using a 7% discount rate). The policy delivers a benefit-cost ratio of 1.56, which means that every $1 invested in the program generates $1.56 of benefits.

Deloitte Access Economics

1 Background

Deloitte Access Economics was commissioned by the Australian Medical Association (AMA) to analyse the financial impact of a proposed policy to integrate non-dispensing pharmacists into general practice clinics.

1.1 Overview of policy

The aim of the policy (which has been developed by the AMA in conjunction with the Pharmaceutical Society of Australia, PSA) is to improve the quality of primary healthcare by:

- increasing compliance and persistence with medication regimens;
- reducing the level and severity of adverse drug events[1] (ADEs);
- optimising the management of long-term conditions; and
- reducing the burden on the Pharmaceutical Benefits Scheme (PBS) that arises from overprescribing of medicines.

A study by Picton and Wright (2013) estimated that rates of non-compliance by patients with their medication regimens are as high as 33%, and hospital admissions related to medications have been estimated to cost $1.2 billion per annum[2] (Roughead et al, 2013). The prescribing of unnecessary medications by GPs also contributes to the total $9.2 billion annual cost of the Pharmaceutical Benefits Scheme (Pharmaceutical Policy Branch, 2014).

In response to these concerns, several roles are proposed for pharmacists as part of the policy (PSA, 2015). These are outlined in the box below.

Roles of non-dispensing pharmacists in the policy

Sharing current drug information with doctors and practice staff

Activities conducted include education sessions, providing information on new evidence and therapeutic uses for medications, providing summaries of new guidelines, teaching medical students and registrars, and performing patient education seminars.

Responding to medicine queries

The pharmacist would answer queries on the PBS, source medications for GPs, provide advice on specific medication concerns from GPs (for example, switching coagulants, antidepressants, and opioid equivalence), and answer questions about medicine formulations.

[1] An adverse drug event is defined as 'an appreciably harmful or unpleasant reaction, resulting from an intervention related to the use of a medicinal product' (Edwards and Aronson, 2000).

[2] This figure is quoted in 2013 dollars.

Increasing practice efficiency and freeing up general practitioners' time

This would be achieved through providing seamless care with community pharmacists, and providing prompt medication reviews and advice on medications.

Delivering patient-directed services

The services include providing in-practice referral-based medicine reviews, private consultations for medication-based concerns for patients, documentation and patient follow up on ADEs, counselling on smoking cessation, lifestyle issues and medicine-based activities, and assisting patients to navigate the health system and medication changes between health settings.

Practice based quality assurance activities

The pharmacist would optimise medication regimens, perform drug utilisation reviews and drug use evaluations, and monitor and advise on prescribing practices.

The policy would require government funding to incentivise GP clinics to hire a non-dispensing pharmacist. The funding arrangements proposed for this policy have been based on the arrangements for the Practice Nurse Incentive Program (PNIP) as described by Department of Human Services (2012). Participating clinics that hire a non-dispensing pharmacist for a minimum of 12 hours and 40 minutes per week would receive $25,000 per annum per 1,000 Standardised Whole Patient Equivalent (SWPE) at the clinic. The funding would be capped at a maximum of five incentives per clinic, and so the maximum funding available to a single clinic would be $125,000. As per the PNIP, a loading of up to 50% for rural practices would apply. Specifically, the loadings would be:

- major cities: no loading;
- inner regional: 20% loading;
- outer regional: 30% loading;
- remote: 40% loading; and
- very remote: 50% loading.

The AMA has advised Deloitte Access Economics that the average annual salary for a pharmacist is $67,000 plus on-costs. Thus, it is anticipated that only clinics with a SWPE of 3,000 or greater would elect to take part in the program (as this would approximately cover the costs associated with hiring one pharmacist).

1.2 Related policies

There are a currently four programs that are funded through the 5th Community Pharmacy Agreement, and perform related roles to the policy. The policy proposed by the AMA is intended to fill a gap in health service delivery, rather than replicate the services provided through these programs.

