

## Chapter 2

### Importance of General Practice and Primary Healthcare

#### Introduction

2.1 Speaking at the AMA National Conference on 29 May 2015, Associate Professor Owler spoke of general practice as the cornerstone of primary healthcare. Associate Professor Owler told Health Minister the Hon Sussan Ley MP and the Opposition health spokesperson Ms Catherine King MP that investment in general practice was vital for healthcare in Australia:

“We need investment in general practice. With investment, GPs will continue their work in providing world class, patient-centred care.”

He [A/Professor Brian Owler] appealed directly to Health Minister Sussan Ley and Labor’s health spokesperson Catherine King to address the task of rebuilding general practice.

“So Minister Ley and shadow minister King, I say to both of you, if you want to improve care and drive lasting change in the health of all Australians, don’t waste your money on fragmenting care in other settings.

Invest in general practice – general practice will deliver for you.”<sup>1</sup>

2.2 The RACGP President, Dr Frank R Jones, made a similar statement in response to the health measures in the 2015-16 Budget:

GPs see more than 80% of Australia’s population every year and are the most cost-efficient pillar of the healthcare system so it makes sense to invest in general practice. Investment in primary healthcare will produce long term health savings and better outcomes for patients.<sup>2</sup>

2.3 From a rural perspective, Ms Jenny Johnson, Chief Executive Officer of the RDAA, told the committee that GPs are often at the heart of a rural community. Any policy which negatively affects GPs will have a magnified impact on the local community:

Detrimental impacts on rural practices will also flow onto other healthcare services in rural communities. I think this is an issue that is largely ignored. Rural doctors traditionally provide a range of primary and secondary care services and some tertiary care services. For example, a rural doctor who is working in his or her general practice will also most likely be providing visiting medical officer services to the local hospital. They will probably be providing mental health services and counselling, they will be teaching

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1 Ms Julie Lambert, 'We will overturn the indexation freeze: AMA vow', *Medical Observer*, 29 May 2015, [www.medicalobserver.com.au/news/we-will-overturn-indexation-freeze-ama-vow](http://www.medicalobserver.com.au/news/we-will-overturn-indexation-freeze-ama-vow).

2 RACGP, 'Budget delivers mixed bag for general practice', Media Release, 12 May 2015.

medical students and they will be providing after-hours and emergency services. They may be providing more advanced procedural services... if a rural practice is forced to close or it loses a doctor because of economic circumstances, then that will flow onto the local hospital, which will have less doctors to fill its after-hours rosters and to provide emergency and secondary care. This in turn will compromise the ability of communities to access after-hours services. It will lead to a downgrading of services in the hospital and then we get into that awful downward spiral.<sup>3</sup>

2.4 The sentiments expressed by the AMA, RACGP, and RDAA are similar to those the committee has heard throughout its inquiry. Throughout more than 30 hearings, witnesses have emphasised the central importance and effectiveness of general practice and the importance of access to primary healthcare for providing:

- better health outcomes;
- cost-effective healthcare; and
- more responsive healthcare than acute care.

2.5 The committee has heard consistent arguments for a primary healthcare model which recognises that GPs at the centre of an integrated healthcare system, working for the patient's best interests with allied health practitioners, specialists and acute care. This chapter records the evidence presented to the committee regarding the need for general practice to be at the centre of primary healthcare.

2.6 Further, as part of its report, both in this chapter and Chapter 3, the committee notes the evidence it has received regarding the risks to general practice and primary healthcare from the government's numerous policy changes (from 2014-15 Budget to the current Budget). Witnesses and submitters have told the committee clearly that without an emphasis on primary care in healthcare policy they fear for the:

- viability of general practice;
- increased inefficiencies in the health sector; and
- loss of opportunity to improve health policy outcomes.

### **Effectiveness of general practice in healthcare**

2.7 The *Bettering the Evaluation and Care of Health* (BEACH) study is a long running study of general practice conducted by the Family Medicine Research Centre, at the University of Sydney. It is unique internationally for its examination of general practice including patient encounters and treatments. Findings from the 2013-14 BEACH study included that:

General practice and primary care represent the interface between complex (and expensive) health care services and the wider community. Australian general practice can reasonably claim to represent world best practice in terms of both cost and patient outcomes... There is ample evidence that

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3 Ms Jenny Johnson, CEO, RDAA, *Committee Hansard*, 5 February 2015, p. 17.

preventive and primary care services that are patient-focussed rather than disease-focussed provide the most cost effective health outcomes for those individuals and communities.<sup>4</sup>

2.8 Although primary healthcare is the most efficient part of the healthcare system, there are already a number of reasons that Australians avoid going to see their GP. According to the *2013-14 Patient Experience Survey* conducted by the Australian Bureau of Statistics, cost is a significant barrier to accessing healthcare. At a national level, the *2013-14 Patient Experience Survey* showed that:

