Primary Care and General Practice in Australia 1990-2012:

A chronology of federal government strategies, policies, programs and funding

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NOTE:

This paper presents a chronology and analysis of Federal Government strategies, policies, programs and funding related to primary care and general practice over the period 1990-2012. This has been done using publicly available materials.

The opinions expressed are solely those of the author who takes responsibility for them and for any inadvertent errors. This work does not represent the views of the Australian Primary Health Care Research Institute (APHCRI) or the Commonwealth Department of Health and Ageing which funds APHCRI.

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Introduction

This paper is a summary, from a policy and budget perspective, of the way in which the delivery and funding of primary care in Australia has changed over the past twenty years.

In Australia primary care is delivered primarily through privately-provided general practice, funded largely on a fee-for-service basis that is supported by patient access to Medicare rebates. Since its introduction in the 1980s, the Medicare Benefits Schedule (MBS) as applied in general practice has been highly successful in meeting the original Medicare aims of affordability (with 81% of General Practitioner (GP) services being provided free of charge to patients in the first quarter of 2012[1]) and universality (with the same basic rebates available to all patients). There are some exceptions to this fee-for-service (FFS) approach: for example, salaried medical officers working in community health centres and Aboriginal Medical Services. Most general practices also receive practice incentive payments.

The Practice Incentives Program (PIP)[2] is aimed at supporting general practice activities that encourage continuing improvements, quality care, enhance capacity, and improve access and health outcomes for patients. It is part of a blended payment approach for general practice. In 2009–10, approximately 4,900 practices participated in PIP, making it the largest Australian Government program aimed primarily at general practices rather than GPs. Some $282 million was paid to general practices and GPs under PIP in 2009–10, with an average payment to a practice of $57,800. However practice incentive payments as a proportion of GP-related government expenditure has decreased since 2002-03.[3]

State and territory governments are also important in the funding and delivery of primary care services in Australia. They provide a range of community health services including maternal and child health services, parenting support, early childhood nursing programs, disease prevention programs, women's health services, and men's health education programs. Some of these services receive federal funding support.

As Australia looks to manage the growing burden of chronic disease and reduce health care costs and reliance on the acute care sector, there has been a focus on strengthening primary care. GPs have a central role in determining the future use of health care resources by patients and so there has been an increased emphasis on incentives for GPs to ensure provision of the most cost-effective care possible, while maintaining quality standards.

While general practice is very successful at meeting the needs of the majority of people requiring treatment for isolated episodes of ill-health, it is less successful at dealing with the needs of people with more complex conditions or in enabling access to specific population groups that are 'hard to reach'. Incentives are provided to encourage care coordination, multidisciplinary care teams, after-hours care and preventive services.

Currently the Australian model of general practice falls short of the ideals of Alma-Ata:[4] a true primary health care model requires collaboration across care providers with the creation of primary health care teams, provision for local planning and community input, an explicit commitment to equity in health care, and strategic planning across all levels of government.

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[1] Metherell M. Bulk billing levels reach record high. Sydney Morning Herald, May 24, 2012. Accessed at http://www.smh.com.au/opinion/political-news/bulkbilling-levels-reach-record-high-20120523-1z5lj.html

[2] Practice Incentives Program. Department of Human Services, Medicare. Accessed at http://www.medicareaustralia.gov.au/provider/incentives/pip/index.jsp

[3] Practice Incentives Program. ANAO Audit Report No.5, 2010–11. Accessed at http://www.anao.gov.au/uploads/documents/2010-11_Audit_Report_No5.pdf

[4] Declaration of Alma Ata. National Primary Health Care Partnership. Accessed at http://www.nphcp.com.au/site/index.cfm?display=34317

Recent reforms, specifically the implementation of Medicare Locals,[5] have seen some progress towards these goals. Indeed it can be argued that the main barrier now to full implementation of the primary health care model is the fact that responsibility for delivering and funding these services is split across the federal and state and territory governments. A significant secondary barrier is the growing rate of out-of-pocket costs experienced by patients using private services provided on a fee-for-service basis.[6] [7]

The Australian government introduced the General Practice Reform Strategy in 1992 to overcome problems in the primary care system which had arisen as the Commonwealth retained responsibility for primary care services via Medicare GP funding and the states and territories retained responsibility for community health care funded via the Medicare block grants and their own resources.[8] The Strategy, as introduced, aimed to address some specific issues facing general practice in Australia, focusing on workforce initiatives, the development of a primary care accreditation system, and remuneration strategies to more appropriately reward quality care.

In the 1992-93 Budget, the Australian government committed funding for the establishment of the Divisions of General Practice[9] to support GPs to work with each other and with other health professionals to improve the quality of service delivery at a local level. Commencing in 1996, an effort was made shift GPs towards a 'blended payments' model of funding. Initially introduced as the Better Practice Program, and subsequently reworked as the Practice Incentives Program (PIP),[10] these initiatives were intended to allow the Government to 'purchase' particular quality improvement activities. At the time there was also an intent to reduce overall financial risk to the federal health budget by increasing the share of GP funding which was capped rather than demand driven. Over time, the PIP has evolved as a range of incentives has been offered, reworked and, in some cases, withdraw. Today the key focus is on incentives to encourage continuing improvements, boost the quality of care, enhance capacity, and improve access and health outcomes for patients.[11]

At the same time new MBS items have also been introduced to improve the delivery and coordination of health services, reward bulk billing, support rural providers and to encourage the use of practice nurses and referrals for allied health services. And alongside changes to general practice funding and the introduction of the Divisions Network, programs to address specific service gaps, for example in Indigenous health and rural health, and to educate,

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[5] Australian Medicare Local Alliance. Accessed at http://amlalliance.com.au/

[6] The Health of Senior Australians and the Out-of-Pocket Healthcare Costs They Face. National Seniors Productive Ageing Centre, November 2012. Accessed at http://www.nationalseniors.com.au/icms_docs/142859_National_Seniors_Productive_Ageing_Centre_Out_Of_Pocket_Healthcare_Report_2012.pdf

[7] Consumers Health Forum. Australian healthcare – out of pocket and out of date? Health Voices, 12, 2013. Accessed at https://www.chf.org.au/pdfs/chf/HealthVoices_APRIL_WEB.pdf

[8] Coote W. General practice reforms, 1989 – 2009. Med J Aust 2009; 191 (2): 58-61. Accessed at https://www.mja.com.au/journal/2009/191/2/general-practice-reforms-1989-2009?0=ip_login_no_cache%3Ddeaad22298926453a2dd85e1f86b6d75

[9] Divisions of General Practice. Department of Health and Ageing. Accessed at http://www.health.gov.au/internet/main/publishing.nsf/content/health-pcd-programs-divisions-index.htm

[10] Fact Sheet 4. Australia's Commonwealth Department of Health and Family Services, Budget Document 1998-99. Accessed at http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pubs-budget98-fact-hfact4.htm

[11] Department of Human Services, Medicare. Practice Incentives Program (PIP). Accessed at http://www.medicareaustralia.gov.au/provider/incentives/pip/index.jsp

train and retain a GP workforce with the needed skills and geographical distribution were introduced.[12]

State and territory governments have also increasingly focussed on funding a range of programs to help integrate community and acute care services. These include programs such as the Hospitals Admission Risk Program (HARP)[13] in Victoria which helps keep chronically ill patients out of hospital, and the Primary Care Partnerships (PCPs)[14] in Victoria and the Connecting Healthcare in Communities (CHIC)[15] initiative in Queensland which aim to reduce fragmentation and improve the patient journey. Other state programs focussed on integrated primary care service delivery models include the NSW HealthOne initiative[16] and South Australia's GP Plus[17] health care strategy. However in recent months there have been disconcerting moves from cash-strapped state governments in Queensland and South Australia to cut spending on community and primary care spending with the expectation that the gap will be filled by federal initiatives.[18]

The Rudd / Gillard Governments have moved to implement reforms in the governance, funding and delivery of health care services in Australia. A number of seminal reports have been commissioned, all of which see a greater focus on primary care and prevention as the key to improved health outcomes and a sustainable health care system into the future. They also have recognised the value in moving Australia's primary health system(s) to one more engaged in delivering primary health care. Regrettably new policy directions and the investment of resources have not always accurately reflected the recommendations of the expert advice that has been provided to the Government.

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[12] Coote W. (2009)

[13] Hospital Admission Risk Program. Department of Health, Victoria. Accessed at http://www.health.vic.gov.au/harp/

[14] Primary Care Partnerships. Department of Health, Victoria. Accessed at http://www.health.vic.gov.au/pcps/

[15] Connecting Healthcare in Communities (CHIC) Initiative. General Practice, Queensland. Accessed at http://www.gpqld.com.au/content/Document/3%20Programs/02_Chronic%20Disease%20Management%20and%20Prevention/FACT%20SHEET%20110609%20CHIC.pdf

[16] HealthOne NSW. NSW Health. Accessed at http://www0.health.nsw.gov.au/initiatives/healthonensw/index.asp

[17] GP Plus Health Care Strategy. Department of Health, South Australia. Accessed at http://www.sahealth.sa.gov.au/wps/wcm/connect/6f9d058043a34090b563fded1a914d95/GP+Plus+Health+Care+Strategy.pdf?MOD=AJPERES&CACHEID=6f9d058043a34090b563fded1a914d95

[18] Sweet M. New SA report shows why governments are failing to control health spending. Croakey, December 10, 2012. Accessed at http://blogs.crikey.com.au/croakey/2012/12/10/new-sa-report-shows-why-governments-are-failing-to-control-health-spending/

Timeline

Date	Initiative
1989	Vocational registration for GPs introduced. Entry in to general practice to require specific training, qualifications and commitment to ongoing education in recognition of general practice being a distinct professional discipline in its 'own right'.
1991-92 Budget	*"Health Care in Australia – Directions for Reform in the 1991-92 Budget"* Budget Paper No 9, Health Minister Brian Howe.
June 1991	National Centre for Epidemiology and Population Health (NCEPH) at the Australian National University conducted a *"General Practice Financing Think Tank".*
Later in 1991	NCEPH published a discussion paper titled *"W(h)ither Australian General Practice?"* which suggested that Departments of General Practice be established.
December 1991	Australian Medical Association (AMA), the Royal Australian College of General Practitioners (RACGPs) and the Commonwealth Government entered into discussions on general practice (around key themes of workforce and standards of care).
March 1992	*"The Future of General Practice"* National Health Strategy, Issues Paper Number 3.
1992-93 Budget	Funding provided for Divisions and Projects Grants Program.
July 1992	*"The Future of General Practice: A Strategy for the Nineties and Beyond"* published under the auspices of the RACGP, AMA and the Department of Health and circulated to all GPs.
1994	General Practice Consultative Group formed.
1994-95 Budget	Reduction in General Practice program outlays in 1994-95 and 1996-97.
1996-97 Budget	After 1 November 1996, doctors required to have full vocational training prior to entering general practice.
1997	Establishment of the Australian Divisions of General Practice (ADGP).
1997	General Practice Strategy Review Group established by Health Minister Michael Wooldridge to review the 1992 strategy.
March 1998	Report of the General Practice Strategy Review Group "*General Practice: Changing the Future Through Partnerships".*
1998	Report of the Ministerial Review of General Practice Training "*General Practice Education: The Way Forward".*
1998	General Practice Partnership Advisory Council (GPPAC) established.
June 1999	Consumers Health Forum Discussion Paper "*Partnerships in General Practice".*

July 1999	The Practice Incentives Program (PIP) and General Practice Immunisation Incentives Scheme replaced the Better Practice Program following a series of recommendations made by the General Practice Strategy Review Group.
August 1999	GP Memorandum of Understanding signed between Federal Government, the Royal Australian College of General Practitioners (RACGP), the Rural Doctors Association of Australia (RDAA) and the Australian Divisions of General Practice (ADGP).
1999-00	Enhanced Primary Care (EPC) MBS items introduced.
2000	Primary Health Care Research, Evaluation and Development (PHCRED) Strategy, Phase 1 introduced.
August 2001	National Health Performance Framework Report to Australian Health Ministers' Conference.
March 2001	Report to DoHA *"Mapping the Role of General Practice in Strengthening the Australian Primary Health Care Sector 1990-2000".*
2003	Productivity Commission *"General Practice Administrative and Compliance Costs*" Research Report.
May 2003	General Practice Red Tape Taskforce established.
2003	Phillips Review of Divisions of General Practice delivered to Government.
February 2004	Health Minister Tony Abbott abolishes GPPAC, saying Government will consult regularly with the General Practice Reference Group.
April 2004	Government response to Phillips Review.
2004-05 Budget	Introduction of MBS items for Practice Nurses working for and on behalf of GPs.
2004-05 Budget	Chronic Disease Management (CDM) items were introduced to replace the existing EPC care planning items.
2004-05 Budget	$302.4 million / 4 years to continue funding the Divisions of General Practice
July 2004	Australian Primary Care Collaboratives (APCC) Program Phase I.
2005	PHCRED Strategy Phase II commenced.
December 2005	Productivity Commission "*Australia's Health Workforce"* Research Report.
2006-07 Budget	Medicare Better Access to Psychiatrists, Psychologists and GPs program introduced.
January 2008	APCC Program Phase II.
April 2008	*"Beyond the Blame Game*" initial report from the National Health and Hospitals Reform Commission (NHHRC).
2008-09 Budget	Funding for 36 GP SuperClinics.
October 2008	Discussion Paper "*Towards a National Primary Health Care Strategy*" released for stakeholder consultation.
January 2009	Review of PHCRED Strategy delivered to Government.

