POLICY REFLECTION
https://doi.org/10.1071/AH23042
Australian Health Review
ahha

Contemporary challenges for primary care

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Received: 10 March 2023
Accepted: 10 March 2023
Published: 6 April 2023

Cite this:
Duckett S and Hunt JB (2023) *Australian Health Review* **47**(2), 135–136. doi:10.1071/AH23042

Primary care in Australia faces short-term and long-term challenges. The problem is, if we do not fix the short-term problems, there may not be a long-term.

The causes of the long-term problems are, in part, that Medicare has suffered from policy neglect for the past decade. The population has changed a lot since Medicare was designed in the 1960s – with an increased prevalence of chronic disease and changed ownership structures of general practices – but policy settings have only adjusted marginally.

Renewing Medicare to be fit for purpose in the contemporary world was the focus of the Strengthening Medicare Taskforce whose report, issued in February this year, included recommendations about voluntary patient enrolment, increased funding for longer consultations, and improved workforce supply.[1] Many of the Taskforce's recommendations have been proposed over the past decade, but were left to gather dust on shelves, or the digital equivalent.

At the time of writing, the government had not released its response to the Taskforce's report, but it will be very surprising if that response does not incorporate phasing in a new model of payment for general practice, including voluntary patient enrolment. The precise shape of voluntary patient enrolment in Australia is not settled but will involve patients signing up to a practice which will be their main source of care, with the practice to have access to a broader range of professionals to better support enrolled patients.

But the devil is in the detail, and new types of funding, or increased funding, may create perverse incentives if the response undermines primary care.

A critical long-term issue is the number of medical graduates entering general practice. Medical school curricula often provide students with limited exposure to general practice, and conversely extensive tertiary or quaternary hospital placements. These factors, together with a biomedical orientation of much of the curriculum, conspire to suggest that hospital-based specialty practice is what students should aspire to. The significantly higher remuneration of procedural specialists compared to general practitioners serves to reinforce the cultural incentives.

These challenges may be overwhelmed by the short-term pressures. There are fewer general practitioners, and fewer still who bulk-bill all patients, which means governments are developing policies for alternative providers for diagnosis and treatment to assure access to primary care. In some circumstances, other practitioners can easily substitute for general practitioners, especially if they work within the same team, or work independently but in collaboration rather than in competition. But competitive arrangements, such as expanding pharmacist prescribing in a way which is not integrated with general practice, will almost certainly undermine integrated primary care.

Although Medicare rebates for general practice have increased in line with the consumer price index over the past 40 years, they have not kept pace with average weekly earnings,[2] and this is true even if one takes into account the increase in the rebate from 85 to 100% of the schedule fee over this period and the introduction of an additional bulk-billing incentive payment for many patients. General practices are therefore facing a squeeze, as their costs increase faster than their revenue. There has been a particular crunch in the past year as inflation has surged resulting in more practices moving away from universal bulk-billing, creating financial barriers to access for many patients.

The recommendations of the Strengthening Medicare Taskforce will take a while to implement, but government may not have the luxury of a slow implementation. Quick action will be needed to stem the decline in bulk-billing.

Unfortunately, government is managing the enormous deficit legacy caused by the response to the pandemic in 2020 and 2021, so the Commonwealth's financial cupboard is currently bare. Although some funding was promised by government during the election campaign, this will not be enough to address all the contemporary issues.

Money will have to be re-distributed within the health portfolio, with one obvious place to look being the extensive subsidies to private hospital care, particularly the Medicare rebate for medical services to private patients in private and public hospitals. This rebate is set at 75% of the schedule fee, which is not a magic number and could be reduced to 25% with the net savings, after taking into account that the Commonwealth subsidises the gap through the private health insurance rebate, re-distributed to general practice. This should take the form of an increase in the bulk-billing incentive, and perhaps making that incentive universal, or at the least, making progress in that direction. This would help to stop the bulk-billing decline and would signal that government is prepared to prioritise supporting general practice over highly remunerative hospital practice. Although increasing GP rebates risks GPs reducing their working hours,[3] that risk is small relative to the contemporary threat to access for many Australians.

Primary care is not only general practice, but primary medical care is a key component of primary care. In the long-term, primary care will be better positioned to respond to contemporary needs through the strengthening of integrated multidisciplinary teams, the introduction of voluntary patient enrolment, and an increased number of medical graduates entering into general practice. These long-term solutions need to be balanced with short-term efforts to strengthen general practice through making bulk-billing more financially attractive and avoiding fragmentation of care. Without addressing the short-term issues, it will become harder and harder to implement long-term solutions.

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