- One in twenty (4.9 per cent) people who needed to see a GP delayed or did not go because of the cost;
- One in twelve (7.9 per cent) who needed to see a medical specialist delayed or did not go because of the cost; and
- Of the one in seven (14.3 per cent) people who had visited an emergency department for their own health in the previous 12 months, one in five (21.6 per cent) thought the care could have been provided by a GP.<sup>5</sup>

2.9 The RACGP noted that hospital admissions are a major driver of Australian healthcare costs. Figure 1 below, taken from the RACGP submission, shows the comparison between rising hospital costs and the relatively stable costs for general practice. The RACGP submission argues that:

Primary healthcare services are the most cost-effective part of the health sector. They can reduce healthcare costs through chronic disease management and health service integration, decreasing emergency department presentations and preventable hospital admissions. Better use of and access to properly resourced general practices will reduce hospital expenditure and stress on the system.<sup>6</sup>

2.10 The AHCRA noted that for the cost of primary healthcare, it is exceptionally efficient:

The total cost of GP services is less than 7% of the total health budget - a relatively small slice of the pie. International research shows that countries with stronger and more easily accessible primary care systems have better overall health status at lower costs.

And in terms of benefit-cost, investment in prevention and early intervention are always the wise choices.<sup>7</sup>

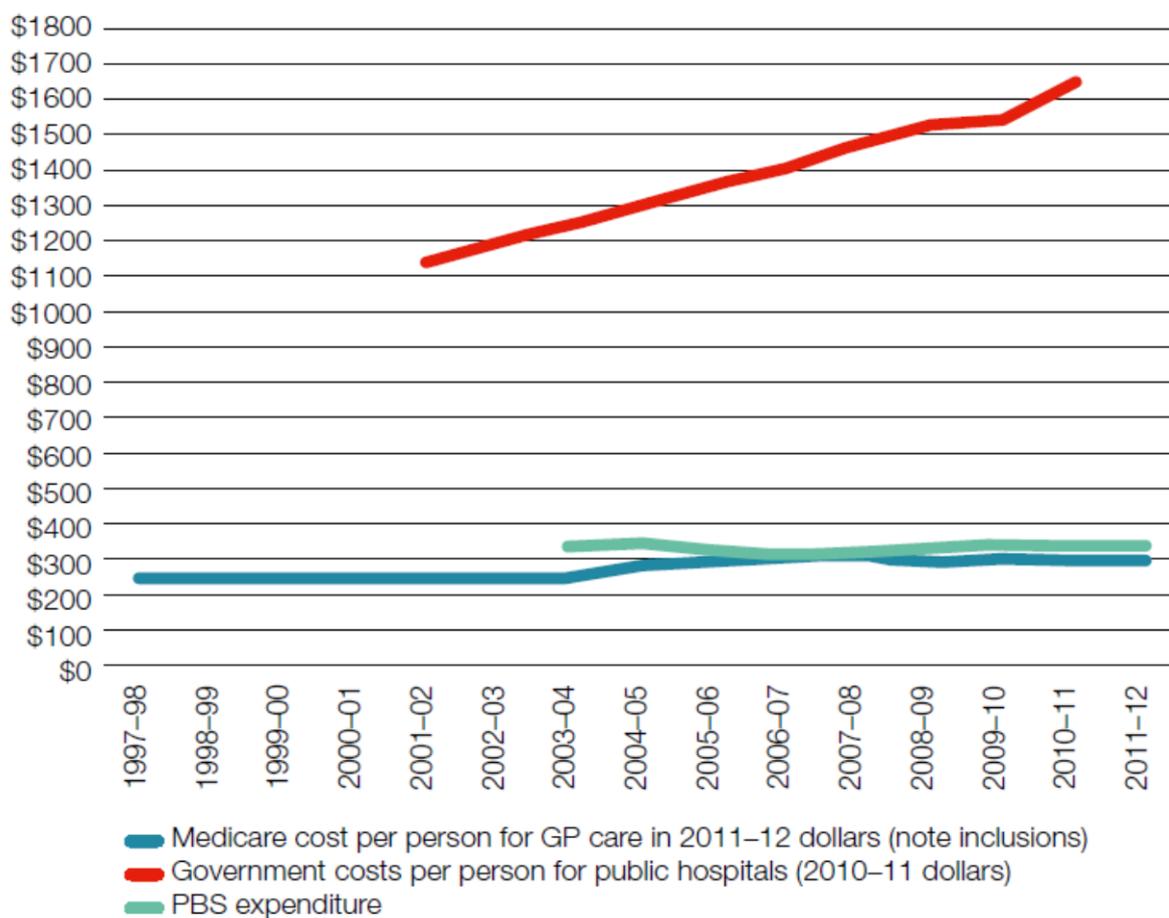
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4 General Practice Series Number 36, 'General practice activity in Australia 2013-14', Bettering the Evaluation and Care of Health (BEACH) Study, Family Medicine Research Centre University of Sydney, p. iii.

