Australian Institute for Primary Care & Ageing
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24 May 2011

Commissioner Mike Woods
Chair, Caring for Older Australians Inquiry
Productivity Commission
GPO Box 1428
Canberra City ACT 2601

Dear Commissioner Woods

Re: Further advice on AIPCA submission to the *Caring for Older Australians* Inquiry

I write to provide you with further advice on two possible reform options for the RACF–primary health care interface, as discussed during my appearance at the hearing of 23 March 2011. In summary, these options are:

- **Reform of the Aged Care Access Initiative (ACAI)** by re-adjusting the existing ACAI framework to use service weightings, rather than service counts.
- **Replacement of the ACAI with a sessional incentive** that rewards GPs for providing more consultation services per visit (i.e. a session) and also addresses the issue of opportunity costs to GPs in providing RACF services. As per the AMA and AGPN submissions to the Inquiry, this is a significant problem that has not been adequately addressed.

In addition, supplementary data relating to AIPCA's submission is provided as an attachment to this letter.

1. Reform of the Aged Care Access Initiative

1.1. As discussed at the hearing, one of the major shortcomings of the ACAI is that all RACF-based GP services contribute equally towards the ACAI incentive payment thresholds, despite differences in the complexity and duration of these services.

1.2. Under the current ACAI model, a simple Level A consultation (MBS item 20) and a more complex and involved Resident Medication Management Review (MBS item 903) contribute equally towards the ACAI threshold. This arguably creates a disincentive against providing these more complex services, since the incentive payment thresholds can be reached by other, less complicated, means. Given the relative undersupply of comprehensive care services (such as RMMRs) to residents, this disincentive must be addressed.

1.3. A simple reform to the ACAI, one that works within the existing ACAI and MBS frameworks, would be to use service-weighted thresholds for the payment of ACAI incentives. The MBS already includes service weightings of a kind—the scheduled fees associated with each service item. From the example, the 2009–10 scheduled fee for a Level A in-facility service was $15.70, whereas the fee for an RMMR service was $98.20. If the ACAI thresholds used

this type of weighted approach, the RMMR service would "count" for substantially more than a Level A consultation.

1.4. While Medicare scheduled fees are not necessarily the most accurate reflection of the complexity of activity involved in any given service, they would be an easily understood form of service weighting involving minimal change to the existing ACAI framework.

Proposed thresholds for ACAI payments

1.5. The ACAI uses a dual-threshold framework for the payment of incentives. The first payment threshold requires the provision of 60 eligible RACF-based services during the financial year; the second threshold requires a total of 140 services.

1.6. Based on 2009–10 service utilisation data, the average Medicare benefit payable per ACAI-eligible service was $41.80. By applying this to current ACAI thresholds, the equivalent "billing-based" service weighted thresholds would be approximately $2,500 (the equivalent of 60 services) and $5,900 (140 services).

1.7. The number of services required to meet these hypothetical service-based thresholds is shown in Table 1 (by type of service). The effect of the weighting is to "favour" provision of services with higher scheduled fees, such as longer consultations (Levels C and D) and comprehensive care items (e.g. RMMRs).

Table 1: Number of services required to achieve hypothetical service-weighted thresholds

Service type (MBS item #)	2009–10 scheduled fee	Number of individual services required to reach threshold	
		Threshold 1: $2,500	Threshold 2: $5,900
Level A consultation (20)	$15.70	160	376
Level B consultation (35)	$34.30	73	173
Level C consultation (43)	$65.20	39	91
Level D consultation (51)	$95.95	27	62
RMMR (903)	$98.20	26	61

1.8. A service mix that is biased towards comprehensive care will achieve the billing-based ACAI thresholds more readily. In terms of threshold attainment, a GP is more than six times "better off" providing a resident with comprehensive care (via an RMMR) as compared to a Level A service.

1.9. In order to be effective, this reform requires that *all* comprehensive care services for residents are included in the ACAI. At present, the new health assessment services that replaced the resident-specific comprehensive medical assessment (CMA; former MBS item 712) are not included in the ACAI. Resident-specific case conferencing items have also been consolidated with those for the general population. While simplification of the MBS is very necessary, these replacement services need to be re-incorporated into a reformed ACAI to ensure that the full spectrum of comprehensive care services for residents are included.

1.10. This reform option would not address the problem of the low resident loads necessary to achieve ACAI incentive payments—an issue raised in AGPN's submission to the Inquiry. From MBS data for 2009–10, the average number of ACAI-eligible services per resident was 16.5; based on this average, the 60 service threshold would be achieved with only four residents. The second threshold, 140 services, would be achieved with just nine residents. Beyond these modest resident loads the ACAI incentive payments are diluted, negating their ability to compensate GPs for the costs incurred with RACF care, such as direct costs (e.g. transport to distant facilities) or opportunity costs (e.g. lost income relative to remaining in their consulting rooms).