June 2009	*"A Healthier Future for All Australians"* Final Report from NHHRC.
August 2009	*"Building a 21st Century Primary Health Care System"* Draft of Australia's First National Primary Health Care Strategy.
September 2009	Launch of National Preventative Health Strategy, "*Australia: The Healthiest Country by 2020".*
January 2010	Rural Primary Health Services Program (RPHS) established to consolidate a range of existing programs.
May 2010	*"Building a 21st Century Primary Health Care System"*, Australia's First National Primary Health Care Strategy.
May 2010	*"Taking Preventative Action"*, the Government's response to the report of the National Preventative Health Taskforce.
2010-11 Budget	Additional funding for GP SuperClinics.
September 2010	ANAO Audit "*Practice Incentives Program".*
November 2010	Medicare Locals announced.
2010	PHCRED Strategy Phase III.
July 2011	APCC Program Phase III.
July 2012	Australian Medicare Locals Alliance (AMLA) replaces Australian General Practice Network (AGPN).
September 2012	Evaluation of the implementation of the GP Super Clinics Program (2007-08) under taken in 2011.
July 2013	Responsibility for the Australian Primary Care Collaboratives Program will be transferred to Medicare Locals, which will work in conjunction with the Improvement Foundation (IF).

The GP Reform Strategy

The 1991-92 Budget foreshadowed initiatives related to the funding and organisation of general practice, with the stated aims of improving quality of treatment and addressing some of the structural issues which had contributed to the growth in Medicare outlays.

The 1992-93 Federal Budget announced funding of **$65.5 million for 1992-93** and an estimated **$280 million / 4 years**[19] for the GP Reform Strategy.

The key program elements of the GP Reform Strategy were:

The Divisions and Project Grants Program

- This provided infrastructure and project funding for the development of local network or Divisions to enable GPs to become involved in cooperative activities and projects to improve integration with other elements of the health care system and meet identified local health needs.
- In particular, Divisions were to provide support at the local level for other GP Strategy initiatives, such as education (for vocational registration), better practice guidelines, and accreditation

Rural Incentives Program

- There were five main elements to the Program which was designed to address the maldistribution of GPs by providing incentives for the recruitment and relocation of GPs to rural areas.
    - Relocation grants **-** one-off incentive grants of $20,000 to assist GPs in relocation from well serviced areas to identified under-serviced areas.
    - Training grants **-** individually based grants of up to $78,000 for relocating GPs, or those already in rural practice, to upgrade their skills in areas necessary for rural general practice.
    - Remote area grants **-** up to $50,000 per annum for GPs practising in isolated and difficult areas where the economic base of the practice may be marginal and there are increased professional difficulties.
    - CME/Locum grants **-** to support and encourage rural GPs to maintain and increase their skills in areas relevant to rural practice and to obtain leave.
    - Undergraduate grants **-** to encourage Medical Faculties to focus on rural medicine and to enable medical students to gain increased experience and understanding of rural and remote practice and thus encourage students to select a rural career.

Better Practice Program

- This enabled GPs who met certain eligibility criteria to supplement their Medicare fee-for-service income by providing a comprehensive range of services.

Development Program

- Support for the development of standards and accreditation for practices to address quality of care initiatives

[19] The Budget Papers are not clear on what is included in the forward estimates and the numbers have been inferred.

General Practice Evaluation Program

- To evaluate the changes made to general practice, and to determine whether these improved the quality and financial value of care in general practice and the wider health system.
- The Support and Evaluation Resource Units (SERUs) were set up as part of this program with a role to assist the Divisions in project development and evaluation. There were four SERUs in the following areas: Public Health and Health Promotion, Access, Education, and Integration.

The passage of time, the lack of detail in early budgets, and the fact that much information from this era is not available on the internet makes it hard to track the funding of the GP Reform Strategy measures with any accuracy.

It appears that uptake of at least some elements of the GP Reform Strategy was slower than expected and the Government used this as the reason to claw back funds in later years. For example, savings of **$44.6 million** were taken in 1994-95 (against estimated allocation of around $70 million) and **$6.4 million** in 1995-96. On the other hand it was reported that expenditure on the funding of Divisional projects grew rapidly from **$18.9 million** in 1992-93 to **$57.6 million** in 1995-96.

In General Practice in Australia: 1996, a document produced by what was then the Commonwealth Department of Health and Family Services,[20] there is a table (reproduced below) which gives the annual appropriations over the years 1991-92 to 1995-96 for the General Practice Strategy.

General Practice Strategy budget

Program items	**1991-92**	**1992-93**	**1993-94**	**1994-95**	**1995-96**
Support and training and evaluation arrangements	$27.4m	$37.5m	$36.5m	$34.7m	$27.3m
Alternative general practice funding arrangements	-	$73.4m	$127.2m	$129.9m	$211.4m
Total	$27.4m	$110.9m	$163.7m	$164.6m	$238.8m

It is not clear how these numbers relate to those quoted above, or to those in the Budget Papers over those years.

By 2000, the key elements of the GP Strategy were described as:

- Divisions and Project Grants Program;
- Rural Incentives Program;
- Practice Incentive Program (formerly Better Practices Program);
- General Practice Evaluation Program;
- Relative Values Study; and

[20] General Practice in Australia: 1996. Department of Health and Family Services. This document does not appear to be available on the internet.

- Quality and training initiatives with the RACGP.[21]

By 2004-05 the Divisions were receiving a total of **$140.6 million / year** in funding; **$66.5 million** (47.2%) was in core funding from the DoHA 'Outcomes Based Funding' of Divisions, **$74.1 million** was in 'external' funding, including funds for the delivery of specific Commonwealth programs ($38.5 million), State government funds ($12 million), and funding from a number of other public and private sources.[22]

DIVISIONS OF GENERAL PRACTICE

The first Divisions of General Practice were formed in response to the federal government announcement in 1992 that funding for ten demonstration Divisions of General Practice would be available. These first 10 pilot sites were followed by funding in the 1992/93 budget of the Divisions and Project Grants Program (DPGP). By 1993, there were 100 Divisions covering 80% of Australia and there were 116 Divisions by 1995.

The Divisions were reviewed in 1998 and the review recommended more emphasis on the population health roles of GPs, uptake of information technology and GPs' role in data collection.[23] As a result of this review, the Australian Divisions of General Practice (ADGP) was formed as the peak body for the Divisions, which by then numbered 123.

The method by which Divisions were funded changed in 1998, from short-term infrastructure grants that had to be applied for, to an outcomes-based funding contract for 3 years, also referred to as 'block funding'.

In 1997 and 1998 all Divisions moved to Outcomes Based Block Grant Funding (OBF). Under this model Divisions receive funds on the basis of the size and demographics of the geographically defined patient population which their GP members serve, in exchange for which they agree to meet defined health outcomes in a number of performance areas.

By 2003 almost all Divisions (90%) had formal mechanisms to involve consumers, although only 28% of Divisions had consumers on their boards. Sixty-six Divisions (55%) had at least one formal mechanism to involve Aboriginal Community Controlled Health Services (ACCHS), Aboriginal Medical Services (AMS) and other Indigenous health organisations in their programs.

The next phase of the development of Divisions came with the Phillips review of that was commissioned in October 2002 and reported in July 2003. The six person review panel was chaired by the Honourable Ron Phillips, former NSW Minister for Health. This review concluded that there was too much diversity in Division activities and that Divisions needed a set of agreed common objectives. This included changed priorities for Divisions, a new national quality and performance system, and improved governance and accountability arrangements.

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[21] Rogers W and Veale B. Primary Health Care and General Practice: A scoping report. National Information Service of the General Practice Evaluation Program, February 2000. Accessed at http://www.phcris.org.au/phplib/filedownload.php?file=/elib/lib/downloaded_files/publications/pdfs/phcris_pub_1150.pdf

[22] Scott A and Coote B. The Value of the Divisions Network: An Evaluation of the Effect of Divisions of General Practice on Primary Care Performance. Melbourne Institute Report No 8, March 2007. Accessed at http://www.melbourneinstitute.com/downloads/reports/No8.pdf

[23] Wooldridge M. Reception of reports on General Practice Strategy Review Group and review of general practice training. 30 March 1998. Accessed at https://www.health.gov.au/internet/main/publishing.nsf/Content/health-archive-mediarel-1998-mwsp980330.htm

The Government responded to the Phillips review in April 2004 and articulated what it considered to be the future core roles for Divisions, namely that they would:

- Support GPs and practices within a changing primary care environment;
- Improve access:
- Encourage integration and multidisciplinary care;
- Focus on prevention and early interventions;
- Better manage chronic conditions;
- Support quality and evidence-based care: and
- Ensure a growing consumer focus.

The Government also confirmed a further round of funding and agreed changes were implemented in the 2005-2008 contract with the ADGP.

In late 2006 the ADGP changed its name to the Australian General Practice Network (AGPN). At that time the Divisions were involved in delivering and managing an increasing range of Federal government programs. These included:

- Workforce Support for Rural General Practitioners Program (WSRGP)
- Access to Applied Psychological Services (ATAPS)
- Aged Care GP Panels Initiative
- Australian Primary Care Collaboratives Program
- Broadband for Health
- More Allied Health Services program (MAHS)
- Nursing in General Practice program
- National Primary Mental Health Care Network
- Better Outcomes in Mental Health Care program
- National Alcohol and Mental Health Comorbidity project
- MindMatters Plus GP initiative
- Enhanced Divisions Quality use of Medicines Program
- General Practice Immunisation Initiative (GPII)
- Rural Palliative Care Program.

By 30 June 2011 there had been some attrition and amalgamation in Divisions so that there were 109 nationwide plus two combined State Based Organisations/ Divisions (in ACT and Northern Territory). These represented 7035 member practices, 20,438 GP members, and 9,672 non-GP members. The number of general practices has been steadily declining in Australia even as the numbers of GPs have increased, as solo and small practices become increasing rare. However the number of GPs who are Division members has fluctuated over time. There has been a dramatic increase in the number of non-GP members since 2001, when there were 582.[24]

[24] See annual data collected by PHCRIS at http://www.phcris.org.au/

As part of the Rudd / Gillard Government health care reforms, Divisions of General Practice now form the foundation of the new Medicare Locals.[25]

GENERAL PRACTICE RURAL INCENTIVES PROGRAM

The General Practice Rural Incentives Program (GPRIP) was designed to encourage GPs to relocate from adequately serviced areas to rural and remote communities that need GP services, and to support those practitioners already in these communities.

Program elements comprised:

- **Relocation incentives grants** in the order of $20,000 each, to assist GPs to relocate to identified rural areas that need GP services;
- **Training grants** of up to $50,000 each, to provide GPs who are seeking to relocate to a rural practice with the opportunity to acquire the appropriate skills and knowledge required for rural general practice;
- **Remote areas grants** ($50,000 per remote area) to foster the recruitment and retention of GPs in very remote or isolated areas.
- **Undergraduate rural support grants** to provide financial support through universities to encourage medical students' exposure to rural practice and gain skills and experience relevant to practising in rural and remote areas.
- **Rural CME support grants** to assist rural GPs maintain and increase their skills such as counselling, women's health or mental health.

By 1996, in a little over 3 years, the GPRIP had assisted over 180 GPs to relocate to areas in need of GP services, assisted 98 GPs with training, and provided support to many rural practitioners.[26]

It appears there were some changes and additions to these incentives over the years, although an exact chronology cannot be established. The Rural Retention Program was introduced in 1999 at a cost of **$43.1 million / 4 years.** The General Practice Registrars Rural Incentive Payments Scheme (RRIPS) was announced as part of the New General Practitioner Registrars Initiative, which was funded under the 2000–2001 Federal Budget's Rural Health Strategy: More Doctors, Better Services. It provided up to $60,000 per registrar over three years of general practice training.

It is not clear if the extent to which these incentives were effective in addressing rural and remote recruitment and retention was evaluated, and in any case, such measurements would be difficult as there were a raft of other initiatives with a similar aim operating at the same time.

The whole program was revamped as part of the 2009-10 Rural Health Workforce Strategy. The new General Practice Rural Incentives Program commenced on 1 July 2010. It now has three components:

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[25] Australian Medicare Local Alliance Fact Sheet. Accessed at http://www.amlalliance.com.au/__data/assets/pdf_file/0020/45605/fact-sheet_stakeholder.pdf

[26] Holub L and Williams B. The general practice rural incentives program development and implementation: Progress to date. Aust. J. Rural Health (1996) 4, 117-127. Accessed at http://onlinelibrary.wiley.com/doi/10.1111/j.1440-1584.1996.tb00198.x/pdf

- GP Component (previously known as the Rural Retention Program)
- Registrar Component (previously known as the Registrars Rural Incentive Payment Scheme-RRIPS)
- Rural Relocation Incentive Grant (RRIG).