Medicines Use Review and Diabetes Medication Management Service

The Medicines Use Review and Diabetes Medication Management Services (also known as MedsCheck and Diabetes MedsCheck, respectively), are in-pharmacy, patient centred services that consist of a face-to-face medication check delivered by community pharmacists to patients who fit the eligibility criteria. They help patients to learn more about their medicines, identify the problems that patients may be experiencing with their medicines, improve the effective use of medicines by patients, and encourage and educate patients about the best practice use and storage of their medicines. The Diabetes MedsCheck also assists patients with improving the use of blood glucose monitoring devices, improving blood glucose control, and reducing the risk of patients developing complications associated with type 2 diabetes (Deloitte Access Economics, 2012).

Home Medicines Review

Under the Home Medicines Review (also known as the Domiciliary Medication Management Review), a patient's GP requests a pharmacist to visit the patient at their home to conduct a review of the patient's medication regimen. The pharmacist provides a report to the GP which is used to develop and implement a medication plan for the patient (Department of Health, 2014b).

Residential Medication Management Review

This is a medication management program provided to residents of government-funded aged care facilities. A resident's GP requests an accredited pharmacist to undertake an assessment of a resident's medication regimen to identify, resolve and prevent medication-related problems. A report is provided to the resident's GP (Department of Health, 2014b).

1.3 Consultation

Deloitte Access Economics consulted with Dr Kean-Seng Lim during the development of this report. Dr Lim has undertaken a small trial of a medicines management scheme at Mt Druitt Medical Centre that is similar to the policy proposed by the AMA. The preliminary results of the trial are not publishable due to patient privacy restrictions. However, the results have been used to triangulate and validate some parameters that have been used in the modelling for this report.

2 Methodology and data

This section presents an overview of the methodology and data that was used to conduct the analysis of the proposed policy.

2.1 Methodology

The approach used in this analysis was to estimate the financial costs associated with the base case (that is, the current situation), and estimate the financial costs associated with the intervention (that is, the policy as proposed by the AMA). This allows for a comparison to be made between the two states (base case and intervention), which provides an estimate of the costs and benefits of the policy. The analysis considers the costs under each state that accrue to the Commonwealth government, jurisdictional governments, and individuals.

2.1.1 Scope of analysis

This analysis is intended to be a high-level examination of the costs and benefits associated with the policy. As such, the scope of the costs has been limited to

- the Commonwealth Government's costs of medicines under the PBS, and GP consultations under the MBS;
- jurisdictional governments' costs of hospital admissions; and
- patients' costs of co-payments for medicines and GP consultations.

The policy has been costed over the four-year forward estimates period from 2015-16 to 2018-19. Costs and benefits over the period were used to demonstrate the net financial impact of the policy, which has been expressed in both whole dollar terms, as a net present value,[3] and as a benefit-cost ratio.

2.1.2 Base case

In order to cost the base case, it is necessary to identify the **target population** for the policy. The target population was used in costing both the base case and the intervention. As this is a high-level analysis of the costs of the policy, the target population was limited to GP patients who had had an ADE in the past six months. The patients in the target population are individuals who, but for the intervention, would have had an ADE, and as such will benefit from the services provided in the policy. Miller et al (2006) analysed data from the Bettering the Evaluation and Care of Health (BEACH) data set on patient responses to questions about ADEs. Through this analysis, it was identified that 10.4% of patients who visited their GP had had an ADE in the past six months. This figure was combined with data from the Australian Bureau of Statistics on the Australian population (ABS, 2015a), and the proportion of the population that attends a GP clinic each year (NHPA, 2015).

[3] A discount rate of 7% has been used for net present value calculations, in line with recommendations by the Department of Prime Minister and Cabinet (Office of Best Practice Regulation, 2014).

The cost items calculated in the base case are set out under the following headings.

PBS expenditure

Expenditure under the PBS was calculated by identifying the number of people in the target population, and making an assumption as to the number of medications that they were currently taking. It was assumed that people in the target population were taking an average of five medications, as these people are most likely to benefit from the policy. The average PBS cost of medications prescribed to patients was based on data from the Pharmaceutical Policy Branch within the Department of Health (PPB, 2014).

MBS expenditure

MBS expenditure was assumed to arise from individuals in the target population that had had an ADE of at least moderate severity. Miller et al (2014) identified three categories of ADE severity:

- **Mild**: a reaction of limited duration which may or may not require further treatment, and has a minimum impact on daily activities.
- **Moderate**: a reaction of longer duration or which requires further treatment, and limits daily activities.
- **Severe**: a reaction of any duration which results in hospitalisations and/or long-term limitations of daily activities.