1.11. These costs are significant barriers to improving the adequacy of primary care for residents, and the ACAI framework (unreformed or reformed) does not alleviate these costs for those GPs with higher resident loads. The next reform option—replacement of the ACAI with a sessional incentive—is designed to overcome opportunity costs while also promoting comprehensive care provision.

2. Replacement of the ACAI with a sessional incentive

2.1. As submitted at the hearing, AIPCA is currently conducting research on the area-level factors impacting on the delivery of comprehensive GP care services to residents. For this research, an indicator of "sessionality"—the number of services provided per visit—was developed as a measure of how GPs organised their service delivery pattern. Our preliminary findings suggest that greater sessionality (i.e. a greater number of standard consultations delivered by a GP per RACF visit) predicts greater delivery of comprehensive care services by GPs.

2.2. While the sessionality measure is a relatively crude reflection of the complexity of activity in RACFs, it does indicate a tendency towards a different style of practice. The measure readily distinguishes between a "fly in, fly out" GP practice pattern (where GPs provide a single service per visit) and a sustained visit consisting of multiple consultations. As above, this latter practice pattern may be characteristic of GPs who are more involved with and experienced in RACFs, and this may have benefits such as higher provision of comprehensive care services to residents.

2.3. As a reform target, sessionality would be innovative in that it moves away from a simple volume-based approach ("any activity, any time") and considers service delivery structure. Beyond the apparent association with higher rates of comprehensive care, sessionality may have other practical benefits for the relationship between GPs and RACFs. For example, where GP visits occur on an *ad hoc* basis, interactions between GPs and senior nursing staff within a facility may be purely coincidental. Where GPs conduct regularly scheduled sessions, facilities can organise their staffing in such a way that allows for a planned interaction between the GP and the facility.

2.4. In the current model, sessionality is substantially constrained by the opportunity costs incurred by GPs who provide care in RACFs for extended periods. The development of any sessional payment incentive must overcome these opportunity costs, or otherwise be "diluted", as is the case with the ACAI.

Current payment model and opportunity costs

2.5. Under the current MBS payment model, GP visits to RACFs are paid according to the "derived fee" system. The overall Medicare benefit payable for GP consultation services in an RACF consists of the scheduled fee for the equivalent in-surgery consultation, plus a loading payment adjusted for the number of residents seen during the visit. In 2009–10, the Medicare benefit payable for a standard Level B consultation service provided in an RACF was the "fee for item 23 [$34.30], plus $43.25 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus $3.10 per patient."[1] The total Medicare benefits payable (2009–10 fees) for an RACF visit composed entirely of Level B consultations (the most common service) is shown in Table 2.

Table 2: Medicare benefit payments for Level B RACF consultations, 2009–10

Number of residents per visit	Loading payment per resident	Total benefit per resident ($34.30 fee + loading)	Total payment for visit
1	$43.25	$77.55	$77.55
2	$21.63	$55.93	$111.85
3	$14.42	$48.72	$146.15
4	$10.81	$45.11	$180.45
5	$8.65	$42.95	$214.75
6	$7.21	$41.51	$249.05
7	$3.10	$37.40	$261.80

2.6. The loading payments use a flat rate approach for reimbursing GPs for the additional expenses incurred in providing consultation services in RACFs. If considering transport to the RACF as the primary direct cost, this cost is constant regardless of the number of residents seen during the visit. As submitted by the AMA, the payment structure does not take into account increases in direct costs (e.g. RACFs being increasingly distant from the GP), the increasing complexity of care required by residents, and—perhaps most critically—the loss of income to GPs who provide services in RACFs rather than in their consulting rooms.

2.7. It is clearly in a GP's financial interest to remain within their consulting rooms, rather than visit an RACF. This is best illustrated using a hypothetical example of a GP providing a single Level B consultation on a visit to an RACF located ten minutes (door-to-door) from the consulting rooms. Based on just the 20 minute round trip, and the 11-minute median length of Level B consultation,[2] the total time away from the consulting rooms is 31 minutes. Assuming that the GP charges the 2009–10 Medicare scheduled fee, then on a benefit-per-minute basis the GP will be paid $2.50/minute for the RACF consultation ($77.55 for 31 minutes). During the same 31-minute period, a GP could provide 2.8 Level B consultations (11 minutes/consultation for 31 minutes) in their consulting rooms. At the scheduled fee of $34.30 per 11 minute consultation, the benefit-per-minute rate in the consulting room for the same

[1] Medicare Benefits Schedule; Item 35.
[2] Britt H, Valenti L, Miller G (2002) "Time for care: Length of general practice consultations in Australia" *Australian Family Physician* 31: 876-880.

service is $3.12/minute, giving the GP a total of $96.66 for the same 31-minute period. Thus, the opportunity cost to the GP providing the single RACF service in this example is $19.11.