The new General Practice Rural Incentives Program received new funding of **$64.3 million / 4 years** in the 2009-10 Budget, in addition to existing funding of **$189.6 million / 4 years**.

BETTER PRACTICE PROGRAM

Finding information about the operation and funding of the Better Practice Program (BPP) has been extraordinarily difficult.

When first established, the eligibility criteria for the BPP were based mainly on the operational aspects of general practice - provision of after-hours services, patient continuity, minimum average consulting time and rural loading. To receive a BPP grant, a practice needed to satisfy all the eligibility criteria.

Uptake was considerably slower than expected; by April 1996 only 32% of practices were receiving such payments.[27] The Government began to claw back the unspent funding provided from the very moment the program was launched, with little effort to understand why the program was not as successful as hoped. These difficulties were not mentioned in the 1996 report from GPEP, which indicated that by April 1996, 1,804 practices were receiving BPP grants.

In the 1996-97 Budget, the Government reversed its previous decision (not clear exactly when this was made) to make savings of **$400 million / 4 years** in the Better Practice Program. It was stated that this was " in recognition of the pivotal role the Coalition Government sees general practice playing in health care in Australia" . Some modest savings on the forward estimates were made due to a slower than anticipated take up rate of the Better Practice Program.

Following a series of recommendations from the General Practice Strategy Review Group, the Practice Incentives Program (PIP) replaced the Better Practice Program on 1 July 1998. Access to the PIP is available only to practices that are fully accredited or new practices that are registered for accreditation and must be fully accredited within 12–months of joining.

As a result of the PIP there was a significant increase in general practice participation; 4480 practices were participating in PIP by 30 June 1999, compared with 2461 practices participating in the Better Practice Program 12 months previously, an increase of 82%.

There were initially five broad elements to the payments:

- **Information management**
  Practices received incentives for providing data to the Australian Government, using electronic prescribing and for having a capacity to send and receive data electronically.
- **After hours care**
  PIP payments for ensuring patients of the practice have access to 24-hour care or where 24-hour care is provided within the practice.

[27] Wilton P and Smith RD. GP Budget Holding for Australia: Panacea or Poison? Centre for Health Program Evaluation, Working Paper 75, October 1997. Accessed at http://www.buseco.monash.edu.au/centres/che/pubs/wp75.pdf

- **Rural status**
  Rural loadings payable depending on the geographical size of the region of the practice location and the remoteness of the practice.
- **Teaching**
  An incentive payment for general practices that host undergraduate students for teaching placements.
- **Targeted incentives – Quality Prescribing Initiative**
  The Quality Prescribing Initiative to assist practices to remain current with information on the quality use of medicines.

In the 2001–2002 Federal Budget, the Government announced five new incentives relating to diabetes, asthma, cervical screening, practice nurses and mental health. These new incentives were introduced from November 2001. More recently Domestic Violence, GP Aged Care Access, e-Health and Indigenous Health incentives have been introduced, while the incentives relating to mental health management, care planning and information management/information technology are no longer available, or have been replaced.

As well as incentive introductions and cessations, PIP incentives have been subject to a large range of changes since their introduction; for example:

- The requirement for an Asthma 3+ Visit Plan was replaced by 'asthma cycle of care' requirements.
- With the development of the Practice Nurse Incentive Program and Medicare Locals, announced in the 2010–11 Budget, the PIP Practice Nurse Incentive was abolished at the end of 2011.
- Tier 1 of the After-hours Incentive ceased in July 2011, with Tiers 2 and 3 to cease by July 2013.

In 2002, the Productivity Commission undertook a research study on the administrative and compliance costs associated with federal Government programs that impact on general practice. The study, delivered in 2003, found that in 2001–02, participation in PIP accounted for 32.8% ($74.6 million) of general practice costs associated with administering government programs. As a consequence of this, some changes were made to PIP and Enhanced Primary Care programs to address concerns about red tape.

More recently, an ANOA audit of the Practice Incentive Program[28] found that it has a number of features that make its management challenging, in particular, a diverse range of incentives with varying aims and payment arrangements. Accreditation, the entry requirement to receive PIP incentives, was also found to be a significant barrier to certain general practices including Aboriginal Medical Services (AMSs) and smaller practices.

A study from the World Bank in 2011[29] concluded that the evidence that the PIP has had impacts on quality of care and outcomes that justify the costs of the program is limited. It was critical of the fact that the Key Performance Indicators (KPIs) that DoHA relies upon for monitoring, reporting and review at the overall program and individual incentive payment level focus on take-up statistics rather than effectiveness measures. Like the ANAO, this study was concerned about the impact on smaller practices serving disadvantaged populations.

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[28] Australian National Audit Office. Practice Incentive Programs. Audit Report No.5; 2010–11 Accessed at http://www.anao.gov.au/uploads/documents/2010-11_Audit_Report_No5.pdf

[29] Cashin C and Chi Y-Ling. RBF in OECD Countries: Australia – The Practice Incentives Program (PIP). The World Bank Results-Based Financing for Health. 2011. Accessed at http://www.rbfhealth.org/rbfhealth/news/item/525/rbf-oecd-countries-australiapractice-incentives-program-pip

THE GENERAL PRACTICE EVALUATION PROGRAM

The General Practice Evaluation Program (GPEP) was funded from 1992 to December 1999 and over that timeframe **$12.2 million** was provided in funding. There was clearly considerable variation in funding over the years; in 1995-96 GPEP funding was **$4.9 million**.

Some 150 GPEP project reports were completed between1992-1998[30] and a total of 248 projects were funded over the lifetime of the program.[31] An evaluation conducted in 1999 concluded that GPEP was an innovative funding program with the potential to make substantial contributions to population health and to strengthen the links between general practice and population health.[32] Only 33 (13%) of the 248 projects were interventional studies; of these 21 (8% of all projects) were randomised trials.[33]

The program was overseen by a Strategic Evaluation Group which consisted of representatives from the Department of Health and Family Services, the AMA, the RACP, the Australian Association of Academic General Practitioners and the CHF. In 1992 a Methodology Working Group was established to formulate recommendations on a broad strategy for monitoring trends in general practice. One of the Working Groups recommendations was the GPEP should support the publication and wide dissemination of a monitoring report. This was first published in August 1996 as *General Practice in Australia: 1996*. Two further reports followed in 2000 and 2004. [34]

[30] Rogers W, Veale B, and Weller D. Evaluation of the Interface Between General Practice and Population Health in Research funded by the General Practice Evaluation Program**.** Australian Journal of Primary Health 5(3) 51 - 59 ; 1999. Accessed at http://www.publish.csiro.au/paper/PY99033.htm

[31] Raupach JC and Pilotto LS. Randomised trials within the general practice evaluation program. Why so few? Aust. Fam. Physician, 2001; 30(5):504-7. Accessed at http://www.ncbi.nlm.nih.gov/pubmed/11432027

[32] Rogers et al (1999)

[33] Raupach and Pilotto (2001)

[34] None of these reports is available on the internet.

Primary Health Care Research, Evaluation and Development (PHCRED) Strategy

In 2000, the Australian Commonwealth Government introduced the Primary Health Care Research Evaluation and Development (PHCRED) program to improve Australia's capacity to produce high quality primary care research involving all stakeholders. This followed the recommendations of the Review of the General Practice Strategy in 1998. It is not clear when this was announced – it does not appear in the publicly available Budget papers for 1999-00 or 2000-01. The Department website states that (as of 2010) total funding of the order of **$135 million** has been provided for the Strategy.[35]

The major Strategy components have included:

- The Australian Primary Health Care Research Institute (APHCRI) which is tasked with providing leadership in primary health care and embedding a research culture in general practice. APHCRI was established at the Australian National University in 2003.
- The Research Capacity Building Initiative (RCBI), established in 2000, which funds university Departments of General Practice and Rural Health to provide training and support in primary health care research, particularly among GPs. This program ceased in 2011.
- Primary health care research grants and awards administered through the NHMRC. These programs provide research training and experience for early, mid and senior level researchers and include the funding of both investigator and priority driven research relevant to both policy and practice.
- The Primary Health Care Research and Information Service (PHCRIS) established in the Department of General Practice at Flinders University to provide support in the area of dissemination and knowledge-exchange. PHCRIS was first established First established in 1995 as the National Information Service (NIS) and changed its name in 2001.

PHCRED PHASE 1

Phase 1 focused on the building the capacity for primary health care research through development of researchers and research infrastructure and on promoting evidence-based practice in primary care. The initial funding provided for PHCRED was **$49.85 million / 4 years**, allocated as follows:

- Research priority setting process - **$0.15 million** in 2000-01.
- Research Capacity Building Initiative (RCBI) - **$19.2 million** over the years 2000-04.
- Researcher development program - **$1.5 million** in 2004.
- Australian Primary Health Care Research Institute (APHCRI) - **$15.8 million** in 2003-04.

[35] Department of Health and Ageing. Primary Health Care Research , Evaluation and Development (PHCRED) Strategy Phase three: 2010-2014. Accessed at https://www.health.gov.au/internet/main/publishing.nsf/Content/4D9AB3396D926315CA2577CB0005D65D/$File/PHCRED%20Strategy%20Oct%202010%20PRINT.pdf

- Grants, scholarships and fellowships - **$13.2 million** over the years 2002-03, 2003-04.

PHCRED PHASE 2

The 2005 independent evaluation of the PHCRED Strategy[36] found that it had helped to build Australian's capacity in the area of primary health care research, but that the program had not yet reached maturity and so should be continued. A major evaluation recommendation was that a revised set of goals, objectives and performance indicators should be developed for the Strategy in order to clarify the directions of the program and to ensure that achievements could be more easily measured in future.

In response to the recommendations of the evaluation, the goals of phase two were to achieve:

- An expanded pool of primary health care researchers;
- More research relevant to practice and policy; and
- In collaboration with other relevant organisations, well informed primary health care practice and policy.[37]

In July 2005, the Minister for Health and Ageing, Tony Abbott, endorsed the continuation of the Strategy and allocated **$61 million** over the next four years (2006-09). This funding is not mentioned in the Budget Papers and the PHCRED Strategy is not discussed in the Portfolio Budget Statements for 2005-06 and 2006-07 and could not be found in media releases. Presumably the funding had been included in the forward estimates and so was not a budget measure which went to Cabinet.

In 2008 a second independent evaluation of the PHCRED Strategy took place, and the final report was provided to DoHA in January 2009.[38] The DoHA website states that the findings of the final evaluation report were largely positive, and highlighted the ongoing need for Government investment in building primary health care research capacity. The evaluation found that the Strategy has been effective in expanding the pool of skilled primary health care researchers in Australia and increasing the competitiveness of the primary health care research sector in accessing research grant funds. Criticisms included the lack of evident linkages between the many different research, health service delivery programs and policy development.

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[36] Summary Report of the Evaluation of the Primary Health Care Research, Evaluation and Development Strategy, April 2005. Accessed at http://www.phcris.org.au/phcred/reports/PHCRED%20Evaluation%20-%20Summary%20Report.pdf

[37] Department of Health and Ageing. Primary health care research, evaluation and development strategy Phase 2 (2006-2009) Strategic plan. December 2005. Accessed at http://www.nswphc.unsw.edu.au/pdf/PHCRED_Strategic_Plan_06_09_Bro.pdf

[38] This evaluation does not appear to be publicly available.

PHCRED PHASE 3

In 2010, and after rigorous evaluation, the PHCRED Strategy was realigned for Phase 3 (2010-2014).[39] Phase 3 is described as focused on the priority areas of the National Primary Health Care Strategy:

- Improving access and reducing inequity
- Better management of chronic conditions
- Increasing the focus on prevention and
- Improving quality, safety, performance and accountability.

This timing also aligns with that around the introduction of Medicare Locals.

Phase three of the PHCRED Strategy includes competitive funding for new Centres of Research Excellence. To date eight such centres have been established.

Total funding levels for Phase 3 are not publicly available.

[39] Primary Health Care Research & Information Service. PHCRED Strategy: Phase three. 2010-2014. Accessed at http://www.phcris.org.au/phcred/phase_three.php

Australian Primary Care Collaboratives Program

The Australian Primary Care Collaboratives (APCC) Program began as a **$14.6 million / 3 years** initiative funded from the Focus on Prevention - Primary Care Providers Working initiative announced in the 2003 -04 Budget.

The APCC Program aims to support general practices to improve clinical outcomes, help maintain good health for those with chronic and complex conditions and to promote a culture of quality improvement in primary health care. Topics for the Collaboratives Program have included diabetes, coronary heart disease, chronic obstructive pulmonary disease, chronic disease prevention and self-management and access to general practice services.[40]

Phase 1 of the Collaboratives Program was implemented from July 2004 to December 2007 and was managed by Flinders University. The Program funded about 500 practices in 42 Divisions of General Practice to participate in the Program.

Phase 2 commenced in January 2008 and was managed by the Improvement Foundation IF). Over 600 practices participated in Phase 2 Collaboratives waves. In the 2007-08 Budget there was additional funding of **$12.7 million / 4 years** on top of the **$22.0 million / 4 years** already included in the forward estimates to continue the program. Note however that DoHA advice is that Phase 2 funding (2007-08 to 2010-11) was around **$26 million**.