The analysis assumed that individuals who had a mild ADE would not seek medical treatment, a moderate ADE would result in a visit to the GP, while a severe ADE would necessitate admission to a hospital and a follow-up visit with a GP upon being discharged from hospital. The MBS cost associated with a standard GP consultation (item 23) was sourced from the Department of Health's annual Medicare statistics publication (Department of Health, 2014a).

Hospital expenditure

As noted in the previous section, patients in the target population who had a severe ADE would need to be admitted to hospital. The number of hospital separations arising from ADEs was provided in Roughead and Semple (2009). The average cost of a hospital separation was sourced from the Australian Institute of Health and Welfare (AIHW, 2015).

Individual expenditure

Individual expenditure is a combination of out-of-pocket costs (co-payments) associated with GP consultations that are not bulk-billed, and prescription medications. GP consultations arise when a patient has a moderate severity or severe ADE.

2.1.3 Intervention

Under the intervention, the policy is progressively rolled-out to suitable GP clinics across Australia, and is aimed at the target population. The take-up rates in each year, and the overall take-up across GP clinics, were determined from the results of a survey of all AMA

members. In the survey, members indicated their willingness to take part in the scheme.[4] It was assumed that all practices who will take part in the policy will do so by the end of the four year period of analysis.

The take-up rate in each year, and the overall take-up rate over the four years, determine the number of people in the target population who are able to access services provided under the policy. Each year, a proportion of the target population (referred to as 'participants') will be able to access these services, and this proportion increases in each subsequent year as more GP clinics take part in the policy. Over the same period, the remaining proportion of the target population (referred to as 'non participants') that attend a clinic that is not part taking part in the policy, will decrease in each subsequent year.

The cost items calculated in the intervention are set out under the following headings.

PBS expenditure

PBS expenditure is calculated as the sum of the PBS cost of medicines prescribed to participants, plus the sum of the PBS cost of medicines that are prescribed to the non-participants. The number of medicines prescribed to the participants will be less than the number of medicines prescribed to the non-participants, as these patients will experience an average net reduction in the number of medicines that they are prescribed. Parameters for the reduction in medications per patient were sourced from Castelino et al (2010).

Reduction in medications per patient (Castelino et al, 2010)

This study examined the impact of GP-led pharmaceutical services on use of medicines by community-dwelling older people in New South Wales. The services provided by the pharmacists in the study include a GP referral to a patient's pharmacist, an interview between the pharmacist and patient, a report from the pharmacist to the GP following the interview, and a medication management plan between the GP and patient based on the report. Similar activities would be performed as part of the AMA's proposed policy, and as such the reduction in the number of medications in the trial was considered to be a suitable proxy for the reduction in medications that would be achieved through the policy.

The study investigated whether pharmacists' recommendations would lead to an improvement in the use of medications as measured by a decrease in the Drug Burden Index score.[5] The study estimated the baseline level of medications consumed by the study population, and the number of medications that were ceased following the pharmacist review.

The PBS cost of medicines prescribed was the same as the cost used in the base case calculations.

[4] The results of this survey have not been made publicly available.

[5] The Drug Burden Index is a tool that measures a person's total exposure to medications that possess anticholinergic and/or sedative properties, using the principles of dose response and maximal effect (Castelino et al, 2010).

MBS expenditure

As with the PBS expenditure, the MBS expenditure is the sum of expenditure for participants plus the sum of expenditure for non-participants. Participants in the program will have a fewer number of moderate severity and severe ADEs, due to having access to services provided through the policy. It should be noted that the policy will not reduce the number of ADEs to zero for participants, as a proportion of ADEs are not totally preventable through the services provided under the policy. The number of moderate severity and severe ADEs will be unchanged for non-participants.

Parameters for the change in the number of moderate severity ADEs for participants were sourced from Miller et al (2006).

Fewer moderate severity ADEs (Miller et al, 2006)

Miller and colleagues used BEACH data and supplementary analysis of nominated data techniques to investigate the frequency, cause and severity of ADEs among general practice patients, and the percentage of ADEs that are considered to be preventable.

The study considers ADEs to be preventable if they are avoidable by means such as better communications between health professions, better communication between patient and health professions, and better knowledge of a patient's medical history. As all these activities would be performed through the AMA's proposed policy, it was considered that the impact of these 'preventability activities' would be a suitable proxy for the impact of the AMA's proposed policy.