2.8. The financial disincentive is even greater where GPs charge above the scheduled fee in their consulting rooms. Using $55.00 for a Level B consultation as a typical example, the per-minute payment rate for the 11-minute consultation is $5.00. At this higher rate, the opportunity cost for the example above becomes $77.45 (compared to the RACF visit at the normal scheduled fee).

2.9. Notably, this hypothetical example does not take into account direct costs incurred by the GP in providing the RACF service (e.g. transport); the 20-minute round trip used here assumes that the RACF is located 10 minutes' *walk* from the GP's consulting rooms. Transport costs and increasing distance between GP consulting rooms and RACFs will only increase the financial disincentive associated with these services. A further limitation in this example is the 11-minute assumption; where consultations with residents take longer than 11 minutes (as is possible given the complexity of their care), the benefit-per-minute rate will decrease further and thus increase the opportunity costs.

2.10. Within the current Medicare payment model, the opportunity cost associated with providing a single consultation during an RACF visit is not abated by increasing the number of consultations provided per visit. Where GPs charge above the scheduled fee, this problem becomes worse. If the hypothetical RACF visit consisted of the same travel time and four Level B consultations rather than one, then the benefit-per-minute rate would increase to $2.82/minute ($180.45 over 64 minutes in total). At a benefit-per-minute rate of $5.00/minute in the consulting rooms, the opportunity cost for that 61-minute RACF visit would be $139.55. Table 3 shows the increasing opportunity cost for GPs providing Level B services, at both the scheduled fee and when charging above schedule ($55.00/consultation).

Table 3: Medicare benefit payments for Level B RACF consultations, 2009–10

Consultations per visit (duration)	Total payment for visit	Benefit-per-minute	Consulting room-RACF opportunity cost	
			c.f. bulk billing	c.f. above schedule ($5/minute)
1 (31 minutes)	$77.55	$2.50	$19.17	$77.45
2 (42 minutes)	$111.85	$2.66	$19.19	$98.15
3 (53 minutes)	$146.15	$2.76	$19.21	$118.85
4 (64 minutes)	$180.45	$2.82	$19.23	$139.55
5 (75 minutes)	$214.75	$2.86	$19.25	$160.25
6 (86 minutes)	$249.05	$2.90	$19.27	$180.95

Reform option

2.11. The current fee structure for RACF consultation services could be reformed in a way that promotes higher sessionality and overcomes the opportunity cost issue. The benefit-per-minute rate for RACF services could be made equivalent to that for services in consulting rooms charged at the scheduled fee. This is not an incentive as such; rather, it simply addresses the current disincentive within the payment model. At the very minimum, a GP

should be "no worse off" financially by visiting an RACF as compared to providing bulk-billed services in their own consulting rooms.

2.12. The "enhanced" benefit-per-minute rate associated with above-schedule consulting room consultations could be used to create the incentive for higher sessionality, activated only when GPs provide a certain number of services during a visit. In 2009–10, the average number of Level B consultations per visit was just under four; as such, the incentive threshold could be set above this to encourage greater sessionality in care delivery.

2.13. This reform would use two different loading payments for GP visits, and for present purposes a minimum threshold of five services per visit will be used as the sessionality threshold. For RACF visits involving four services or less, the loading payment would only meet the opportunity costs relative to a bulk-billing GP in their consulting rooms. Again, using the 20-minute travel example and Level B services to illustrate, this reform would result in a loading payment of $63.25 (a $20.00 increase per visit on 2009–10 payments). As per Table 4, no opportunity cost is incurred by GPs providing four services or fewer in the RACF compared to bulk-billing the same Level B service in their consulting rooms. In an attempt to encourage greater sessionality, above-schedule opportunity costs persist below the sessionality threshold.

2.14. For GP visits to RACFs involving five or more services, the enhanced benefit-per-minute rate would apply and the loading payment applicable to the visit would increase to $203.50. Since the loading payment is constant, some slight opportunity cost ($20.70) will be incurred for visits of six or more services *at the above-scheduled rate*; however, GP payments will remain substantially higher (approx. $140) than bulk-billing services in their consulting rooms.