Phase 3, which ran from July 2011 to June 2012, was also managed by IF. Funding provided for Phase 3 was **$4.4 million**.

There was an announcement that in 2013 responsibility for the APCC Program would shift to the Australian Medicare Locals Alliance, which means that further funding will be forthcoming.[41] IF will continue to be involved in the management of the APCC program; their website states that they will manage Phase 4 of the program which will continue through 2015 (funding levels not provided). Phase 4 will be implemented through three quality improvement waves to Medicare Locals and through IF's direct engagement with over 300 general practices, which will be supported by their Medicare Local.[42]

A recent report found that 1185 health services (covering 83 % of DGPs) participated in 13 waves between 2005 and 2011.[43] Program results for Phase 2 do not seem particularly striking in terms of getting practices to better manage their patients with chronic conditions.[44]

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[40] Department of Health and Ageing. Australian Primary Care Collaboratives Program. Accessed at http://www.health.gov.au/internet/main/publishing.nsf/content/health-pcd-programs-apccp-index.htm

[41] Kaye B. Medicare Locals to run collaboratives program. Medical Observer, 13 November 2012. Accessed at http://www.medicalobserver.com.au/news/medicare-locals-to-run-collaboratives-program

[42] Improvement Foundation. The Australian Primary Care Collaboratives Program continues to 2015. Accessed at http://createsend.com/t/r-3749774720FC7B02

[43] Knight AW, Caesar C, Ford D, et al. Improving primary care in Australia through the Australian Primary Care Collaboratives Program: a quality improvement report. BMJ Quality & Safety Online First, 18 July 2012. Accessed at http://qualitysafety.bmj.com/content/early/2012/07/17/bmjqs-2011-000165.full.pdf

[44] Improvement Foundation. Australian Primary Care Collaboratives Program Results. Accessed at http://www.apcc.org.au/about_the_APCC/program_results/

After hours care

Provision of after hours (AH) services in general practice is an important element in the delivery of primary care. After Hours Care is one of the significant quality indicators used in General Practice Accreditation. Over the years a succession of Australian governments has attempted to improve access to AH primary care services through a variety of mechanisms. These have included:

- MBS items for AH services provided in a consulting room, residential aged care facility, institution or home
- PIP incentives
- Round the Clock Medicare (RTCM)
- After Hours Primary Medical Care Program
- The National Health Call Centre Network.

In 1998 four trial sites (Hobart, Central Grampians, Maitland, Central Sydney/Broken Hill) were selected to test different After Hours Primary Medical Care service delivery and funding arrangements. The evaluation of these models was reported in 2002, but this report was rescinded in 2006.[45]

In the 2001-02 Federal Budget, the Australian Government announced the introduction of the After Hours Primary Medical Care (AHPMC) Program, with a funding commitment of **$43.4 million / 4 years**. Over those four years, 117 projects were funded across Australia at a cost of **$41.6 million**, including GP Assist in Tasmania and GP Access After Hours in the Hunter urban region of NSW. An evaluation of this program in 2005 found that "The extent to which this represents the provision of services to address past unmet needs is difficult to assess because of lack of data."[46]

By 2005-06, 61% of DGPs reported activities to improve after hours services, up from 51% of Divisions in 2004-05. PIP data from that time indicated that around 97% of all PIP registered practices were claiming incentives for ensuring patient access to 24 hour care, while around two-thirds (65%) of practices had their own GP/s available for at least 15 hours a week after hours. Just over one quarter (26%) of practices were accessing payments under the highest tier of PIP, which required practices to provide cover 24 hours a day, seven days a week.[47]

It was during this time frame that the Howard Government introduced Round the Clock Medicare (RTCM). For the period 2004-05 to 2008-09, RTCM: Investing in After Hours General Practice Services had a total budget of **$62.5 million**. The 2004 Coalition election policy identified five sites to receive 2004-05 start–up grants. To October 2007, DoHA had executed 144 funding agreements. In the 2007-08 Budget – the first Budget of the Rudd Government, **$32.6 million** was taken in savings from After Hours Primary Care and RTCM.

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[45] Department of Health and Ageing. After Hours Primary Medical Care Trials. National Evaluation Report. 2002 (archived). Accessed at http://www.health.gov.au/internet/main/publishing.nsf/Content/4723E70DD490B9FECA256F19001D101C/$File/ahpmctne_2.pdf

[46] Australian Healthcare Associates. Evaluation of the After Hours Primary Medical Care Trial. Final Report. June 2005. Accessed at http://www.health.gov.au/internet/main/publishing.nsf/Content/61025BB057A2FA7ACA25720B00801141/$File/AHPMCProgramEvalFinalReport.pdf

[47] Medicare Australia statistics reported in Aboriginal and Torres Strait Islander Health Performance Framework. Accessed at http://www.health.gov.au/internet/main/publishing.nsf/Content/9A1A6B79C4BF3659CA25759A00168244/$File/3.14%20-%20Access%20to%20after%20hours%20primary%20health%20care.pdf

An ANAO report on RCTM released in 2007 found that DoHA's administration of RTCM could be strengthened by improvements at the operational level and by evaluating the extent to which the program is meeting its objectives. The report said this: "For DoHA to be in a position to determine whether the program is meeting its aims, it also needs to develop and make use of a more effective performance management framework. The RTCM performance indicator is a single broad measure of performance that assesses the number of services funded. It does not capture other key elements of the objectives of the program, particularly the provision of services to areas of high demand. Measuring and reporting the number of services funded does not inform DoHA, Parliament, or the Australian public about where, when or how these services are being provided, the quality of the service, the patients being treated, or the workforce providing the services. Nor does the indicator assist DoHA's program managers to administer the program."[48]

In February 2006 COAG agreed to establish the National Health Call Centre Network (the NHCCN) which commenced its roll-out in July 2007 under a single national name, *HealthDirect Australia*. The NHCCN was scheduled to begin operations nationally from 1 July 2008. During the second quarter of 2012, *HealthDirect* took 210,190 calls.[49]

Most recently Medicare Locals have been tasked with a range of AH primary care roles and responsibilities so that all Australians, regardless of where they live, can access effective AH primary care services.

In 2011, Medicare Locals undertook a needs assessment to identify gaps in access to AH care within their region and in 2012 the Medicare Locals developed and implemented a plan to address the priority gaps identified during the needs assessment. These plans built on existing face-to-face AH arrangements and make best use of the available local health infrastructure. It is not clear if this exercise was undertaken by all Medicare Locals, given that they are in various stages of establishment.

From 1 July 2013, Medicare Locals will administer additional after hours funding to further improve access to AH care, ensuring that communities across their region have suitable after hours services in place.

[48] Australian National Audit Office. Administering Round the Clock Medicare Grants. Audit Report No 25, 2007-2008. Accessed at http://www.anao.gov.au/Publications/Audit-Reports/2007-2008/Administering-Round-the-Clock-Medicare-Grants

[49] HealthDirect Australia. Accessed at http://www.healthdirect.org.au/

Primary care for Indigenous Australians

The Australian health care system is built on a base of primary care, which works well for most Australians. But there is strong evidence that the difficulty Indigenous Australians face in accessing culturally sensitive primary care has contributed to Indigenous disadvantage and poorer health outcomes. It was problems with access to primary care that provided the momentum for the development of the Aboriginal Community Controlled Health Services (ACCHS), beginning in 1971. Funding responsibility for Indigenous primary care was transferred from the Aboriginal and Torres Strait Islander Commission (ATSIC) to the Commonwealth Health Department in 1995. DoHA, then the Department of Human Services and Health, established the Office for Aboriginal and Torres Strait Islander Health Services (OASTIHS) at that time to specifically focus on Indigenous health. Later OATSIHS changed its name to become the office of Aboriginal and Torres Strait Islander Health (OATSIH).

Primary care is a central element to the efforts of 'closing the gap'. OATSIH funding, which has been steadily increasing since 1995-96, is directly mainly to:

- Funding health service providers for the delivery of primary care services to their local communities;
- Funding new programs and services through new budget measures (some of which are directed at facilitating access to primary care services); and
- Increasing the uptake of the MBS and PBS.

The Primary Health Care base funding program provides ongoing funding to support Indigenous Health organisations to provide primary health care services; undertake testing and treatment for communicable diseases; undertake capital projects that support delivery for Indigenous health organisations; and improve the quality of and access to services. In 2010-11, primary health care services provided 2.5 million episodes of care to about 428,000 Indigenous people.[50] Aboriginal Community Controlled Organisations funded by OATSIH are included in a direction issues under Section 19.2 of the *Health Insurance Act 1973* that allows GPs who work there to claim MBS funding.

An ANAO evaluation in 2009[51] of the Primary Health Care Fund (PHCF) administered by DoHA through OATSIH, and covering the period between 2003–04 to 2007–08, found that the methods by which OATSIH determines health priorities and funding decisions are heavily weighted towards process-oriented objectives, and there was the suggestion, through proxy measures, that OATSIH is enabling improved access to primary health care services by Indigenous Australians. However the review also found that lack of data made it difficult to provide a definitive assessment of improvements in access.

OATSIH is undertaking a Primary Health Care Funding Review to examine a number of new models for the distribution of funds for primary health care services.[52]

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[50] Australian Institute of Health and Welfare. Aboriginal and Torres Strait Islander health services, 2010.-11. OATSIH services reporting – key results. 2012. Accessed at http://www.aihw.gov.au/publication-detail/?id=10737423052

[51] Department of Finance and Deregulation, Office of Evaluation and Audit (Indigenous Programs). Evaluation of Primary Health Care Funding to Aboriginal and Torres Strait Islander Health Services. August 2009. Accessed at http://www.anao.gov.au/~/media/Uploads/Documents/evaluation_of_primary_health_care_funding_to_aboriginal_and_torres_strait_islander_health_services.pdf

[52] Department of Health and Ageing. Office of Aboriginal and Torres Strait Islander Health. Accessed at http://www.health.gov.au/internet/main/publishing.nsf/Content/oatsih-primary-funding-review

PRIMARY HEALTH CARE ACCESS PROGRAM

In the mid-1990s the Council of Australian Governments implemented Aboriginal Co-ordinated Care Trials in four sites to test the impact of pooling Commonwealth and State/Territory funding on the development of primary care services, including fund-holding for secondary and tertiary care services. In his forward to the evaluation report, issued in 2001, then Health Minister Michael Wooldridge was enthusiastic about the success of these trials.[53]

Building on these trials, the Primary Health Care Access Program (PHCAP) was announced in 1999–2000 and was implemented in a partnership between the federal, state and territory governments, the ACCHS sector and ATSIC.

PHCAP had three objectives:

- To increase the availability of primary health care services in areas where they are inadequate
- To reform the local health system so that it meets the needs of Indigenous Australians
- To empower people to take better care of their own health.

A total of **$78.8 million / 4 years** was allocated in the 1999–2000 Budget, and a further **$19.7 million / year** to be allocated from 2003–04 was committed in the 2001–02 Budget, taking the total recurrent base to **$54.7 million / year**. One study states that in the first three rounds of budget allocations, a total of **$64.8 million** was provided to the PHCAP program.[54]

A 2008 report described the PHCAP process as “slow and complex” and found that “only a few urban sites have seen any benefits from the program”.[55]

The Human Rights and Equal Opportunity Commission (HREOC) note in their *Social Justice Report 2005*[56] that PHCAP has never received adequate funding. Furthermore, they were critical that "not all zones have been rolled out and there are no plans to roll out further PHCAP zones in the Top End. Similarly, the Department of Health and Ageing has not provided estimates of the funding required to implement PHCAP up to the benchmark funding level in Aboriginal and Torres Strait Islander communities over the next 5 years."

A document on the FaHCSIA website states: “Since 1996, Indigenous health funding has increased by over $260 million - a real increase of more than 170%. This increased funding has been delivered mostly through the Primary Health Care Access Program (PHCAP). Since 2003-04 this program has funded over 200 additional health professionals (General Practitioners, nurses and Aboriginal Health Workers) and 220 additional other service and

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[53] Department of Health and Aged Care. The Aboriginal and Torres Strait Islander Coordinated Care Trials. National Evaluation Summary. 2001. Accessed at http://www.health.gov.au/internet/main/publishing.nsf/Content/health-oatsih-pubs-coord.htm/$FILE/coord.pdf

[54] Rosewarne C and Boffa J. An analysis of the Primary Health Care Access Program in the Northern Territory: A major Aboriginal health policy reform. Aust. Journal of Primary Health 2004: 10(3): 89 – 100. Accessed at http://www.publish.csiro.au/?act=view_file&file_id=PY04052.pdf

[55] Scrimgeour M and Scrimgeour D. Health Care Access for Aboriginal and Torres Strait Islander People Living in Urban Areas, and Related Research Issues: A Review of the Literature. Cooperative Research Centre for Aboriginal Health. Discussion Paper Series No 5, 2008. Accessed at http://www.lowitja.org.au/sites/default/files/docs/DP5_final-pdf.pdf

[56] Australian Human Rights Commission. Social Justice Report 2005. Accessed at http://humanrights.gov.au/social_justice/sj_report/sjreport05/index.html

support positions (including other health workers, patient transport drivers, child/youth workers, etc.), as well as the associated capital infrastructure."[57]

At some point around 2007, PHCAP morphed into the Family-centred Primary Health Care Program. This was described as providing better access to primary care for Indigenous families and communities in rural and remote areas through the provision of **$38.2 million / 4 years** to provide:

- Up to 45 additional health professionals to enhance existing Indigenous primary health care service delivery;
- New and upgraded buildings and clinics in six rural and remote areas across Australia;
- Business management training for 100 Indigenous health service managers.[58]

ABORIGINAL AND TORRES STRAIT ISLANDER CHRONIC DISEASE FUND

The Aboriginal and Torres Strait Islander Chronic Disease Fund (ATSICDF) was established in the 2011 Budget and came into operation on 1 July 2011. **$833.27 million / 4 years** has been provided for the Fund's operation (from 1 July 2011 to 30 June 2015). It supports activities to improve the prevention, detection, and management of chronic disease in Indigenous people to contribute to the Government's target of closing the gap in life expectancy. The Fund consolidates 16 existing programs into a single flexible fund. The three priority areas targeted are:

- Tackling chronic disease risk factors
- Primary health care services that can deliver
- Fixing the gaps and improving the patient journey.