Estimates for the change in the number of severe ADEs were provided in Chan et al (2001). Preventability of severe ADEs was limited to severe ADEs that were considered to be definitely preventable, and did not include any ADEs that were considered to be possibly preventable (insufficient information was provided in the study as to the nature of activities that would have avoided a 'possibly preventable' severe ADE). Activities that would have prevented the ADE in the study were considered to be similar to the activities performed by a pharmacist as part of the policy.

Fewer severe ADEs (Chan et al, 2001)

A study of the cause and preventability of hospital admissions for elderly patients was undertaken on admissions to acute medical units of the Royal Hobart Hospital over an eight week period. These admissions were all caused by an ADE, and causality was graded as either definite, or probable/possible (this second category was added in cases where the study authors strongly suspected that an ADE was the cause of the admission, however, it had not been recognised by the treating doctor at the time).

The preventability of the ADE was classified as:

- Definitely preventable: the drug event was a result of a drug-treatment procedure that was inconsistent with present-day knowledge of good medical practice or was clearly unrealistic, taking the known circumstances into account.

- Possibly preventable: the prescription was not erroneous, but the drug event could have been avoided by an effort exceeding obligatory demands.

- Not preventable: the drug event could not have been avoided by any reasonable means, or it was an unpredictable event in the course of a treatment fully in accordance with good medical practice.

Hospital expenditure

The number of avoidable severe ADEs (which result in hospitalisation) was sourced from the Chan et al (2011) study outlined in the previous section. The total hospital expenditure costs are the sum of costs arising from participants and non-participants who have an ADE and are admitted to hospital. The rate of severe ADEs is lower for participants, when compared to non-participants.

Individual expenditure

Individual expenditure is the sum of co-payment costs for medical consultations and medicines for participants, plus the sum of these co-payments for non-participants. Each group is subject to the same unit costs for consultations and medicines. However, the participant group requires fewer consultations and medicines as a result of the services delivered through the policy.

Policy costs

As outlined in Section 1.1, government funding is required for the policy to be implemented. The proposed funding arrangement is based on the PNIP funding guidelines, and would provide $25,000 per annum to a participating general practice for each 1,000 SWPE at the practice. The funding would be capped at a maximum of five incentives per clinic, and a loading of up to 50% for rural practices would apply.

2.1.4 Limitations of analysis

The scope of works for the analysis conducted by Deloitte Access Economics necessitates that the costs and benefits be limited to selected components. In addition, uncertainty around the final design of the policy makes it difficult to cost certain elements of the policy with any degree of certainty. A more complete analysis of the proposed policy could include costs and benefits in the following areas:

- GP roles under the policy: it is unclear what the roles of GPs would be under the policy, and the extent to which they would perform these roles. For example, it is not yet known how many medication reviews would be undertaken by GPs, and how many reports pharmacists would prepare for review by GPs[6]. It is likely that some roles performed by the GP under the policy would require reimbursement through the MBS. The value of reimbursable items could potentially range from $37.05 (item 23, consultation at consulting rooms) through to $154.80 (item 900, Domiciliary Medication Management Review).
- Improved health outcomes: the policy will likely lead to improved compliance and persistence[7] with medication regimens, which will result in improved health outcomes for patients. This will result in significant avoided financial and economic costs for both the patient and the health system, as well as avoided broader economic costs such as lost productivity that arise when a health condition is treated and managed sub-optimally.

The financial impacts of the policy have been modelled on the assumption that the time of the non-dispensing pharmacists in GP clinics is devoted to the policy roles outline in Section 1.1. Were the staff to do activities unrelated to these policy roles, then the financial savings from the policy would necessarily be smaller. Alternatively, there may be a need for monitoring processes (for example, random audits) to help ensure that taxpayer funded personnel are performing the tasks that they have been hired to do.

2.2 Data

The data for this analysis was sourced from a variety of publicly-available databases as well as from peer-reviewed journal articles. Table 2.1 presents all data items that were used in this analysis.

[6] No information was located to enable an estimate to be made of the rate at which GPs would conduct medication reviews for the target population. Medicare data from the Department of Human Services (2015) provides information on the number of MBS rebates paid for item 900 (Domiciliary Medication Management Review) and item 903 (Residential Management Medication Review) in 2013-14. However, no information was located that estimated the targeted population for these policies, and as such it was not possible to estimate the rate at which these medication reviews were requested by GPs.