Table 4: Fee payments and opportunity costs for sessionality incentive

Consultations per visit (duration)	Incentivised loading payment	Total payment for visit (loading + fee)	Benefit-per-minute	Consulting room-RACF opportunity cost	
				c.f. bulk billing	c.f. above schedule ($5/minute)
1 (31 minutes)	$63.25	$97.55	$3.15	-$0.83	$57.45
2 (42 minutes)	$63.25	$131.85	$3.14	-$0.81	$78.15
3 (53 minutes)	$63.25	$166.15	$3.13	-$0.79	$98.85
4 (64 minutes)	$63.25	$200.45	$3.13	-$0.77	$119.55
5 (75 minutes)	$203.50	$375.00	$5.00	-$141.00	$0.00
6 (86 minutes)	$203.50	$409.30	$4.76	-$140.98	$20.70

2.15. Once again, these calculations were based on Level B services and the hypothetical 20-minute travel time and 11-minute consultation duration. Longer travel times will result in opportunity costs in this model, and this can only be overcome by scaled loadings payments based on GP–RACF distance.

2.16. Given the assumptions involved, the likely cost of this reform is difficult to estimate in the absence of detailed modelling. However, in 2009–10 1.9 million Level B consultations were delivered in RACFs, at a total cost of $88.6 million (including loading payments). Under the hypothetical model proposed above, if all those Level B consultations were delivered at just

below the current level of sessionality (i.e. three consultations per visit), the cost under this model would be $105.9 million (a $17.3 million increase). If those Level B consultations were reorganised into six consultations per visit, the total cost under this model would be $130.4 million (a $41.9 million increase).

2.17. Even at the lower level, this represents a substantial premium compared to the $9.7 million cost of ACAI bonus payments for 2010. The overall cost-benefits of this reform would need to be considered, given that it may positively influence comprehensive care provision, GP–RACF interactions and encourage GPs to take up the care of more residents.

Summary

The various submissions made to the Inquiry regarding the RACF–primary care interface indicate substantial, systematic problems with how GP services are delivered to residents. The interface has been the target of special policy initiatives, most recently the ACAI. The ACAI itself has several shortcomings; while the first reform option presented here addresses one of these shortcomings, it does not necessarily address the wider issues.

The second proposed reform, the sessionality incentive, attempts to alleviate the problem of opportunity costs and improve the structure of GP service delivery to residents. The proposed sessionality threshold is intended to encourage GPs towards greater levels of engagement with RACFs. The hypothetical example presented here is limited to Level B consultations, and more detailed data and modelling is required to support this type of reform, particularly around the issue of transport time: the uniform 20 minutes' *walk* between a GP's consulting rooms and the RACF would be the exception, rather than the rule (or even the average). The Inquiry should consider that while such a model can operate within the Medicare framework, sessionality itself moves the system towards a Visiting Medical Officer (VMO)-style arrangement with RACFs. Under a VMO arrangement, GPs would provide services to RACFs on a contractual basis, rather than via Medicare, and sessional care would be an in-built requirement. VMO-style arrangements between GPs and RACFs would have the additional advantage of being able to make specific provision for travel and other costs to GPs, instead of the flat-rate approach to loading payments within the Medicare system.

AIPCA will conduct further modelling of the RACF–primary care interface to determine the viability of a VMO-style model in Australia, and to disseminate results to the sector.

Yours sincerely

Attachment: Additional data

AIPCA was requested to provide additional information on the utilisation rates for consultations presented in the original submission to the Inquiry.

The original submission presented the utilisation rates as relative to the base year of 2000-01. This is necessary in order to compare changes in the different service types over time, and to present this in the graph. The relative scale does not show the magnitude of the individual utilisation rates. For Level B consultations, the magnitude is far greater than the other service types, as this is the most commonly provided service. Despite the relatively low frequency of delivery (compared with Level B), the recent changes observed in the other service types remain substantial, as per the original submission.

The tables below provide the "raw" data: the age – sex standardised rate of service delivery per 1,000 residents for the period 2000–01 to 2009–10.

Service type	Standardised utilisation rate per 1,000 residents				
	2000-01	2001-02	2002-03	2003-04	2004-05
Level A	444	434	426	463	492
Level B	10,537	10,501	10,641	10,767	10,702
Levels C/D	906	945	1,075	1,183	1,244
Levels C/D and special items*	906	945	1,075	1,183	1,447
Total	11,887	11,880	12,142	12,413	12,642

Service type	Standardised utilisation rate per 1,000 residents				
	2005-06	2006-07	2007-08	2008-09	2009-10
Level A	512	554	620	775	959
Level B	10,842	11,006	11,432	12,458	13,182
Levels C/D	1,280	1,350	1,429	1,275	1,310
Levels C/D and special items*	1,683	1,906	2,236	2,262	2,330
Total	13,037	13,466	14,288	15,495	16,471

*Note: "special items" for residents were introduced in 2004-05.