The majority of the funding that makes up the ATSICDF comes from the Indigenous Chronic Disease Package (ICDP) which provided **$805.5 million / 4 years** (2009-10 to 2012-13) as the Commonwealth's contribution to the National Partnership Agreement (NPA) on Closing the Gap in Indigenous Health. Note that only some of the initiatives in this Package addressed primary care.

On 18 April 2013 the Commonwealth announced continued funding of **$777 million / 3 years** for the NPA, which was due to expire on 30 June.[59] This was described as "an increase over previous per annum expenditure." That is true, but this statement ignores the fact that funding over the past four years was ramped up and in 2012-13 was **$317.9 million**. So the reality is that funds for each of the next three years will be less than in 2012-13.

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[57] Department of Families, Housing, Community Services and Indigenous Affairs. Family Centred Primary Health Care, 2007. Accessed at http://www.fahcsia.gov.au/about-fahcsia/publications-articles/corporate-publications/budget-and-additional-estimates-statements/indigenous-affairs-budget-2007-08/family-centred-primary-health-care

[58] FaHCSIA, 2007.

[59] Prime Minister of Australia. Media release, 13 April 2013. Accessed at http://www.pm.gov.au/press-office/777-million-renewed-effort-close-gap-indigenous-health

Health Care reforms from 2007

The Rudd Labor government came to power in November 2007 promising to enact "the single biggest health reform in a quarter of a century". The Government established the National Health and Hospitals Reform Commission (NHHRC) which undertook an overall review of the health system and produced a detailed final report in 2009 making 123 recommendations for health system reform.

The NHHRC undertook the following tasks and reports:

- Development of a set of principles to shape the total health and aged care system - public and private, hospital and community based services.[60]
- Advice on the framework for the next Australian Health Care Agreements (AHCAs), including robust performance benchmarks in areas such as elective surgery, aged and transition care, and quality of health care. This was the subject of the Commission's first report - *Beyond the Blame Game: Accountability and performance benchmarks for the next Australian Health Care Agreements*.[61]
- *A Healthier Future for all Australians* - Interim Report delivered December 2008,[62]
- *A Healthier Future for all Australians* - Final Report delivered June 2009.[63]

There were several other key reports.

In June 2008 the Minister for Health and Ageing, Nicola Roxon, announced that the Government would develop a National Primary Health Care Strategy. An External Reference Group of health experts was established to support the Government in developing the Strategy. The following documents were released:

Towards a National Primary Health Care Strategy: A Discussion Paper from the Australian Government was produced in August 2009.[64]

- The final report, *Building a 21st Century Primary Health Care System: Australia's First National Primary Health Care Strategy* was released in June 2010.[65]

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[60] National Health and Hospitals Reform Commission. Principles for Australia's Health System. Acccessed at http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/principles-lp

[61] National Health and Hospitals Reform Commission. Beyond the Blame Game. Accountability and performance bencmarks for the next Australian Health Care Agreements. 2008. Accessed at http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/504AD1E61C23F15ECA2574430000E2B4/$File/BeyondTheBlameGame.pdf

[62] National Health and Hospitals Reform Commission. A Healthier Future for all Australians - Interim Report. 2008. Accessed at http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/interim-report-december-2008

[63] National Health and Hospitals Reform Commission. A Healthier Future For All Australians – Final Report. 2009. Accessed at http://www.health.gov.au/internet/nhhrc/publishing.nsf/content/nhhrc-reporthttp://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/nhhrc-report

[64] Department of Health and Ageing,. Towards a National Primary Health Care Strategy. A discussion paper form the Australian Government. 2008. Accessed at http://www.health.gov.au/internet/main/publishing.nsf/content/d66fee14f736a789ca2574e3001783c0/$file/discussionpaper.pdf

[65] Department of Health and Ageing. Building a 21st Century Primary Health Care System. Australia's First National Primary Health Care Strategy. 2010. Accessed at http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/3EDF5889BEC00D98CA2579540005F0A4/$File/6552%20NPHC%201205.pdf

- It was accompanied by *Primary Health Care Reform in Australia - Report to Support Australia's First National Primary Health Care Strategy*.[66]

- A National Preventative Health Task Force was established in April 2008. It produced:

- A discussion paper *Australia: the healthiest country by 2020* in October 2008, [67]
- The *National Preventative Health Strategy* which was launched on 1 September 2009.[68]

The Strategy comprises three parts: an overview; a roadmap for action; and technical papers focused on the three key areas - obesity, tobacco and alcohol. It is directed at primary prevention and provides a blueprint for tackling the burden of chronic disease currently caused by obesity, tobacco, and excessive consumption of alcohol.

Overall the Government's reform package, which has been considerably modified since it was first introduced, addresses structural changes, funding and national standards. Regrettably, a number of key recommendations from the reports have not been picked up or responded to.

GENERAL PRACTICE AND PRIMARY HEALTH REFORMS

With respect to GP services and primary care, the federal Government has stated that it will work with the States and Territories on system-wide policy and state-wide planning for general practice and primary health care services, including at the local level through Medicare Locals, to improve the delivery of health care in local communities. However an initial commitment to assume control and funding of all primary care services has not eventuated due to opposition from several states.

The Government recognises that a strong health system requires more focus and investment in primary health care and preventive health services and the Minister for Health is consistently quoted as wanting to "shift the centre of gravity of the health system from hospitals towards primary health care".[69]

GP SuperClinics

GP SuperClinics are seen by the Government as a key element in the strategy to build a stronger primary health care system with a greater focus on management of chronic

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[66] Department of Health and Ageing. Primary Health Care Reform in Australia. Report to Support Australia's First National Primary Health Care Strategy. 2009. Accessed at http://www.health.gov.au/internet/yourhealth/publishing.nsf/Content/nphc-draftreportsupp-toc/$FILE/NPHC-supp.pdf

[67] National Preventative Health Taskforce. Australia: The Healthiest Country by 2020. A discussion paper. 2008. Accessed at http://www.preventativehealth.org.au/internet/preventativehealth/publishing.nsf/Content/A06C2FCF439ECDA1CA2574DD0081E40C/$File/discussion-28oct.pdf

[68] National Preventative Health Taskforce. Australia: The Healthiest Country by 2020. National Preventative Health Strategy and accompanying roadmap and technical papers. 2009. Accessed at .http://www.preventativehealth.org.au/internet/preventativehealth/publishing.nsf/Content/national-preventative-health-strategy-1lp

[69] Plibersek T. Speech to National Primary Healthcare Conference, 8 November 2012. Accessed at http://www.health.gov.au/internet/ministers/publishing.nsf/Content/BFF4ABC14405FD79CA257AB0001B110A/$File/TP081112.pdf

disease, health promotion and illness prevention and better coordination between privately provided GP services, community health and other state or territory Government services. It is intended that each GP SuperClinic should bring together GPs, practice nurses, allied health professionals, visiting medical specialists and other health care providers to deliver primary health care services aimed at addressing the health care needs and priorities of the local communities.

The federal Government has committed around **$650 million** to:

- build more than 60 GP SuperClinics around Australia
- for Primary Care Infrastructure Grants to upgrade and extend around 425 existing general practices, primary care and community health services, and Aboriginal Medical Services.

In 2007, as part of the Rudd Government's election commitments, **$275 million / 5 years** was allocated for the construction or refurbishment of existing infrastructure for the first 31 GP SuperClinics. In August 2009 a further five SuperClinics were announced within this funding allocation.

In the 2010-11 Budget the Government announced it would invest a further **$355 million** to support the construction of around 23 new GP SuperClinics.

When the roll-out of GP SuperClinics was evaluated in 2011, only 29 of the 36 clinics announced in 2007-08 had been delivered and only seven of these had been running for longer than six months.[70] Otherwise the evaluation, not released until September 2012, is very uninformative. The limited period covered by the evaluation, and the small number of operational GP SuperClinics involved, meant that there could not be a comprehensive evaluation of the benefits and cost effectiveness of the program. Most of the 32 recommendations focused on administrative processes, rather than the delivery of health care or improvements in health outcomes for patients.

The Australian National Audit Office (ANAO) is currently conducting an audit of the GP SuperClinics Program.

Medicare Locals

A key component of the Government's National Health Reforms is the establishment of a new nation-wide network of primary health organisations known as Medicare Locals (MLs). A key aim of Medicare Locals is to make it easier for patients to use and move through the primary care system. They will be responsible for a range of functions aimed at:

- Making it easier for patients to navigate the local health care system;
- Providing more integrated care;
- Ensuring more responsive local GP and primary care services that meet the needs and priorities of patients and communities; and
- Making primary care work as an effective system as part of the overall health system.[71]

[70] Department of Health and Ageing. Evaluation of the Implementation of the GP Super Clinics Program 2007-08. Questions and Answers. Accessed at http://www.health.gov.au/internet/main/publishing.nsf/Content/gpsc-evaluation-qanda

[71] Department of Health and Ageing. Establishment of Medicare Locals and better access to after hours care. Accessed at http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/factsheet-gp-01

The possibility exists that MLs, by addressing local needs and integrating health care with public health and prevention, can tackle the social determinants of health and thus become the deliverers of primary health care.

The Government has committed to invest **$493 million / 4 years** from 2010-11 to establish and operate a nation-wide network of MLs.

The Divisions of General Practice will form the foundation of the new MLs through a process of transition. The implementation of MLs will be done in three stages:

- A first tranche of 19 MLs began operating in July 2011
- The second tranche of 18 MLs commenced in January 2012
- The remainder of the MLs commenced in July 2012.

From 1 July 2012, the ongoing work of the network of MLs is managed by the Australian Medicare Locals Alliance, which has evolved from the AGPN.

The 2012-13 Budget provided **$50 million / 2 years** to Medicare Locals to assist GPs and other health care providers to adopt and use the Government's new Personally Controlled Electronic Health Record (PCEHR) system. The Federal Government significantly boosted the role of Medicare Locals when it announced in November 2012 that delivery for the Australian Primary Care Collaboratives Program will be shifted to Medicare Locals. At the same time a new Disease Prevention and Health Promotion in Medicare Locals Program with funding of **$5 million** was also announced.

PRIMARY HEALTH CARE STRATEGY

Building a 21st Century Primary Health Care System: Australia's First National Primary Health Care Strategy was released in June 2010.[72] It represents the first comprehensive national policy statement for primary health care in Australia. The Strategy identifies five key building blocks which are considered essential system-wide underpinnings for a responsive and integrated primary health care system for the 21st century:

- Regional integration
- Information and technology, including eHealth
- Skilled workforce
- Infrastructure
- Financing and system performance

The Strategy has four priority directions for change:

- Improving access and reducing inequity
- Better management of chronic conditions
- Increasing the focus on prevention
- Improving quality, safety, performance and accountability

[72] Building a 21st Century Primary Health Care System. Australia's First National Primary Health Care Strategy. 2010. Accessed at http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/3EDF5889BEC00D98CA2579540005F0A4/$File/6552%20NPHC%201205.pdf

Medicare Locals now become the main delivery mechanism of the National Primary Health Care Strategy. To have a significant impact on achieving any of the four priority areas, MLs will need to facilitate improvements at the service delivery level through multidisciplinary teams of providers supporting patients, carers and families to prevent and manage chronic conditions. Greater community involvement and strong partnerships with local councils, the Aboriginal community, NGOs, housing and education will be essential if the social determinants of health are to be addressed effectively.

Dr Tony Hobbs, who chaired the External Reference Group that developed the Strategy said this; "Medicare Locals will not deliver the desired improvements in the above four key priority areas unless they have the capacity for population level planning and service delivery, flexibility in funding arrangements, strong partnerships with non-health sector groups and their local communities, and transparency in reporting their progress to their local community partners & their funders."[73]

A consultation draft of a National Primary Health Care Strategic Framework was recently released.