5 Australian Bureau of Statistics, *4839.0 – Patient Experiences in Australia: Summary of Findings 2013-14*, 28 November 2014, [www.abs.gov.au/ausstats/abs@.nsf/mf/4839.0](http://www.abs.gov.au/ausstats/abs@.nsf/mf/4839.0).

6 RACGP, *Submission 115*, p. 2.

7 AHCRA, 'Government still tunnelling away to undermine universal health care', Media Release, 14 December 2014.

**Figure 1—Healthcare expenditure between 1997-98 and 2011-12<sup>8</sup>**

2.11 Evidence received by the committee of the benefits of primary healthcare, delivered through a model in which GPs are central, is explored below in the following sections:

- better health outcomes;
- cost-effective healthcare; and
- greater responsiveness than acute care.

#### ***Better health outcomes for health consumers***

2.12 In his submission, Professor Andrew Bonney, Roberta Williams Chair of General Practice, University of Wollongong detailed a recent UK study which examined the effect that general practice could have on delivering better health outcomes for a community:

Twenty quality of care indicators were selected by the researchers, each indicator having evidence of mortality reduction. This broad range of activities included items such as influenza vaccination in patients with

diabetes, coronary heart disease, stroke or emphysema; treatment of hypertension, diabetes and hypercholesterolaemia; use of beta-blockers in patients with coronary disease and other evidence based use of medication in chronic illnesses; and Pap smears.<sup>9</sup>

2.13 The results of the study demonstrated clearly the value of general practice in delivering life-saving primary health interventions to health consumers:

High performing practices were potentially saving over 300 lives per 100,000 of the population per year from these 20 activities alone (there are many other mortality reducing activities not included in this study). Given that the overall mortality rate for this population is approximately 900 per 100,000 per year, the impact of high functioning general practice on the health of a community is significant (Ashworth, Schofield et al. 2013).<sup>10</sup>

2.14 Ms Ellen Kerrins, the Manager of Advocacy and Policy at the Health Consumers Alliance of South Australia drew the committee's attention to a quote from the Director-General of the World Health Organisation which succinctly summarises the benefits of primary healthcare:

Decades of experience tell us that primary health care produces better outcomes, at lower costs, and with higher user satisfaction.

... ..

It can prevent much of the disease burden, and it can also prevent people with minor complaints from flooding the emergency wards ...<sup>11</sup>

### ***Cost-effective healthcare***

2.15 In its submission, the Hunter General Practitioners Association (HGPA) gave a series of examples which highlight the role GPs play in providing cost-effective healthcare:

It is far more cost effective (*and better for the patient!*) for a GP to both see a patient and administer a joint injection, than for a GP to see a patient and then refer the patient to a specialist for the same joint injection. So why has the MBS item number for GP joint injections been removed?

It is far more cost effective (*and better for the patient!*) for a GP to see and treat early a patient with a skin infection. The alternative is for the same service to be done at the emergency department for a much higher system cost; or for an extraordinarily higher system cost to be imposed if the patient has to be admitted due to a late presentation.

It is far more cost effective (*and better for the patient!*) for a GP to optimise the care of a patient with diabetes and high blood pressure, than for the

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9 Professor Andrew Bonney, Roberta Williams Chair of General Practice, University of Wollongong, *Submission 128*, p. 1.

10 Professor Andrew Bonney, Roberta Williams Chair of General Practice, University of Wollongong, *Submission 128*, p. 1.

11 Ms Ellen Kerrins, Manager, Advocacy and Policy, Health Consumers Alliance of South Australia, *Committee Hansard*, 11 June 2015, p. 39.

patient to have a stroke, be hospitalised, undergo months of rehabilitation, and then spend the rest of their life in an aged care facility.

So why try to deter people from presenting to their GP?

International research shows over and over again that primary care is, when viewed from a “whole-of-system” perspective, the most cost-effective way to deliver health care. (Starfield, 2010)<sup>12</sup>

2.16 The HGPA submission's examples demonstrate the main reasons why GPs are at the forefront of cost-effective primary healthcare:

- improved access to healthcare;
- reduced cost to the overall healthcare system; and
- superior preventative health outcomes.

#### *Access to healthcare*

2.17 As primary healthcare is one of the fundamental foundations of the Australian healthcare system, access to general practice for consumers is essential. A strong and properly resourced Medicare system, which provides universal primary healthcare for all Australians, is fundamental to ensuring access to general practice.