[7] Compliance refers to the extent that the patient conforms to their treatment protocol in terms of timing, dosage and frequency. Persistence refers to whether the patient continues the treatment for the prescribed duration (Cramer et al, 2008).

Table 2.1: Data items

Item (A – Z)	Source	Detail
Bulkbilling rate	DoH (2014a)	82.2%
Deprescribing	Castelino et al (2010)	For 372 patients, the total number of medications fell from 576 medications to 401 patients following the intervention.
GP consultations	NHPA (2015)	84.7% of the population see a GP each year
Health CPI	ABS (2015b)	Average rate of the health component of CPI for the last five years is 5.0%.
Hospital separations	AIHW (2014)	There were 9,702,304 hospital separations in 2013-14, at an average cost (in 2011 dollars) of $4,918 per separation.
Incentive per 1,000 SWPE	AMA	$25,000 per year
Location of GP clinics	Carne (2013)	Major cities: 72%; inner regional: 7%, outer regional: 15%; remote: 4%; very remote: 1%.
Location of GP clinics by SWPE	AMWAC (2005)	See Appendix A.
Medications costs	PPB (2014)	In 2013-14, there were 209,816,009 medications prescribed at a total cost to government of $7,308,560,369 and total cost to individuals of $1,545,054,740.
Medicines per participant	DAE assumption	It was assumed that individuals in the target population were consuming five medicines per person, on average, as people consuming five or more medicines are likely to be a target for the policy[8].
Number of GP clinics	PC (2015)	5,210 clinics. This is a proxy for the number of accredited clinics in Australia, as per the PNIP policy[9].
Population growth and size	ABS (2015a)	23,490,736 as at end June 2014. Average growth rate past five years: 1.6%.
Preventable Moderate ADEs	Miller et al (2006)	25% of ADEs seen by GPs are avoidable by undertaking tasks that would be performed by pharmacists in the policy
Preventable severe ADEs	Chan et al (2001)	53% of ADEs that lead to hospital admission are avoidable by undertaking tasks that would be performed by pharmacists in the policy
Primary care costs	DoH (2014a)	MBS schedule fee for GP consultation (item 23): $37.05 Average co-payment for GP consultation: $30.26
Rate of ADEs	Miller et al (2006)	10.40% of GP patients had an ADE in the past six months
Take up rate in each year	DAE assumption	2015-16: 20%; 2016-17: 30%; 2017-18: 40%; 2018-19: 10% (assumed to be independent of the locations of GP clinics).
Take up rates	AMA member survey	Proportion of all clinics that would adopt policy: 48%; proportion of all clinics that might adopt policy: 23%
Types of ADEs	Miller et al (2006)	Mild ADEs: 53.9%; Moderate ADEs: 35.8%; Severe ADEs: 10%; Unknown ADEs: 0.3%.

Source: Deloitte Access Economics research. Notes: ABS = Australian Bureau of Statistics; AMWAC = Australian Medical Workforce Advisory Committee; CPI = consumer price index; DoH = Department of Health; NHPA = National Health Performance Authority; PC = Productivity Commission; PPB = Pharmaceutical Policy Branch.

[8] The most recent estimate of the number of medicines used per person in Australia is provided in the Australian Bureau of Statistic's 1995 National Health Survey. According to the survey 9.9% of people consumed four or five medicines, and 4.6% of people consumed six or more medicines (ABS, 1999). Smaller surveys of specific populations have been undertaken since then (for example Morgan et al, 2012).

[9] Data on the total number of practices has not been available since 2010-11, when data collected by the Primary Health Care Research and Information Service's Annual Survey of Divisions ceased.

Where necessary, historical cost data was adjusted to 2015-16 dollars using the health component of the consumer price index (CPI) from the Australian Bureau of Statistics (ABS, 2015b). Costs of medicines under the PBS, and GP consultations under the MBS, were considered fixed over the four year period of analysis. Individuals' co-payments for medicines and consultations, and hospital separation costs, were indexed using the health component of the CPI.

3 Results

This section presents the information on the number of GP clinics taking part in the policy each year, outlines the costs under the base case and the intervention, and compares the costs under each state to demonstrate the financial savings that can be realised through implementation of the policy.