[73]Hobbs T. in Sweet M. A mega-wrap of analysis of the Medicare Locals plans. Croakey blog, 28 February 2011. Accessed at http://blogs.crikey.com.au/croakey/2011/02/28/a-mega-wrap-of-analysis-of-the-medicare-locals-plans/?wpmp_switcher=mobile

Budget Analyses

The tables below attempt to track spending on federal GP / primary care initiatives from 1992 through to 2012. This information has been sourced from the Budget Papers.

1992-93 BUDGET

	1992.93 $m	**1993-94 $m**	**1994-95 $m**	**1995-96 $m**	**Total $m**
Local Networks or Divisions of General Practice	17	[17]	[17]	[17]	[68]
Practice accreditation	3				Up to $7.21 / 3 years
Vocational Registration	3	3*	3*	3*	12*
Practice Enhancement Grants	8	[8]	[8]	[8]	[32]
Trial of practice budgets	12	[12]	[12]	[12]	[48]
Continuation of Practice Grants Program	11.5	[11.5]	[11.5]	[11.5]	[46.5]
Rural Incentives Program	8	15.19	15.19*	15.19*	53.6*
Evaluation	3	3*	3*	3*	12*

The 1992-93 Budget Papers provided **$65.5 million** in 1992-93 for new GP initiatives, as foreshadowed in the 1991-02 Budget.

It is not clear exactly how these initiatives are funded over the forward estimates, but it appears that the cost of the total package was of the order of **$280 million / 4 years**.

However a careful reading of the Budget papers reveals that the previously announced funding for this initiative (in 1991) has been cut by **$57.2 million** and redistributed over the forward estimates.

1994-95 BUDGET

	1994-95 $m	**1995-96 $m**	**1996-97 $m**	**1997-98 $m**	**Total $m**
Reduction in General Practice Program outlays	-44.6	-6.4	-	-	-51.0

In the 1994-95 Budget the Government 'reduced outlays' for the General Practice Program with savings of **$51 million / 2 years**.

1996-97 BUDGET

	1996-97 $m	1997-98 $m	1998-99 $m	1999-00 $m	Total $m
Reduction in Better Practice Program funds	-28.48	-26.86	-1.78	-	-57.12
Limited Medicare access for new GPs without VR	-23.86	-100.12	-171.74	-241.67	-537.39

In this Budget the Government reversed its previous decision to make savings of **$400 million / 4 years** in the Better Practice Program. (This seems like a huge sum to cut from the program which was not planned to cost that much in the first place. It has not been possible to determine how and where these proposed cuts would have been made.) The Budget Papers stated that this was "in recognition of the pivotal role the Coalition Government sees general practice playing in health care in Australia." It did take what was described as "modest savings" (**$57.12 million**) due to a slower than anticipated take up rate of the Better Practice Program.

Considerable savings of **$537.39 million / 4 years** were achieved by requiring vocational registration for all GPs in order for them to qualify for full MBS rebates. (Given the generous grandfathering provisions this seems like a large savings.)

1997-98 BUDGET

	1997-98 $m	1998-99 $m	1999-00 $m	2000-01 $m	Total $m
Combine GP evaluation programs and adjust to reflect current spending	-2.0	-2.0	-2.1	-2.1	-8.2
Refocus GP Strategy on outcomes	-34.4	-28.0	-37.9	-39.9	-140.2

Savings of $8.2 million / 4 years were taken by amalgamating the Evaluation of General Practice Reforms and the General Practice Evaluation Programmes, and adjusting funds to reflect current spending levels. These programs were described as providing "a better information base to guide decisions about the funding and delivery of services under Medicare as well as the General Practice Strategy."

In this Budget the Government announced its intention to negotiate with the medical profession a change in the focus of the Better Practice Program (BPP) which was expected to lead to savings from reduced Medicare benefit payments, thus indicating a desire to shift the emphasis, at least marginally, from fee-for-service to bundled payments.

As part of the review of the General Practice Strategy and the BPP, the Government indicated that it would negotiate with the medical profession to:

- structure the BPP payments in a way which will make the BPP more attractive to the profession and increase its take-up rate
- change the emphasis of the BPP to focus more on medical outcomes (not solely on operational aspects)

- encourage adoption of best practice by the profession in the diagnosis and treatment of certain prevalent conditions, such as asthma and diabetes.

The new program was to commence operation on 1 February 1998, with the precise nature of the criteria and structure to be decided as part of the review.

1998-99 BUDGET

	1998-99 $m	1999-00 $m	2000-01 $m	2001-02 $m	Total $m
New Directions in General Practice	12.1	12.2	-8.3	-18.1	-2.1

The Budget Papers describe this measure as providing "a substantial strengthening of the role of general practice in the Australian health system, and the financial basis to respond to the General Practice (GP) Strategy Review and the Review of General Practice Training."

New funding **of $367.0 million** over the period 1998-99 to 2001-02 was provided. This was more than offset by savings of **$369.1 million**, principally from changes in the remuneration arrangements applying to GP Registrars. The new funding comprised:

- **$127.3 million / 4 years** for two increases in MBS fees for GP consultations, comprising:
  - an increase from 50% to 100% indexation in the 1 November 1998
  - fee adjustment and a further increase in MBS fees from 1 March 1999
- **$57.0 million / 4 years** to increase the funds available to strengthen and reform general practice. Allocation of these funds within the GP Strategy was to be decided in consultation with the profession and consumers
- GP Registrars who began their training in 1999 to be paid by salary rather than fee-for-service, at a cost of **$182.7 million / 4 years**. The change was recommended by the Review of GP Training in order to strengthen the educational outcomes of the GP Training Program. (This provision was never implemented.)

No further information is available about how this funding was broken down over the forward estimates.

1999-00 BUDGET

	1999-00 $m	2000-01 $m	2001-02 $m	2002-03 $m	Total $m
GP involvement in coordinated care planning	3.6	11.2	16.8	22.9	54.5
Multidisciplinary case conferencing	0.9	2.4	3.6	4.8	11.7
PIP new care plan targets – admin costs	0.4	0.1	0.1	0.1	0.7
GPs multidisciplinary care planning education and training	2.4	2.4	1.6	1.7	8.1
Retention payments for GPs in rural and remote areas	10.5	10.7	10.9	11.0	43.1
Quality incentives for prescribing pharmaceuticals	-28.3	-38.9	-55.5	-64.7	-187.4
Improving access to health services for Indigenous Australians	6.8	16.0	22.5	33.5	78.8

The 1999-00 Budget provided **$75 million / 4 years** to fund a package of new Enhanced Primary Care measures to assist, in particular, older Australians, people with chronic illnesses and those who require a range of different services to support them in the community. These measures included new items of the Medicare Benefits Schedule, to encourage GPs to work with other health professionals, including other medical practitioners, domiciliary nurses, and home and community care providers, to develop coordinated care plans for people with chronic and complex care needs, education and training. Some of these funds (not specified in the Budget papers) went to the Sharing Health Care initiative.

Use of the EPC MBS items commenced in November 1999 and the program of training GPs in the use of these items through the GP Education, Support and Community Linkages component of the EPC package commenced in 2000.

The accompanying PIP incentive payments were to be for those GPs who achieved coordinated care plans for a proportion (not prescribed in the Budget) of their patients aged 65 years and over with chronic and complex health care needs. The cost of these incentive payments was to be met from within the existing Practice Incentives Program; the minor expenses shown for this measure reflected departmental expenses required to establish this new program.

A new incentives program was also provided to encourage GPs to improve their prescribing practices. This program eventually became known as the Enhanced Divisional Quality Use of Medicines (EDQUM) program. The program was predicted to deliver considerable savings of **$187.4 million / 4 years** over the cost of the program**.** A two-year pilot program was implemented in July 2002, with participation by 13 Divisions, targeting antibiotics, peptic ulcer drugs and cardiovascular drugs. Given the narrow scope of this pilot, it seems doubtful that the expected savings were achieved.

The Budget also introduced retention payments for long serving GPs as an incentive for them to continue to practice in rural and remote areas. **$43.1 million / 4 years** was provided for this measure.

The **$78.8 million / 4 years** for improved Indigenous access to health services is included here; this funding was used to initiate the Primary Health Care Access Program (PHCAP).

2000-01 BUDGET

	2000-01 $m	**2001-02 $m**	**2002-03 $m**	**2003-04 $m**	**Total $m**
New GP Registrars	10.1	20.6	31.6	39.7	102.1
More Allied Health Services	10.5	11.4	12.6	14.9	49.5
Workforce Support for rural GPs	2.1	2.6	2.7	2.7	10.2

In the 2000-01 Budget the Government funded a $562 million Regional Health Strategy – claimed to be "the largest ever effort by an Australian Government to redress the historical imbalance between rural and city health." Some of these measures related directly to GP services and primary care.

These included:

- **$102.1 million** to fund an extra 50 GP post-graduate training places across Australia, earmarked for country areas.
- **$49.5 million** to pay for allied health professionals including extra nurses, psychologists and podiatrists in rural areas through the MAHS program.
- **$10.2 million** will be spent improving support services for rural GPs.

2001-02 BUDGET

	2001-02 $m	2002-03 $m	2003-04 $m	2004-05 $m	Total $m
Increases in patient rebates for GP services	49.3	82.6	82.6	86.1	300.6
Proactive GP management of asthma – 3+ Visit Plan	7.6	12.3	14.1	14.4	48.4
Cervical screening initiatives for GPs	5.2	15.7	23.2	27.8	71.9
Integrated National Diabetes Program	9.3	12.5	12.6	15.4	49.8
After Hours / Emergency Primary Medical Care	8.8	10.4	11.6	12.6	43.4
New MBS item for Medication Management Review	1.8	4.3	5.5	6.5	18.1
Mental Health, More Options, Better Outcomes	4.2	24.6	39.9	51.7	120.4
Additional Practice Nurses for Rural Australia and areas of need	15.1	27.8	29.6	31.8	104.3
Improved primary health care for ATSI communities	-	-	19.7	20.5	40.2

This was a generous budget for GPs. It gave full implementation to the General Practice Memorandum of Understanding (GP MOU), signed in 1999 and which was due to expire in June 2002. It committed a total of **$797 million / 4 years** to a raft of new SIPs and MBS items and assistance for GPs to access allied health services and Practice Nurses.

Funding of **$40.2 million / 2 years** was provided to the Indigenous PHCAP program. It is not clear if this was additional funding (taking annual funding to around **$53 million**) or represents a cut in funding over that provided in the 1999-00 Budget for 2002-03 **($33.5 million**).

2002-03 BUDGET

	2002-03 $m	2003-04 $m	2004-05 $m	2005-06 $m	Total $m
Better Arthritis Care	1.5	3.0	3.5	3.5	11.5
More doctors for outer metro regions	12.0	18.0	25.0	25.0	80.0

The 2002-03 Budget saw the introduction of a further SIP for arthritis care at a cost of **$11.5 million / 4 years.** The Government also provided funding of **$80 million / 4 years** to increase the supply of doctors working in designated outer-metropolitan areas of the six state capital cities by 150.

In this Budget the Government was shamed into reversing a decision made in 2002 where savings of **$5 million** were taken from the Asthma Management Program and the Medical Specialist Outreach Assistance Program to provide for the co-location of national general practice organisations in a new building to be known as `GP House'.

2003-04 BUDGET

	2003-04 $m	**2004-05 $m**	**2005-06 $m**	**2006-07 $m**	**Total $m**
New GP training places	12.9	37.5	63.0	76.0	189.5
More nurses and allied health workers for urban areas of need	15.0	15.7	16.4	17.1	64.2
Encourage GP uptake of HIC Online	4.2	2.0	1.3	0.2	9.0
Improved information and practice management	1.8	1.9	1.4	1.0	6.1
GP incentive payments to bulk bill patients with concession cards	46.8	80.0	103.1	115.6	346.2
Focus on Prevention – primary healthcare providers working together	2.7	4.6	4.6	4.5	16.4
Sharing health care initiative	?	?	?	?	?
GP involvement in coordinated care planning	15.3	16.7	17.9	19.3	69.2
Multidisciplinary care conferencing	1.3	1.3	1.4	1.4	5.4
GP Education, Support and Community Linkages program – redirection of funding	-1.4	-1.7	-1.8	-1.8	-6.7
Enhanced Divisional Quality Use of Medicines program – maintain funding	10.9	17.0	19.2	21.6	68.6

The 2003-04 Budget had a significant number of measures to support GPs and primary care.

From 2004 an additional 150 training places, targeted at outer-metropolitan and other areas of workforce shortage, were added each year to the GP training program. The existing Practice Nurse program was extended to outer-metropolitan and urban areas where there is a workforce shortage. This measure was expected to provide for up to 800 practices to employ nurse or allied health worker such as a physiotherapist, Aboriginal Health Worker or podiatrist. The funding provided **($64.2 million / 4 years**) was in addition to the funding provided in the 2001-02 Budget.

For the first time, this Budget provided incentives to GPs to bulk bill the seven million people covered by a Commonwealth concession card, at a cost of **$346.2 million / 4 years**. This measure was the forerunner of several attempts by the Howard Government to address the dropping levels of bulk billing which were continually highlighted by the Opposition. It included grants of $750 in city areas and $1,000 in rural areas to those GPs agreeing to bulk bill concession card holders to help with the purchase of equipment and set-up costs for connection to HIC Online.