2.18 Dr Anne-marie Boxall, Senior Policy Adviser with the National Rural Health Alliance argued that universality—a key aspect of Australia's Medicare system—has been lost in the current healthcare funding debate:

We have been talking a lot about the impact on patients of the potential changes, which is right, but the potential changes also have a big impact on our health system if they are implemented. One of those is that threat to universality. High bulk-billing rates have been pursued by both sides of government for a long time, and there is a reason for that. It is because it essentially functions as a safety net. Whilst some people may be able to afford to pay more, and they do, through the taxation system, bulk-billing is seen as a universal benefit. So if we are undermining a system and scaling back bulk-billing and making it a targeted system, we then need to be very sure that the safety nets we have in place are effective, and that is something that we are not entirely sure about at the moment, and we have evidence that people are falling through the safety nets.<sup>13</sup>

2.19 Bulk-billing allows equity of access to healthcare, in particular for vulnerable groups and those with chronic illness. Dr Graeme Alexander of the Claremont Village Medical Centre, Tasmania, maintained that the practice of bulk billing was a means to achieving better health outcomes:

We use bulk billing to get better health outcomes. We might use it to pay part of the cost of an urgent visit eg. Acute Myocardial Infarction, a child

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12 Hunter General Practitioners Association, *Submission 123*, p. 2. Original emphasis in italics maintained from submission.

13 Dr Anne-marie Boxall, Senior Policy Adviser, National Rural Health Alliance, *Committee Hansard*, 5 February 2015, p. 44.

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with a fractured arm presenting directly from school, improve follow up, treating those with ongoing chronic illness and also helping those who have troubles handling their finances e.g. mental health patients.<sup>14</sup>

2.20 Dr Con Costa, President of the Doctors' Reform Society, argued that adding barriers to healthcare access, in the form of any price signal, would reverse the gains made since the introduction of Medicare, particularly for lower socio-economic areas in both cities and rural areas:

Let us be quite clear about what we will lose. We will lose all those gains that we outlined before [Medicare's expansion of GP care to outer urban areas, rural areas, for working people and lower socio-economic areas]. There were very few doctors in the western suburbs. Working people never had a family doctor, and the only women who had pap smears were the women in the inner city. This would come back. People would leave the poorer country towns, for example. There are no hospitals around the poorer country towns, and so where they will go, I do not know. There will be a cost explosion for sure. I am certain there will be a cost explosion, which will need to be covered by the private health funds. And you will lose that control of costs where Medicare bulk-billing is holding back on the whole system.<sup>15</sup>

2.21 Dr Stephen Duckett, Director Health Program, Grattan Institute, told the committee that the debate about Medicare had originally been one regarding the efficiency and equity of a universal scheme. He observed:

...I am old enough to remember what life was like before Medibank [now known as Medicare] was introduced. Before Medibank was introduced a number of programs were introduced to try to target and introduce special programs for poor people. The reality was, even with special programs for poor people, there were other people who could not afford health care because they fell outside the restricted definitions and restricted mean tests. So the debate about Medibank and Medicare was: is it more efficient and more equitable to introduce a universal scheme so no-one falls through the cracks or should we have schemes where it is possible for people to fall through the cracks? The Australian people have made the decision time and time again that the right way to do it, and in my view demonstrably the efficient way to do it, is a universal scheme.<sup>16</sup>

### *Reduced cost to the healthcare system*

2.22 Regarding cost to the healthcare system, many submitters argued that the better the primary healthcare system, the lower the costs for acute care and the overall health system. For example, Professor Andrew Bonney, Wollongong University, told the committee:

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14 Dr Graeme Alexander, Claremont Medical Village, Tasmania, *Submission 129*, p. 3.

15 Dr Con Costa, President, Doctors Reform Society, *Committee Hansard*, 5 February 2015, p. 75.

16 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 5 February 2015, p. 66.

The first is that internationally we know, and there is no doubt, that jurisdictions with strong primary care also have lower costs and reduced rates of health expenditure increase. At worst, in comparisons among countries in Europe, strong primary care is associated with lower levels of health expenditure increase even if the baseline healthcare costs were higher in the first place. So there is no conflict between seeking to contain costs and improve health outcome, providing that it is recognised that serious policy investment in primary care is the vehicle.<sup>17</sup>

2.23 When announcing the campaign against the government's attempt to introduce a health price signal by co-payment, the RACGP observed that primary healthcare delivers far more for far less than acute care:

The RACGP believes that the Australian health system is complex and that there are many opportunities for improved efficiency without targeting general practice.

According to Bettering the Evaluation and Care of Health (BEACH) data, the average cost of a patient visit to the GP is \$47 as opposed to the emergency department, which can cost as much as \$599.

GPs in Australia see approximately 85% of the population annually with referrals to secondary and tertiary care accounting for less than 5–10% of consults. However, in terms of comparative Government spending, general practice and hospital spending represents 15.5% and 84.5% respectively.<sup>18</sup>

#### *Improved health prevention and management*

2.24 The Victorian Health Promotion Foundation (VicHealth) stated in its submission that Australia currently invests less in preventative health than most other OECD countries 'with just 1.7 per cent of 2010–11 health spending going towards prevention efforts, or less than 0.2 per cent of GDP.<sup>20</sup>'<sup>19</sup> Yet, as VicHealth's submission argues, the economic benefits of investing in preventative health are substantial:

Conservative estimates in 2008 found that if the prevalence of key risk factors were reduced to realistic targets, it would save \$2.3 billion across the lifetime of the adult Australian population. In addition, economic evaluation of the costs and benefits of specific health interventions shows that some can be very cost-effective, and in some cases investment can have cost savings.<sup>20</sup>

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17 Professor Andrew Bonney, Roberta Williams Chair of General Practice, University of Wollongong, *Committee Hansard*, 5 February 2015, p. 25.

