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GP Financing Group Negotiations

The GP Financing Group's Progress Report (distributed by ADGP via email on 3rd February and attached to the email version of this paper) raises a number of issues that are relevant to divisions. This paper outlines some of the issues that appear to be the most pressing for divisions to consider if they wish to have input into the GP Financing Group's further negotiations on the GP Financing Agreement with the Department of Health & Aged Care (DH&AC). It is not a summary of the report, nor a comment on all sections of it.

ADGP, which represents all Australian divisions on the GP Financing Group has advised GPDV that it needs to receive feedback by the end of February, if it is to use it to represent divisions' positions. Divisions' responses should be sent to John Aloizos, Chair of ADGP and GPDV would be interested to receive a copy of Victorian divisions' submissions.

GPDV Board has received this paper but has not yet discussed its response to the Progress Report and will be doing so at a meeting later in February.

Rural, Remote and Metropolitan Areas (RRAMA) (3.3)

Section 3.3 states the that current RRAMA classification system will continue to be used "while other systems are being developed." There has been much discussion over the past 18 months about the classification of some postcodes as metropolitan, while the GPs and patients in them believe they are **not** metro. This applies in fringe metropolitan areas as well as around provincial centres. Practices in these postcode areas will receive less money through the Practice Incentives Program (PIP) than they would if the area's rurality was recognised.

GPDV has previously raised this problem with the Department of Health & Aged Care, as have a number of divisions that are affected. Those divisions may wish to take this opportunity to encourage DH&AC to ensure the matter is addressed.

Dealing with underspend of the PIP (3.6.3)

The progress report lists a number of ways any unspent PIP money may be spent in the current year. A number of these options would require significant time to be developed and are therefore unlikely to be implemented in the current year. The first two options listed in the report would be able to be implemented more quickly. These are an extra payment to GP practices, calculated per standardised whole patient equivalent (SWPE), and/or a payment towards communications equipment e.g. fax or computer. These options may require further consideration before being supported.

The effect of the first point would be to reward those GPs who are participating in the PIP in the current year, which may lead to some resentment from GPs in practices that do not apply for the PIP before 30 June. It also might give the impression that the PIP is simply an extra source of money for GPs, rather than a tool for enhancing the way GPs practise. (The PIP is

intended to offset the limitations of the fee-for-service system, which is geared to reward a high volume of short consultations.)

Funding GPs to acquire faxes and computers might be seen to run counter to the view that general practices are private and autonomous businesses. It is possible that other health professionals and the wider community would argue that this would be a subsidy of GPs' business costs, rather than provision of incentives for GPs to practise in alternative ways.

Divisions may wish to consider providing feedback to ADGP on options for spending any remaining PIP funds in the current financial year.

Amalgamation payments (4)

There is much that could be said about the failure of the discussions about practice amalgamations to clearly identify the primary purpose of amalgamation. While there are many potential benefits, the reasons underlining the public funding of incentives to amalgamate has not been made totally clear. If, for example, the primary motivation for amalgamation is increased business efficiency, it begs the question of why public funding is being used to subsidise a business decision (a position which has been argued on GP email discussions, as well as at a GPDV Board meeting some time ago). If, on the other hand, the main purpose of amalgamation is patient benefit (continuity of care through sharing of medical records facilitated by a group practice), questions arise about the optimal size practice. If the purpose of amalgamation relates to workforce (e.g. sharing after hours care, having the flexibility to cover colleagues' periods of leave) a different set of issues arise.

One aspect of amalgamation that seems to have received little attention is the metropolitan context in which amalgamation discussions have been automatically placed. While GPs are aware that amalgamation is unlikely to be desirable (or even an option) in rural areas with a shortage of GPs, and where patients have to travel significant distances to have access to a doctor, there has been little discussion about micro economic reform in a rural context.

Divisions may wish to consider whether amalgamations can (or should) apply to rural practices; and if not, whether this should be flagged as an issue, and some strategies put in place to address rural needs e.g. that rural practices receive preferential access to any virtual amalgamation processes (when these are worked through at a later stage).

Measure and share (5.2)

It is not completely clear in the progress report whether the suggestion is that savings would be paid: 1) to the division to run activities and/or services for GPs; 2) to the practice to fund improvements; or 3) as a personal payment to GPs. Aggregating and distributing the savings would mean that the good practice of a few GPs would benefit those GPs who did not improve their prescribing practice at all. This collective model might not provide an effective incentive.

As this measure and share procedure is based on public funds, it might be thought more appropriate that savings should go towards further programs/services to support GPs in the enhancement of health care in the long run. Because the savings come from taxpayers' funds, it is likely to be thought inappropriate to use a model from the private sector in which profits are distributed as personal benefits to shareholders or employees.

The proposed methodology of calculating and aggregating the savings made by each practitioner in a division, and then paying it back to GPs in the division is likely to be extremely time-consuming to administer. It is unclear who would undertake this. If it is envisaged that divisions of general practice would act as agents for the system's administration, a number of issues would need to be examined in detail. These would include: ascertaining whether divisions have the resources and technical expertise to carry out the task of aggregating prescribing data and calculating payments to GPs in their area; privacy issues of divisions obtaining practice data both for GPs who are members of the division and non-member GPs; and whether holding and distributing payments for better prescribing is an appropriate role for a division, rather than the DH&AC.

Feedback on the GP Financing Group's progress report may be sent to:

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GPDV would also be interested to receive a copy of Victorian divisions' submissions.