The accompanying Budget Papers state that the Government had to date already provided GPs with over **$400 million** to assist with IT and information management. This Budget contributed a further **$24.3 million / 4 years**.

There were a number of provisions to encourage GPs to better manage their patients with chronic conditions. These extended the provisions first provided in the 1999-00 Budget.

Continued funding of **$69.2 million / 4 years** was provided through the MBS to support GPs' involvement in coordinated, multidisciplinary care planning. This represented a decrease over funding provided in 2002-03 **($22.9 million**). Similarly, there is a substantial reduction in funding provided for MDC case conferencing **($5.4 million / 4 years** compared to **$11.7 million / 4 years** in 1999-00). .

$16.4 million / 4 years was provided to set up a system to help primary care providers work together to improve clinical outcomes, reduce lifestyle risk factors, and help GPs to maintain good health for those with chronic conditions in partnership with other health care providers. Some of these funds **($6.7 million**) came from savings made in the GP Education, Support and Community Linkages program. This program was introduced in the 1999-2000 Federal Budget as part of the Enhanced Primary Care Package to enable DGPs to promote multidisciplinary care planning to GPs and General Practices. Some of this new funding was proposed to support a small number of pioneer general practices and DGPs to develop evidence-based approaches to improve prevention activities and patient outcomes within a community setting.

Continued funding (amount not identified in the Budget Papers) was also included for the Sharing Health Care initiative which was part of the original EPC package. The Sharing Health Care Initiative had a number of components, including the Sharing Health Care demonstration projects, training for Health Service Providers and consumers, and a range of communication components. It funded eight demonstration projects that aimed to:

- Improve the health-related quality of life for people with chronic conditions, particularly those with co-morbidities;
- Improve the use of the health care system by people with chronic conditions; and
- Encourage collaboration between clients, their families and health service provider in the management of chronic conditions.

Apparently the Initiative received total funding of **$36.2 million**. A report on the evaluation of the demonstration projects was completed in June 2005.[74] The report stated that "the outcomes of the SHCI will feed into the National Chronic Disease Strategy (NCDS), which is currently being developed by the National Health Priorities Action Council."

This Budget also provided continued funding for an expanded EDQUM program. This was now expected to save **$39.8 million / 4 years** (dramatically less than proposed in 1999-00) which means that the actual cost of the program was **$61.4 million / 4 years**.

Medicare Plus

The Howard Government's 'A Fairer Medicare – Better Access, More Affordable' package, which was released as part of the May 2003-04 Budget, was very controversial and the legislation to implement this was referred by the Senate to the Select Committee on Medicare. The Select Committee tabled its report on 30 October 2003. Following the release of the report, in November 2003 the Government announced a revised Medicare package entitled 'Medicare Plus'. Under the new proposal, about **$2.4 billion** (or **$1.5 billion** more than in the Fairer Medicare package) was allocated to Medicare up to 2007.

MEDICARE PLUS PACKAGE

	2003-04 $m	**2004-05 $m**	**2005-06 $m**	**2006-07 $m**	**Total $m**
Assistance for GPs and specialists re-entering the work force	0.3	4.4	8.7	13.4	26.8
Grants to encourage uptake of HIC Online	1.0	2.4	2.9.	0.8	7.8
Higher rebates for nonVR GPs	3.0	6.4	6.4	6.5	22.4
More pre-vocational doctors to OM, regional, rural & remote areas	2.4	21.7	22.5	23.7	70.3
Incentives to GPs who bulk bill children and concession card holders	136.0	263.0	273.7	283.1	956.7
Support for additional accredited GP training practices and GP supervisors	1.5	3.6	3.0	3.1	11.1
Support for PNs through new MBS item	5.6	19.5	24.4	26.5	76.0
Support for rural and remote GPs	8.6	30.3	30.8	31.4	101.2

[74] Department of Health and Ageing. National Evaluation of the Sharing Health Care Initiative demonstration projects. Accessed at http://www.health.gov.au/internet/main/publishing.nsf/Content/chronicdisease-nateval

2004-05 BUDGET

	2004-05 $m	2005-06 $m	2006-07 $m	2007-08 $m	Total $m
Primary Health Care Access Program for ATSI Australians	10.0	10.0	10.0	10.0	40.0
Increased incentives for GPs who bulk bill in regional, rural, remote areas and Tasmania	39.0	40.5	41.9	43.5	174.7
New MBS items for health professionals and dentists	41.1	39.4	40.6	41.3	162.6
GP services – improving A/H access	1.7	1.7	1.7	1.7	6.9
Continued funding for DGPs	73.4	74.8	76.3	77.9	302.4
Continued higher rebate for non-VR GPs in rural areas	28.1	29.4	30.0	30.9	118.4
Additional medical indemnity assistance for rural procedural GPs	?	?	?	?	17.5

This 2004-05 Budget provided **$302.4 million / 4 years** to continue funding the Divisions of General Practice network. It's not possible to know what the funding was in the years immediately prior to this Budget, but this is a considerable increase over that first promulgated in the 1992-93 Budget ($17 million / year).

There were further incentives for GPs to bulk bill and to encourage non-VR GPs to work in areas of workforce shortage. The provision of new MBS items for services provided by dentists and allied health professionals marked the change-over from the EPC program to the Chronic Disease Management (CDM) program

$6.9 million was provided to allow up to 10 after-hours GP clinics to be set up with assistance from the States. These clinics – which could be co-located with a public hospital – were to improve access to after-hours GP services and reduce pressure on hospital emergency departments. The funding provided in the Budget was only for the first four clinics; the remainder of funds were in the Contingency Reserve.

The Government funded, through medical indemnity insurers, 75% of the difference between the medical indemnity insurance premiums of procedural GPs in rural areas and those for non-procedural GPs in similar circumstances. The cost of this measure (**$17.5 million / 5 years** including $1.9 million in 2003-04) was absorbed from within existing DoHA resources.

Funding of **$40 million / 4 years** was provided for PHCAP – again it is not clear if this is additional funding or continued funding.

In May 2004 it was announced that funding for the General Practice Immunisation Incentives (GPII) Scheme would continue and a further four years of funding was provided for the

Australian Primary Care Collaboratives program. These funds were included in the forward estimates and so do not appear in the Budget papers.

2005-06 BUDGET

	2004-05 $m	2005-06 $m	2006-07 $m	2007-08 $m	2008-09 $m	Total $m
Cervical Cancer Screening incentives	[27.8]	31.6	-	-	-	31.6
Asthma Management program	[14.4]	8.3	6.1	6.3	6.4	27.1
National Integrated Diabetes program	[15.4]	19.0	10.9	6.9	7.5	44.2
Continuation of Better Outcomes in Mental Health	[51.7]	38.0	21.0	21.0	22.0	102.2
Expansion of Better Outcomes in Mental Health	2.2	8.4	10.5	10.7	10.9	42.6
Total BOMH	53.9	46.4	31.5	31.7	32.9	
Additional PNs for rural Australia and other areas of need	[31.8]	31.4	32.1	32.8	33.5	129.7
PNs in rural areas	1.1	2.4	3.6	5.0	5.7	17.8
National Rural and Remote Health Support program	-	-1.1	-1.1	-1.1	-	-3.4
Round the Clock Medicare – A/H GP services	47.0	97.8	110.2	124.7	136.5	516.0
Round the Clock Medicare – grants for A/H GP services	-	5.2	10.8	11.7	11.9	39.7
Round the Clock Medicare – A/H Primary Care Program	-					58.2
MBS item for GP participation in Home Medicine Reviews		7.5	-	-	-	-
Increase Medicare rebate to 100% of scheduled fee	252.0	505.7	503.5	504.7	505.8	2,271.7
PHCAP – additional funding	-	7.0	9.0	11.0	13.0	40.0

A key focus of the 2005-06 Budget was the Round the Clock Medicare (RTCM) initiatives. New funding of **$555.8 million / 5 years covered**:

- **$449.6 million / 5 years** for higher Medicare rebates for AH GP services.
- **$106.2 million / 5 years** for three new grants programs to support AH general practice infrastructure, comprising:
    - **$20.6 million / 4 years** for operating subsidies, to a maximum of $200,000 a year for new and recently established AH GP services,
    - **$66.5 million / 5 years** for start-up grants of up to $200,000 over two years and for the Medicare costs for new AH GP services, with up to five to be funded this financial year, and
    - **$19.1 million / 4 years** for supplementary assistance to AH services in outer suburban and regional areas to ensure their viability.

This Budget also supports continuation of the existing After Hours Primary Medical Care Programme at a cost of **$58.2 million/ 4 years**. This program was previously funded at **$43.4 million / 4 years**.

In this Budget we start to see diminishing financial support for PIP / SIP initiatives.

- Funding for the Cervical Cancer Screening Incentive was only for 2005-06 on the basis that the incentive was to be examined over the next 12 months.
- Funding for the Asthma Management program was at reduced levels over 2004-05.
- Funding for the National Integrated Diabetes program declined considerable over the forward estimates.

$129.7 million / 4 years was provided to continue funding for general practices in areas of high workforce pressure to employ and provide training and support for practice nurses. Funding of **$4.2 million / 3 years** for the Re-entry and Up-skilling Scheme, which was previously funded through this activity was transferred to the Rural Nursing Scholarship Program measure.

$144.8 million / 5 years (including $53.9 million in 2004-05) was provided for the continuation and expansion of the Better Outcomes in Mental Health Care Initiative. The expansion funding was an election commitment to allow the program to address new issues such as the need for better integration of mental health, drug and alcohol abuse and suicide prevention activities, and provide additional support for GPs and their patients in rural and remote communities

Additional funding of **$40 million / 4 years** was provided for PHCAP to improve primary care access for Indigenous Australians. This added to the $10 million / year provided in the 2004-05 Budget.

2006-07 BUDGET

	2006-07 $m	2007-08 $m	2008-09 $m	2009-10 $m	Total $m
COAG Mental Health					
Funding for mental health nurses	2.1	24.0	37.9	54.9	118.8
Better Access through MBS	51.2	91.9	108.5	130.1	381.8
Mental health services in rural and remote areas	5.4	9.4	10.7	12.4	37.8
Better arthritis and osteoporosis care	3.6	3.7	3.7	3.8	14.8
Cervical Cancer Screening incentives	24.7	23.2	24.4	24.9	97.2
COAG Health Services — improving access to primary care services in rural and remote areas	0	0.5	0.6	0.6	1.7
Continuation of bulk-billing incentives for GPs in areas of workforce shortage and lower than average bulk-billing rates	18.0	23.7	-	-	45.7
MBS item for GP participation in Home Medicine Review — continue funding	8.9	10.1	11.2	11.4	41.6
More doctors for OM areas	15.0	15.4	16.3	17.8	64.5

The 2006-07 Budget delivered a raft of measures agreed by COAG, in particular **$1.9 billion / 5 years** was provided for mental health initiatives. GPs and primary care services benefited directly from several of these provisions. The introduction of the Better Access program regrettably saw the focus shift away from the delivery of mental health services in primary care through a multidisciplinary care team, as provided for under the Better Outcomes program.

Continued funding was provided for arthritis and osteoporosis care at current levels and for the cervical cancer screening PIP at reduced levels over previous years. It does not appear that there was a review of this incentive in the period between the 2005-06 Budget (when funding was provided for only one year) and this Budget.

As part of a COAG agreement on health services and improving access to primary care in rural and remote areas, there was a provision in this Budget which allowed primary care services provided in small rural hospitals and health services in areas of workforce

shortages to be billed to MBS through special exemptions. The exact cost of this provision was not provided - funding for this purpose was included in the Contingency Reserve to be released when agreements on eligible areas were reached with the States and Territories – but administrative funds were provided. As part of the proposal, the States and Territories will also be required to commit to maintaining health facilities and providing support for primary health care services.

In 2010 there were 16 exempted sites in Queensland (12), Western Australia (2) and the Northern Territory (2). A program evaluation was conducted for the initiative, and found that in communities where the COAG 19(2) exemption initiative had been implemented:

- more than 29,000 services had been billed to the MBS, at a cost of $2.2 million (up to 30 June 2009)
- patients had greater access to primary care services in these communities and
- benefits had been gained through increased access to bulk billed services, shorter waiting times, greater continuity of care, increased access to clinics which better manage chronic conditions and to workforce retention.[75]

$45.7 million / 2 years was provided to continue the bulk-billing incentive introduced on 1 September 2004 for GPs in eligible metropolitan areas where there were both doctor shortages and lower than average bulk-billing rates. Funding for 2008-09 and later years was to be determined following a review of the program.

Continued funding for GP involvement in Home Medication Reviews was provided at increased levels across the forwards estimates. Again, there does not appear to have been a review of this initiative, which was only funded for one year in the previous Budget.