18 Networking Health Victoria, 'RACGP releases information sheet on co-payment and rebate freeze', Media release, 14 January 2015.

19 VicHealth, *Submission 80*, p. 5.

20 VicHealth, *Submission 80*, p. 5.

2.25 Professor Andrew Bonney, University of Wollongong, argued that primary care provided by GPs is the most effective method for delivery of preventative healthcare:

Primary care provides first access to medical care for the whole of the population – young, old, male and female. In the course of that care a relationship with a practice is formed and from this ongoing person-focused care opportunities arise for preventive activities such as checking blood pressure or screening for diabetes or Pap smears. This is all part of a comprehensive range of care provided at a practice. Where chronic disease has developed, continuity and co-ordination of care improves chronic disease management and secondary preventive activities. This includes reaching targets for diabetes, blood pressure and cholesterol level control; as well as appropriate immunisations. Unnecessary and avoidable hospitalisations are prevented and patient satisfaction, trust and compliance are higher. The net result over time is improved health outcomes at lower costs, demonstrated by international research (Starfield, Shi et al. 2005).<sup>21</sup>

2.26 Dr Stephen Duckett, the Director of the Health Program at the Grattan Institute, noted that there are national and international studies showing that better access to primary health results in improved preventative health rates and better health management. With general practice being recognised as the most efficient level of the healthcare system, internationally the trend is towards improving access and encouraging health consumers to visit general practice:

Certainly we know that, if you have out-of-pocket costs, people defer visits to doctors. We also know that, if you have out-of-pocket costs and people defer a visit to a doctor, the patient cannot make a judgement about what is necessary care and what is unnecessary care; so they end up missing out on necessary care as well. And there have been a number of overseas studies which have shown that. There has been a major study which has assessed the impact of co-payments... Generally, the overseas policy direction is not to have financial barriers in general practice. The whole international direction of health policy is to try to strengthen general practice, to try to strengthen primary care because this is the most efficient level of the health system. I am not saying that general practice or primary care is perfectly organised in Australia at the moment and, indeed, I do not believe it is. I think there need to be changes, but the changes you need to make are not forcing the consumer to drive all the change in primary care when they are people who just do not know what is necessary care and what is not necessary care.<sup>22</sup>

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21 Professor Andrew Bonney, Roberta Williams Chair of General Practice, University of Wollongong, *Submission 128*, p. 1.

22 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 5 February 2015, p. 66.

2.27 Similarly, Associate Professor Owler, told the committee that in primary healthcare 'the first step when someone has a problem is the key to prevention and the key to chronic disease management. That is not where we want a price signal.'<sup>23</sup>

2.28 The government's previous policy of \$7 and \$5 co-payments as a price signal on GP visits drew much criticism for the potential negative effects on preventative health and management of chronic conditions. Organisations such as the Doctors' Reform Society of Australia argued that GPs must be the ones to decide if medical care is needed. The submission advocates for minimum barriers to a person's decision to seek medical advice:

We doctors want patients to see us with what they might think could be trivial complaints because we know it can save lives. The indigestion which is really a heart attack, the blood in the faeces which could be piles but could be completely curable bowel cancer, the small ulcer in a diabetic which if ignored leads to gangrene and amputation, the mild/moderate depression which could progress to suicide. Let doctors be the judges of how trivial the problem is. That is why we are expensively and highly trained. Patients aren't, whether rich or poor.<sup>24</sup>

2.29 Dr Emil Djakic, a GP from Ulverstone, Tasmania, told the committee that his experience was that Australians understood the role GPs have in preventative health. Dr Djakic felt that this attitude was reflected in part in the increase in GP visits. He observed:

The last point I would like to make in my introduction is clearly the role of GPs over this past 30 years has moved into a space that I do not think people predicted, and that is significant involvement in prevention. Some simple statistics I can look at in my municipality: in 1991 when I first appeared as a registrar in my patch, the population of Ulverstone and Penguin, which were two separate municipalities, was about 19½ thousand. Those populations are now about 22,000. In that period of time, my practice, when I was training there, saw about 85 people or 85 contacts a day. The number of practices in the area has not changed, but the doctor numbers have. Recently, in this same population, my practices are now seeing 300 people a day.<sup>25</sup>

2.30 In concluding his opening remarks Dr Djakic echoed the sentiments of other witnesses at previous hearings:

So I see us in a grave situation of disenfranchising the very sector of the healthcare system that is the highest value... if we want to aspire to the very best health for Australians, then we need to be investing in primary care, not divesting in primary care.<sup>26</sup>

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23 Associate Professor Brian Owler, President, AMA, *Committee Hansard*, 5 February 2015, p. 6.