3.1 Take up of policy

Based on the results of the AMA survey and assumed take up rates in each year presented in Table 2.1, the total number of GP clinics that will take up the policy over four years is estimated to be 3,100. This result is considered to be a reasonable estimation of the number of practices taking part in the policy, as there are an estimated 3,267 GP clinics with a SWPE of 3,000 or greater, and it is assumed that only clinics with a SWPE of 3,000 or greater would be incentivised to take part in the policy. The cumulative number of clinics in each year is shown in Table 3.1. A full breakdown of clinics by SWPE and location is provided in Appendix A.

Table 3.1: Clinics taking part in policy

Clinic size	2015-16	2016-17	2017-18	2018-19
5,000 SWPE	390	976	1,756	1,951
4,000 SWPE	115	287	517	574
3,000 SWPE	115	287	517	574
Total	**620**	**1,550**	**2,790**	**3,100**

Source: Deloitte Access Economics calculations using data from Productivity Commission (2015) and Australian Medical Workforce Advisory Committee (2005), combined with survey results from the Australian Medical Association and assumptions on the take up rate in each year. See Table 2.1 for further details.

3.2 Base case results

The analysis estimates that costs under the base case are $8.01 billion over the four year period. This is shown in Table 3.2.

Table 3.2: Base case results

Cost item	2015-16 ($)	2016-17 ($)	2018-18 ($)	2018-19 ($)	4 year total ($)
PBS	372,018,049	377,970,338	384,017,863	390,162,149	**1,524,168,398**
MBS	36,245,532	36,825,461	37,414,668	38,013,303	**148,498,963**
Hospitals	1,340,712,966	1,430,272,592	1,525,814,801	1,627,739,230	**5,924,539,588**
Individuals	92,516,530	98,696,634	105,289,569	112,322,912	**408,825,644**
Incentives	-	-	-	-	**-**
Total	**1,841,493,076**	**1,943,765,024**	**2,052,536,901**	**2,168,237,593**	**8,006,032,594**

Source: Deloitte Access Economics calculations.

The most significant costs in the base case analysis are hospital costs, which comprise 74% of total costs over the four years. This is followed by PBS costs (19%), individual costs (5%), and MBS costs (2%). The net present value of the base case costs over the four years is $6.75 billion.

3.3 Intervention

The analysis estimates that costs under the intervention are $7.46 billion. This is shown in Table 3.3.

Table 3.3: Intervention results

Cost item	2015-16 ($)	2016-17 ($)	2018-18 ($)	2018-19 ($)	4 year total ($)
PBS	358,567,917	343,807,003	321,539,957	319,631,535	**1,343,546,412**
MBS	34,899,770	33,407,226	31,163,400	30,956,316	**130,426,712**
Hospitals	1,255,516,020	1,203,052,337	1,089,497,378	1,110,557,644	**4,658,623,378**
Individuals	89,165,978	89,760,713	88,130,456	91,983,643	**359,040,790**
Incentives	74,579,142	186,447,855	335,606,139	372,895,710	**969,528,845**
Total	**1,812,728,827**	**1,856,475,133**	**1,865,937,329**	**1,926,024,848**	**7,461,166,136**

Source: Deloitte Access Economics calculations.

As per the base case, hospital costs (62%) are the largest component, followed by PBS costs (18%). However, the next largest cost component in the intervention case is the incentive payments to GP clinics taking part in the policy (13%), followed by individual costs (5%) and MBS costs (2%). The net present value of the intervention costs over the four years is $6.31 billion.

3.4 Comparison

A comparison of costs under the base case and the intervention is shown in Table 3.4.

Table 3.4: Comparison

Cost item	2015-16 ($)	2016-17 ($)	2018-18 ($)	2018-19 ($)	4 year total ($)
PBS	13,450,132	34,163,335	62,477,906	70,530,614	**180,621,987**
MBS	1,345,762	3,418,235	6,251,268	7,056,987	**18,072,252**
Hospitals	85,196,946	227,220,255	436,317,423	517,181,585	**1,265,916,210**
Individuals	3,350,552	8,935,921	17,159,113	20,339,269	**49,784,855**
Incentives	-74,579,142	-186,447,855	-335,606,139	-372,895,710	**-969,528,845**
Total	**28,764,249**	**87,289,891**	**186,599,572**	**242,212,746**	**544,866,458**
BCR	*1.39*	*1.47*	*1.56*	*1.65*	*1.56*

Source: Deloitte Access Economics calculations.
BCR = benefit cost ratio

As can be seen, over a four year period the policy generates savings of $544.87 million. The policy requires $969.53 million of funding for the incentive payments; however, this is more than offset by the $1.51 billion in savings.

