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Divisions' Issues in the Memorandum of Understanding

The notes below identify some of the issues that may be relevant for divisions, as distinct from the AMA and the RACGP, to consider in weighing up the value of the proposed Memorandum of Understanding. The analysis used here of what constitutes relevant issues for divisions is discussed more fully in GPDV Policy Issues Paper no.7 *Defining Divisions Business.*

ADGP has asked for divisions' responses to be provided to them by 27 July. GPDV would also be interested to hear what decisions the members of Victorian divisions' have made about the MoU.

Meaning of the MoU

It is important to remember that a Memorandum of Understanding is not binding and that much of the MoU contains only broad directions for future planning and development, not the detail of those plans or their implementation. Much of the current MoU's content would be open to a range of interpretations. The importance of the MoU lies in the fact that it will provide a basis for future directions for general practice structure, policy and funding and that, if signed, the Commonwealth will claim a mandate from the general practice profession to proceed in the directions indicated in the MoU.

Divisions Program Funding (clause 20)

Issue: the Divisions' Program funding is not assured under the MoU.

Clause 20 states that the government will continue to fund the "General Practice Infrastructure Training and Support Program" ($841m over 4 years i.e. approximately $210m p.a.) and states that this Support Program includes the Divisions Program. Although the "General Practice Infrastructure and Support Program" is mentioned in the 1999-2000 Budget, a program of this name is not mentioned in any of the other documents where one would expect to find it, e.g. the GP Strategy Review Report. It is therefore unclear what the Program means, what its components are (apart from the Divisions Program) and how the promised funding differs, or remains consistent with, the current funding for initiatives related to the GP strategy. (This is particularly unclear because the published information on the 1999-2000 budget does not seem to give a breakdown of amounts spent on the GP Strategy in a way that is comparable to previous years).

The wording of the clause also means that the assurance is that the whole support program will be funded; not necessarily the Divisions Program specifically. However funding for rural workforce agencies, the rural retention incentives and the fly-in fly-out female doctor program is mentioned specifically in clause 21.

Workforce (clause 11a)

Issue: The significance of a variation of 200 FTE in the GP workforce is debatable and the consequences of a funding review is unclear in the MoU.

This clause states that an increase of more than 200 FTE GPs per year will result in a review of funding under clause 4. Two questions arise here.

1) How has the figure of 200 FTE been reached?

Is this realistic, or a minor addition to the workforce? How does this compare with the number of graduates entering general practice each year? What is the definition of FTE that the MoU is referring to, but does not specify?

The most up to date Medicare data and labour force data (from AIHW) that we have shows there are around 17,000 – 18,000 VR GPs nationally (4,240 in Vic – excluding OMPs), but we would need to do further analysis to reach FTE numbers (and this would depend on the definition used). Does this MoU mean VR or include non-VR? (*see below re clause 14*)

2) What does the funding review in clause 4 mean?

Clause 4 appears to mean that the government will increase minimum funding available for rebates if service volume has increased because of workforce as result of:

- Commonwealth policy
- actions of universities, Australian Medical Council
- State or Territory Governments

It may also mean that if a workforce increase occurs for any other reason (though the list above covers most foreseeable reasons) the "government and profession will jointly analyse the causes and address them." That phrase could mean reducing funding or sacking doctors, or increasing funding, or anything.

One interpretation of how this is likely to be implemented is that the Commonwealth would have an incentive to keep the increase in numbers of FTE GPs below 200 per annum, and adjust their policies accordingly, so that the increase of workforce is simply paid for through existing (capped) budget.

Vocational Registration / Other Medical Practitioners (clause 14)

Issue: It is unclear what is meant by a mechanism for other medical practitioners to become vocationally registered.

This issue may be relevant to divisions in terms of quality of general practice, and workforce issues.

What is the meaning of the "mechanism for" OMPs to become VR? Doesn't such a mechanism already exist, through the College? If as many OMPs as possible achieve recognised GP status, will this affect the increase in number of FTE GPs, limited to 200 in clause 11) before funding is reviewed?

Capping Medicare

Issue: The consequences of capping Medicare are unknown in terms of quality of care concerns and impact on the way GPs work.

Obviously, the issue of capping Medicare is the one that has dominated the debate around the MoU. This issue has far-reaching consequences, but it is difficult to know in advance what those consequences are likely to be.

Capping the income of individual GPs is an AMA issue, rather than a divisions' one; the question for divisions is what effect on the healthcare system, and on the way GPs work, will capping Medicare have?

This is a huge question, impossible to answer quickly, and probably impossible to answer definitively in any case, until it happens (if it happens).
Possibilities may include:

- limiting the number of patients a GP takes on (as has occurred in Canada)
- limiting the number of consults per patient?
- increased likelihood of spending more time in a consultation, since GPs will get no extra money for seeing more patients, if cap is reached, or neared?
  or
- increased likelihood of spending more time outside clinical practice e.g. on research; holidays; working in divisions, other leave.

Clause 4 indicates some events outside the control of the profession or government which would result in increased minimum funding if they occurred (e.g. epidemic). Are the exceptions in the MoU adequate to continue to provide reasonable quality service to patients?

Cost shifting (clause 11b)

Issue: the action that will result after identifying cost shifting needs to be clearer.

Cost shifting is an issue that frequently hampers the work of divisions.
Clause 11b says that after identifying and measuring cost shifting between State and Commonwealth that would impact on outlays in the MoU, the government and profession "will develop mechanisms to appropriately adjust funding to address it?" What does this statement mean?

The intention may be to ensure that rather than being forbidden per se, cost shifting **is** possible, where it is a positive thing, leading to better health care, etc. However, if this is the intention, the MoU does not make this clear. The clause could be interpreted to mean that funding will be reduced where cost shifting has occurred, (because the expense should no longer incurred by the Commonwealth, if the State is paying for it) or that cost shifting should never occur. The intention, and the resulting action needs to be made clearer in the MoU.

Relative Value Study

The relevance of the RVS to divisions lies in how it affects the **ways** in which GPs work, the quality of practice and health care (e.g. allowing non face to face work including case conferences, removal of incentives for numerous short consultations, remuneration for long, complex consultations etc), **not** in the rebate amounts.