24 Doctors Reform Society of Australia, *Supplementary Submission 85*, p. 2.

25 Dr Emil Djakic, Ulverstone GP, *Committee Hansard*, 17 April 2015, p. 26.

26 Dr Emil Djakic, Ulverstone GP, *Committee Hansard*, 17 April 2015, p. 26.

### ***More responsive than acute care***

2.31 The Australasian College of Emergency Medicine (ACEM) is well placed to provide comment on the differences between primary and acute care. Dr Anthony Cross, President of the ACEM, told the committee that the problem for acute care was with treating patients whose conditions were preventable:

We work in emergency. But so much of what we see is preventable. If it were not for alcohol, tobacco, speed—as in driving fast—there would be work for three or four emergency physicians in Australia. I am exaggerating. I am sorry. But we would be very pleased to see that. The burden of preventable disease that we see is dramatic, all throughout the health system. So of course, yes, anything to improve primary and preventative care we would be supporting 100 per cent. This is where you get the bang for your buck in health care.<sup>27</sup>

2.32 Acute care is aimed at treating emergencies, not chronic and ongoing conditions, as Dr Simon Judkins, Victorian Councillor, ACEM, noted. Dr Judkins told the committee that patients who chose the emergency department over the GP due to increased cost would not be able to receive the ongoing care and management they required:

...we do not need anything to encourage patients to come to us to access care because we do not provide good GP type of care for patients. We see them once and send them on their way. We are not there for continuity of care. We are not there to treat chronic conditions. We are there for accidents and emergencies.<sup>28</sup>

2.33 The ACEM argued that any policy which targets primary healthcare for cost savings will be ineffective, 'as research has shown that the increase in the rates of GP visits is in fact more cost-effective than if these services were provided in other areas of the health care system'.<sup>29</sup>

### **Risks to general practice and primary healthcare**

2.34 The evidence of the effectiveness of primary healthcare and general practice is indisputable. However, this has not deterred the government from targeting general practice as a source of budget savings. While the proposed co-payments have now been dropped,<sup>30</sup> the Minister for Health, the Hon Sussan Ley MP, has stated that the indexation freeze will remain in place and that the government still believes that Medicare spending is unsustainable.<sup>31</sup>

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27 Dr Anthony Cross, President, ACEM, *Committee Hansard*, 8 October 2014, p. 22.

28 Dr Simon Judkins, Councillor, ACEM, *Committee Hansard*, 5 February 2015, pp 55–56.

29 Australasian College of Emergency Medicine (ACEM), *Submission 132*, p. 1.

30 The Hon Sussan Ley MP, Minister for Health 'Government continues Medicare consultation', Media release, 3 March 2015.

31 The Hon Sussan Ley MP, Minister for Health, 'Abbott Government to deliver a healthier Medicare', Media release, 22 April 2015.

2.35 As a result of this government policy, the committee has heard growing concerns from submitters and witnesses for the future of general practice. In particular:

- the viability of general practice;
- increased inefficiencies in the health sector; and
- the loss of opportunity to improve health policy.

### ***Viability of General Practice***

2.36 While the Prime Minister has insisted that the co-payment would not be greater than five dollars,<sup>32</sup> Dr Duckett told the committee that in reality the co-payment could be as high as \$40 per visit. Dr Duckett argued that the impact on general practice of the government's proposed changes to Medicare is likely to amount to a 10 per cent decrease in general practice income:

There are two changes that are taking place. There is a rebate reduction that only applies to GPs' patients...who do not have a concession card and are over 15. That is \$5. That is the first change. The second change is the freeze in rebates through to July 2018. That is a bigger change in its cumulative effect. If you assume a two per cent increase or so inflation per annum, it is a six or so per cent impact in reduction in revenues to GPs, versus a four or so percentage impact from the \$5. So it is a 10 per cent impact we are talking about altogether.<sup>33</sup>

2.37 Dr Graeme Alexander, a GP from the Claremont Village Medical Centre near Hobart warned that the government's policies threatened the ongoing viability of general practice in Australia:

There will be a vastly inferior health system for the poor and the disadvantaged whether they access clinics or get their health care through the pharmacy. There is an interesting thing happening at the moment: as general practice comes under attack—and I point out to you that one of the few areas of general practice that will survive is the large corporate-run clinic, and people should be asking the question why. The huge void that this will fill as general practices' doors close—and that is what we are talking about; we are talking about the viability of general practice, because general practices are going to the wall as we sit here now and they are going to go to the wall with this new health policy.<sup>34</sup>

2.38 Dr Richard Terry, Practice Principal of the Whitebridge Medical Centre near Newcastle, outlined the impact of the government's proposed changes to Medicare on solo practices:

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32 The Hon Tony Abbott MP, Prime Minister, the Hon Peter Dutton MP, Minister for Health, transcript of press conference, 9 December 2014, p. 3.