The benefit cost ratio of the project in each year is positive, and over the four year period the benefit cost ratio is 1.56. This means that for every $1 invested in the program, $1.56 of benefits are generated. The cumulative roll-out of the policy over the four years means that the benefit cost ratio improves over each subsequent year. The net present value of savings generated by the policy (expressed in 2014-15 dollars) is $440.23 million.

The share of costs and benefits between the Commonwealth government, jurisdictional governments and individuals is shown in Table 3.5. A negative sign indicates a net financial cost.

Table 3.5: Share of costs and benefits

Group	2015-16 ($)	2016-17 ($)	2018-18 ($)	2018-19 ($)	4 year total ($)
CW	-59,783,248	-148,866,285	-266,876,964	-295,308,108	**-770,834,607**
S/T	85,196,946	227,220,255	436,317,423	517,181,585	**1,265,916,210**
Individuals	3,350,552	8,935,921	17,159,113	20,339,269	**49,784,855**
Total	**28,764,249**	**87,289,891**	**186,599,572**	**242,212,746**	**544,866,458**

Source: Deloitte Access Economics calculations.
Notes: CW = Commonwealth government. S/T = jurisdictional governments.

The policy represents a net cost to the Commonwealth government (assuming that the Commonwealth government funds the policy incentive payments), although it generates net savings for the jurisdictional governments through reduced hospital costs, and net savings for individuals through lower co-payments for GP consultations and medicines.

3.5 Sensitivity analysis

Sensitivity analysis was conducted on the model to illustrate the impacts of the assumed take up rates on the model output. As shown in Table 2.1, the model assumes that 48% of

all GP clinics would take part in the policy, and 23% of clinics are undecided as to whether they would take part. The sensitivity analysis varies these assumptions to generate two new scenarios:

- Scenario 1 (low take up): 40% of clinics take part in the policy, and 20% of clinics are undecided.
- Scenario 2 (high take up): 60% of clinics take part in the policy, and 25% of clinics are undecided.

The results of these scenarios (and the original model results) are shown in Table 3.6. For each scenario, the table shows the cost of the intervention, the comparison between the base case and intervention costs, the NPV of the comparison costs at 7%, and the BCR, over the four year period. For each scenario, the costs under the base case ($8,006,032,594) remain constant.

Table 3.6: Sensitivity analysis

Scenario	Intervention ($)	Comparison ($)	NPV ($)	BCR
Scenario 1	7,548,161,621	457,870,973	369,940,022	1.56
Original scenario	7,461,166,136	544,866,458	440,228,626	1.56
Scenario 2	7,342,119,684	663,912,911	536,413,031	1.56

Source: Deloitte Access Economics calculations.

The results of the sensitivity analysis show that the BCR remains constant at 1.56 under each scenario. In Scenario 1, a smaller proportion of GP clinics take up the policy, and so the benefits of the policy are restricted to a smaller proportion of the population. This means that fewer costs associated with PBS, MBS, hospital and individual expenditure are avoided. However, as fewer clinics are taking part in the policy there is a reduction in the level of funding required for the policy incentives. The reverse occurs in Scenario 2, where a larger amount of GP clinics means that there are a higher amount of avoided costs, and a higher amount of payments for policy incentives.