33 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 5 February 2015, pp 68–69.

34 Dr Graeme Alexander, General Practitioner, Claremont Village Medical Centre, *Committee Hansard*, 5 February 2015, p. 37.

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I would just like to draw attention to the financial vulnerability of solo practice. I have been in solo practice for a long, long time, and for the last 10 to 15 years we have suffered a lack of indexation medical rebates—10c a year on some rebates. Many of us in solo practice have stayed in practice for the love of our patients, because our actual remuneration, which is the money left in the pot at the end of the day, has been going down as the cost has increased... Certainly if that Medicare level B [short consultations policy] fiasco had gone through, you would have seen practices dropping by their thousands, because you simply would have had to close the door because you could not afford to keep it open. I think that the co-payment and the lack of indexation again have the similar effect.<sup>35</sup>

2.39 The RACGP President, Dr Jones, talked about the difficulty of balancing quality care, and managing a general practice in the face of the government's proposed changes:

Australian general practice patient services have been unfairly targeted by the government to find savings within the health budget. GPs and practices are now faced with an ethical dilemma of providing ongoing quality care balanced against practice business imperatives. Please remember that most general practices in Australia operate as small businesses.<sup>36</sup>

2.40 The RACGP felt that the result of the Medicare reforms was that 'the Government has shifted the onus of finding savings onto GPs'.<sup>37</sup> Feedback from the members of the RACGP indicates that, facing the decision of whether to pass on greater costs to patients or absorb the costs from their own practice, 'most GPs will not be in a position to absorb these costs'.<sup>38</sup> The RACGP noted that:

While these changes [\$5 co-payment and extended indexation freeze] will clearly have a negative impact on patient access and tertiary healthcare expenditure, they will also threaten the sustainability and viability of the business of general practice and the future of the profession.

Operating as small businesses, general practice owners will now be forced to reevaluate the viability of their business model and determine if, under the proposed arrangements, the return on investment will be sufficient to continue operating. It is likely that many practices will cut practice staff, general practice registrars, medical students, and patient services as required.<sup>39</sup>

2.41 According to the RACGP, the cut to funding for primary healthcare is also negatively affecting the future of general practice:

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35 Dr Richard Terry, Practice Principal, Whitebridge Medical Centre, *Committee Hansard*, 5 February 2015, p. 27.

36 Dr Frank Jones, President, RACGP, *Committee Hansard*, 5 February 2015, p. 9.

37 RACGP, *Supplementary Submission 115*, p. 2.

38 RACGP, *Supplementary Submission 115*, p. 2.

39 RACGP, *Supplementary Submission 115*, p. 2.

Feedback received indicates that many young doctors view general practice as an unattractive vocation and that the proposed government changes are forcing many GPs who are currently practising to reconsider their chosen speciality.<sup>40</sup>

2.42 Dr Ian Kamerman of the North-West Health practice in Tamworth provided a clear example of the concerns voiced by others that the out-of-pocket costs to patients was likely to be much higher than the \$5 in the government's announcement:

...it is a concern to me as a business owner and operator as well as a GP that there is no funding now, essentially, to support the actual practice of general practice. Certainly it is marginal at the moment, and, with the changes to indexation, the gap between expenses and income is going to increase from marginal to about \$100,000 a year that I am going to need to make up in costs and income in my practice. Either I am going to have to put staff off or I am going to have to increase patient fees to do that over a period of time. Currently, my non-concessional patients pay a \$35 gap. That gap is going to increase to about \$60 or \$65 if I am going to stay afloat as a business. It is certainly much more than what has been talked about as the cost of a latte. Either that or I am going to need to cut out bulk-billing altogether.<sup>41</sup>

### ***Increased inefficiencies in the health sector***

2.43 Dr Duckett noted that there are national and international studies showing that better access to primary healthcare results in improved preventative health rates and better overall health management. With general practice being recognised as the most efficient level of the healthcare system, internationally the trend is towards improving access and encouraging health consumers to visit general practice:

Certainly we know that, if you have out-of-pocket costs, people defer visits to doctors. We also know that, if you have out-of-pocket costs and people defer a visit to a doctor, the patient cannot make a judgement about what is necessary care and what is unnecessary care; so they end up missing out on necessary care as well. And there have been a number of overseas studies which have shown that. There has been a major study which has assessed the impact of co-payments... Generally, the overseas policy direction is not to have financial barriers in general practice. The whole international direction of health policy is to try to strengthen general practice, to try to strengthen primary care because this is the most efficient level of the health system. I am not saying that general practice or primary care is perfectly organised in Australia at the moment and, indeed, I do not believe it is. I think there need to be changes, but the changes you need to make are not forcing the consumer to drive all the change in primary care when they are

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40 RACGP, *Supplementary Submission 115*, p. 2.

41 Dr Ian Kamerman, North-West Health, Tamworth, *Committee Hansard*, 5 February 2015, p. 26.

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people who just do not know what is necessary care and what is not necessary care.<sup>42</sup>

***Loss of opportunity to improve health policy outcomes***

2.44 The committee heard from witnesses that the government's single-minded focus on "budget repair" has led to the government developing policies which will damage Australia's primary healthcare system. As a result, the national healthcare reform debate has been side tracked into protests against the government's poor policy formulations and the opportunity has been lost to engage meaningfully with stakeholders on positive health policy reform.

2.45 Associate Professor Owler told the committee that the government had focused on fiscal saving to the detriment of debate about beneficial health policies:

I think the proposals that have been made...have all been fiscal. They have all been about saving money. No-one would introduce those measures if they were to look at the impacts through the prism of health. I think one of the most disappointing things over the past 12 months is that we have just had no health policy developed in this country. We need to get back to talking about how we are going to make the health system better. I am pleased that the new minister appears to be embarking on that process, but I think it has been a disappointing 12 months from that perspective.<sup>43</sup>

2.46 Dr Linda Mann, a GP from Strathfield, Sydney revealed the loss of trust between the government and general practice:

General practitioners, I think, are very insulted by the idea that we are the part of medicine that has to show a price signal.<sup>44</sup>

2.47 Dr Charlotte Hespe, a GP from Glebe in Sydney with 20 years of experience, articulated the frustration of GPs with non-evidence based, fiscally driven policy making:

There seems to be a concern about the amount of money that the government is spending on health, with the increasing population and the increasing complexity of medicine that is before us; therefore, there is this need to take control of the amount of expenditure that goes into health. If that is truly what the government wants then this attack on primary health care—which, can I say, has come from three directions in the budget: the co-payment, the change with Medicare Locals and the change with the GP training scheme—is completely ludicrous. When you look internationally, there is astounding evidence that the way to make your health system efficient, to increase its capacity, to improve health outcomes and to achieve the triple aim of universal health—which is improving the patient journey, improving the health of your population and decreasing cost—is to build up your primary health care. The co-payment as an example of that is

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42 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 5 February 2015, p. 66.

43 Associate Professor Brian Owler, President, AMA, *Committee Hansard*, 5 February 2015, p. 7.

44 Dr Linda Mann, GP, private capacity, *Committee Hansard*, 19 February 2015, p. 29.

ridiculous. It is not going to do that at all. What signal it puts out is ridiculous.<sup>45</sup>

2.48 Dr Duckett summed up the views of many who spoke to the committee with his observations on the progress of the Minister's 'wider consultations' process:

We had the unusual situation which I do not think I have seen in health policy in this country of three health policies in less than a month, which suggests that policy is being made on the run. As I said earlier, we do need to look at primary care in general practice and we do need to think about whether the current arrangements are right for the future.<sup>46</sup>

### **Committee observations**

2.49 The evidence heard by the committee indicates that from the 2013 election to the recent 2015-16 Budget, the government's apparently single-minded focus on making savings in healthcare has blinkered its approach to policy. The government's fiscally drive approach has resulted in unjustified cost burdens falling on the primary healthcare sector and in particular on general practice.

2.50 As this chapter has discussed, there is overwhelming evidence of the importance of general practice and access to primary healthcare. The evidence gathered by the committee has demonstrated that general practice provides:

- better health outcomes for consumers;
- cost-effective healthcare with an ability to focus on preventative health; and
- more responsive healthcare than acute care, particularly in providing continuity of care and management of chronic conditions.

2.51 Despite this evidence, witnesses continually told the committee that government policy has threatened the viability of general practice. In particular, the committee notes with disapproval the government's renewed commitment to non-indexation until an agreed "value signal" is reached with stakeholders in primary healthcare.

2.52 The committee observes with concern that instead of beginning a public discussion about positive healthcare reform, the government has eroded the trust and goodwill of the medical community. The government's targeting of primary healthcare for budget savings has led to:

- threats to the viability of general practice as GPs are forced to pass on costs to patients from the continued indexation freeze;
- poorer outcomes for patients as out-of-pocket expenses increase or the indexation freeze prevents GPs from maintaining viable practices (particularly in rural areas where attraction and retention of GPs is already problematic);

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45 Dr Charlotte Hespe, Private capacity, *Committee Hansard*, 19 February 2015, p. 29.

46 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 5 February 2015, p. 67.

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- increased inefficiencies in the health sector as patients who cannot pay for primary health enter the public hospital system with preventable conditions or mis-managed chronic conditions;
  - loss of opportunity to introduce positive healthcare programs and policies; and
  - the loss of the trust and goodwill of the primary healthcare sector.

2.53 The committee agrees with Dr Duckett's observation about a future approach to healthcare policy:

Further, public policy should be based on both costs and benefits. Purely focussing on outlays without considering the benefits from those outlays can again focus policy attention in the wrong place.<sup>47</sup>

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47 Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Supplementary Submission 29*, p. 2.