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Appendix A: GP clinic data and results

Table A.1: Clinics taking part in policy (cumulative)

Category	2015-16	2016-17	1017-18	2018-19
5,000 SWPE, major city	288	720	1,296	1,440
5,000 SWPE, inner regional	34	85	152	169
5,000 SWPE, outer regional	54	136	245	272
5,000 SWPE, very remote	12	30	54	60
5,000 SWPE, very remote	2	5	9	10
5,000 SWPE subtotal	*390*	*976*	*1,756*	*1,951*
4,000 SWPE, major city	80	199	358	398
4,000 SWPE, inner regional	8	21	38	42
4,000 SWPE, outer regional	18	46	83	92
4,000 SWPE, very remote	8	19	34	38
4,000 SWPE, very remote	1	2	4	4
4,000 SWPE subtotal	*115*	*287*	*517*	*574*
3,000 SWPE, major city	80	201	362	402
3,000 SWPE, inner regional	8	20	36	40
3,000 SWPE, outer regional	21	52	94	104
3,000 SWPE, very remote	4	9	17	19
3,000 SWPE, very remote	2	5	9	10
3,000 SWPE subtotal	*115*	*287*	*517*	*574*
Total	**620**	**1,550**	**2,790**	**3,100**

Source: Deloitte Access Economics calculations.

Table A.2: Number of practitioners (proportions) by location of GP clinics

No. of practitioners	Major city	Inner regional	Outer regional	Remote	Very remote	Not stated	Australia
1	0.164	0.133	0.171	0.219	0.294	0.116	**0.159**
2	0.124	0.122	0.131	0.185	0.254	0.046	**0.123**
3	0.113	0.108	0.136	0.086	0.159	0.053	**0.112**
4	0.112	0.114	0.12	0.172	0.067	0.057	**0.112**
5+	0.405	0.456	0.356	0.271	0.16	0.295	**0.403**
Not stated	0.082	0.067	0.086	0.067	0.066	0.433	**0.091**
Total	**1**	**1**	**1**	**1**	**1**	**1**	**1**

Source: Australian Medical Workforce Advisory Committee (2005).

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AMA POSITION STATEMENT

Private Health Insurance and Primary Care Services - 2014

March 2014

The AMA believes that any move to expand the role of private health insurers (PHIs) should be carefully planned and negotiated with the profession to ensure that the outcome is in the best interest of patients and does not compromise the clinical independence of the profession or interfere with the doctor/patient relationship.

The AMA would not support any move to completely deregulate the funding of GP services by PHIs, or any changes that would undermine the principle of universal access to health care.

Areas that could be explored include wellness programs, maintenance of electronic health care records, hospital in the home, palliative care, minor procedures, and GP directed hospital avoidance programs.

Any model implemented would need to:

- recognise and support the usual GP as the central coordinator of patient care;
- adopt a collaborative approach to care, with the usual GP retaining overall responsibility for the care of the patient;
- provide patients with appropriate access to care based on their clinical needs;
- preserve patient choice;
- protect clinical autonomy; and
- recognise the rights of medical practitioners to set their own fees.

Background

Under the *Private Health Insurance Act 2007*, PHIs are prevented from providing a benefit for out of hospital services where there is a Medicare benefit payable, unless the Private Health Insurance (Health Insurance Business) Rules provide otherwise. This limits the extent to which PHIs can fund GP services for their members.

In 2007 the Government made limited legislative reforms to private health insurance arrangements that introduced the concept of Broader Health Cover (BHC), which enabled health insurers to offer benefits to members for programs that either prevent or substitute for hospitalisation, or that help patients with a chronic disease better manage and reduce the effect of the disease.[1]

Key concerns

Key concerns about any expanded role for PHIs in primary care include equity of access, the maintenance of the relationship with the usual doctor, the independence of the doctor/patient

[1] Biggs, A. (2013) Chronic disease management: the role of PHI, Dept of Parliamentary Services Research Paper, 2013-14

relationship, the potential rationing of care and the risk that PHIs might focus on cost reduction as opposed to the quality and continuity of care.

Existing programs

As a result of the 2007 BHC reforms, PHIs have introduced a number of programs that provide their members with access to services such as exercise physiologists, dieticians, and physiotherapists to better manage their chronic conditions. While these programs can potentially be of benefit to patients, they generally work in isolation of the usual GP who is best placed to understand the patient's care needs. Rather than work in parallel or in competition with the usual GP these programs should only be offered with the full knowledge and support of the usual GP.

AMA Recommendation

GPs provide holistic and well-coordinated care for patients, including preventive health. By supporting a greater role for GPs in PHI arrangements, the coordination of patient care could be improved, care could be provided in the most appropriate clinical settings, and unnecessary hospital admissions can be avoided.

The AMA is supportive of targeted reforms that would better support GPs to effectively utilise PHI funded wellness/support programs in caring for patients and also allow PHIs to fund a broader range of GP services for privately insured patients.