[75] Department of Health and Ageing. Improving access to primary care in rural and remote areas – s19(2) exemptions initiative. Accessed at http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/factsheet-gp-05

2007-08 BUDGET

	2007-08 $m	2008-09 $m	2009-10 $m	2010-11 $m	Total $m
Continued funding Australian Primary Care Collaboratives	5.6	9.6	9.6	9.8	34.7
Continued funding Divisions of General Practice	-	79.5	81.1	82.7	243.3
Discontinuation of EDQUM program	-1.6	-2.4	-2.9	-3.5	-10.9
Continued funding General Practice vocational training	-	46.6	79.6	-	126.2
New / reorganised MBS AH items	0.1	17.2	26.7	27.8	71.8
Increased mental health services for drought affected communities		?	?	?	30.7
Continued funding for Multidisciplinary Case Conferencing	1.4	1.5	1.7	1.8	6.4
Continued funding Rural Retention Program	21.7	23.2	24.0	24.9	93.8
Continued funding Sharing Health Care initiative	4.0	6.5	6.5	5.5	22.5

The 2007-08 Budget had a number of provisions in it for general practice and primary care initiatives but these represented continued funding for existing, or modifications of existing, programs.

While the Divisions of General Practice must have been pleased with their increased funding, dismay was expressed at the time that the Government had cancelled the EDQUM program. This measure supposedly achieved considerable savings (expected to be **$39.8 million / 4 years** in 2003-04), with 50% of these savings going back to the individual DGPs. However in 2006 it was reported that of 21 DGPs involved in the program only six had achieved any savings.[76] The amount of savings taken here does not appear to be proportional to the spending outlined in the 2003-04 Budget. It is worthwhile noting here that EDQUM was the only implementation of a policy approach called “measure and share” which was worked up a number of times, based on the notion that GPs or Divisions who provided savings could share in them.

[76] Smith P. PBS savings plan fails to follow script. Australian Doctor, 18 January 2006. Accessed at http://www.australiandoctor.com.au/news/latest-news/pbs-savings-plan-fails-to-follow-script

The **$34.7 million / 4 years** provided to expand the Australian Primary Care Collaboratives is considerably more than the **$14.6 million/ 3 year**s initially provided in the 2003-04 Budget. The Budget Papers state that it is expected that the number of practices participating in the APCC would increase from 500 to 800 over the four years to 2010-11.

The Budget provided funds for increased mental health services for drought-affected communities: **$20.6 million / 4 years** to the COAG *Mental Health — mental health services in rural and remote areas* measure announced in the 2006-07 Budget, and **$10.1 million / 2 years** to individual DGPs for training and support. This was not new money but met from within existing DoHA resources.

2008-09 BUDGET

	2007-08 $m	**2008-09 $m**	**2009-10 $m**	**2010-11 $m**	**2011-12 $m**	**Total $m**
GP SuperClinics	33.1	76.6	66.3	49.3	49.8	275.2
e-Health incentive	-	-16.1	-32.3	-31.8	-30.6	-110.7
AH services incentive	-	-3.6	-5.8	-8.7	-8.2	-26.2
Mental health incentive	-	-1.8	-1.8	-1.8	-1.9	-7.2
Immunisation incentive	-	-14.6	-22.6	-23.1	-23.6	-83.7
Australian Primary Care Collaboratives program	-	-4.2	-4.1	-4.2	-4.2	-16.7
Adjusted funding for specific health programs*						-376.1

**GP and primary care programs that were cut are specified in following table*

Savings in GP and primary care programs

	Savings over forward estimates **$m**
General Practice Infrastructure Training and Support - Primary and Coordinated Care	-20.0
General Practice Infrastructure Training and Support - Primary Care Financing	-11.5
Primary Care Collaboration and Research	-6.3
After Hours Primary Care and Round the Clock Medicare: Investing in After Hours GP Services	-32.6
Reduced funding for the Mental Health Nurse Incentive Program (COAG mental health package)	-188.0
Reduced Funding for Mental Health Services in Rural and Remote Areas Program (COAG mental health package)	-15.5
Reduced Funding for - Better Access to Psychiatrists, Psychologists and GPs through the MBS (Better Access) initiative - Education and Training component (COAG mental health package)	-29.7
Sharing Health Care Initiative	-6.0
Reduced Funding for the Training for Rural and Remote Procedural GPs program	-33.5
Reduced Funding for the prevocational General Practice Placement Program	-30.0
Reduced Funding for the Registrars Rural Incentives Program	-3.0

The 2007-08 Budget, the first from the Rudd Labor Government, delivered on the Government's election commitments. New spending was offset by considerable savings, many of them impacting GP and primary care and apparently taken without consideration of the underlying policy. Indeed, some of these savings, taken in the name of "Responsible Economic Management', were later restored.

The budget contained **$275.2 million / 5 years** for the establishment of 31 GP Super Clinics in listed locations. At least 26 of these clinics were election commitments. The cuts included **$227.8 million** in incentive payments to GPs, **$16.7 million** from the Australian Primary Care Collaboratives program, and **$376.1 million** in a raft of programs in primary care.

2009-10 BUDGET

	2009-10 $m	2010-11 $m	2011-12 $m	2012-13 $m	Total $m
Prevocational training for GPs	8.9	10.4	10.5	11.4	41.2
GP training – expanding the role of GPET	-0.2	-0.8	-0.8	-0.8	-2.6
GP training – extension of time for rural placements	-	-0.2	-0.3	-0.3	-0.8
GP training – consolidating regional training providers	-1.3	-3.0	-3.0	-3.0	-10.3
New GP Rural Incentives Program	7.0	16.4	19.1	21.8	64.3
Locum relief for GPs in rural and remote areas	?	?	?	?	22.6
DGP – new funding formula	1.9	3.1	2.6	-	7.6
PIP – quality and administrative improvements	2.1	0.6	-13.7	-14.8	-25.8
Better Access – GP training requirement	-7.4	-17.2	-6.1	9.1	21.7
Continuation of Mental Health Support for Drought-Affected Communities	5.2	-	-	-	5.2
Continuation of existing mental health services in rural and remote areas	2.7	1.5	1.2	1.3	6.7
Sharing Health Care Initiative — further efficiency	-2.7	-0.7	-	-	-3.4

There was considerable tinkering at the margins of a number of GP / primary care programs in the 2009-10 Budget, most of it done in the name of 'further efficiency'. This was exemplified in the GP workforce provisions, which saw an expanded role for GPET.

The Budget provided funding for 160 additional places / 4 years in the Prevocational General Practice Placement Program (PGPPP), bringing the total number of annual places in 2012-2013 to 410. A separate provision in the Budget made savings of **$2.6 million / 4 years** in this program by transferring its administration from the Australian College of Rural and Remote Medicine and the Royal Australian College of General Practitioners to General Practice Education and Training (GPET).

A new General Practice Rural Incentives Program **($64.3 million / 4 years**) was formed by consolidation of the Rural Retention Program (RRP) and the Registrars Rural Incentive Payments Scheme, with retention and relocation payments geared to the level of remoteness. It appears that this funding is on top of that already supplied, although this is not clear in the Budget Papers. In the previous five years almost **$100 million** was spent on the Rural Retention Program which was apparently successful at retaining GPs in rural and remote areas but failed to attract new doctors. Retention efforts were also boosted by the provision of funds for a locum relief program.

A small amount of new funding went to the Divisions of General Practice via a new funding formula based on the new classification system for remoteness areas. The Budget Papers said that longer term funding arrangements were to be considered prior to the expiry of the current new funding agreements on 30 June 2012 – we now know that this was changed with the introduction of Medicare Locals.

The 2009-10 Budget made further cuts to the PIP program. These changes were described as improving quality and safety and simplifying administrative changes, although establishing how these aims would be achieved from the information provided in the Budget Papers was not possible. The simplification of administration was achieved at a cost of **$9.6 million** to Medicare Australia.

The changes to the Better Access program provided for a lower MBS fee for GP Mental Health Care Plans prepared by GPs who have not completed level 1 mental health training. The key assumption underlying this provision is that GPs will resist getting the needed training, thus saving **$21 million / 4 years**. The consequence is that the services they do deliver will be reimbursed at a lower rate which may or may not impact on their quality.

The Mental Health Services in Rural and Remote Areas Program was provided with an additional **$6.7 million /4 years** for DGPs in a move that restored some of the **$15.5 million** cut from this program in the 2008-09 Budget. This program was part of the Australian Government's 2006 COAG mental health package, where it was funded at **$55.5 million / 5 years** (2006-07 to 2010-11). The 2007-08 Budget contained **$10.1 million / 2 years** to provide funding for up to 39 DGPs in drought affected areas, although this was reduced to **$7.4 million** when the Government of the day announced the roll-out of funding in September 2007.

Further cuts were made in the Sharing Care program. This program was originally part of the 1999-2000 Budget, and was funded at **$22.4 million / 4 years** in the 2007-08 Budget. It appears that the focus of this program was narrowed to Indigenous and CALD groups.

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2010-11 BUDGET

	2010-11 $m	2011-12 $m	2012-13 $m	2013-14 $m	Total $m
Coordinated diabetes care	5.7	12.0	183.2	247.0	447.9
Establishing Medicare Locals and improving access to AH primary care	14.0	66.6	156.6	179.7	416.9
GP SuperClinics and improved primary infrastructure	56.7	179.4	119.1	-	355.2
More places in GP training	3.3	30.8	104.0	206.9	345.0
Additional places in Prevocational GP Placement program	26.4	34.1	44.2	44.9	149.6
New practice nurse grants initiative	2.5	70.7	147.7	168.2	390.3
More mental health nurses	5.3	7.7	-	-	13.0
Flexible care packages for patients with severe mental illness	-3.0	5.1	2.4	1.3	5.9
NHHN – Aged Care – improving access to GPs and primary care	14.1	14.7	35.3	34.6	98.6

The 2010-11 Budget promised to deliver **$1.2 billion / 5 years** boost to GP and primary care. This included **$447.9 million** for better coordination of diabetes care, **$355.2 million** for infrastructure, including 23 additional GP Super Clinics, and **$416.9 million** for Medicare Locals. However most of this was not due to roll out until 2012-13. To the extent that these provisions represented the government's adoption and implementation of the National Primary Health Care Strategy, most would agree there is much more to be done.

A total of **$416.9 million / 4 years** was provided to establish a nation-wide network of Primary Health Care Organisations to be known as Medicare Locals and to improve access to AH care. **$126.3 million** was provided for this latter purpose; this was not in fact new money but continued funding, at reduced levels, for the National Health Call Centre Network which was set up by COAG and the Howard Government in 2006.

The development of Medicare Locals, which built on the existing Divisions of General Practice, was one of the Government's response to recommendations of the National

Primary Health Care Strategy. Over time, it is proposed that Medicare Locals will also support community health promotion and prevention programs, and take a greater role in community-based mental health service provision. However it is not clear how Medicare Locals will integrate with Local Hospital Networks. Once established, **$180 million** in contracted funding to Divisions will be redirected to Medicare Locals.

It is unfortunate that the coordinated diabetes care proposal fell victim to AMA opposition and was downgraded to a small pilot program.

In addition to the provisions responding to the National Primary Health Care Strategy, there was **$494.6 million / 4 years** for GP training.

$390.3 million / 4 years was provided for a new practice nurse grants initiative which will replace the existing incentives for GP practices to employ PNs. It is unclear how much of this is new funding as this replaces the current funding through the PIP practice nurse incentive and the MBS practice nurse items. In 2004-05 the PIP incentive was funded at **$112.4 million / 4 years**, and MBS currently provides reimbursement for wound care, immunizations, pap smears, certain CDM items and antenatal care. It is likely that there was little new money here, although there should be enough to allow for expansion of the program to urban areas.

Funding of **$13 million / 2 years** was provided to the Mental Health Nurse Incentive Program which funds mental health nurses in general practices and private psychiatric practices. When first introduced this program was funded at **$191.6 million / 5 years**. This funding was cut by **$188.0 million / 4 years** in the 2008-09 Budget, due to low uptake of the program. However the new funding level for this program was given at May 2008 Senate Estimates as **$49.45 million / 5 years**, and in the August 2008 and September 2008 progress reports it is given as **$34.5 million / 5 years**. The January 2009 progress report gives the funding level as **$56.8 million / 5 years** and February 2010 progress report states that this program was funded at **$68.7 million / 6 years** (2006-2011) with no explanation provided for the variation.

Funding of **$58.5 million / 5 years** was to provide personal multidisciplinary care packages for patients with severe mental illness by expanding the existing Access to Allied Psychological Services (ATAPS) program. This program allows GPs to refer patients to mental health nurses, psychologists, occupational therapists, social workers and social support services. In actual fact this measure provided only **$5.9 million / 5 years** in new funds. The remainder **($52.4 million**) came from a requirement, effective July 1, 2010, that occupational therapists and social workers could no longer bill Medicare for mental health services provided under the Better Access program – a decision that was later rescinded.

This Budget provided **$98.6 million / 5 years** to improve access to GPs and primary care for people living in residential aged care. The Budget also committed continued funding (included in the forward estimates) of the measure that allows emergency departments and outpatient clinics in public hospitals to provide MBS eligible services. To be eligible, hospitals must be in an area of workforce shortage with a population of less than 7,000. In 2006-07 this provision was funded at **$3.0 million / 5 years.** There is no way to know how much this initiative actually costs or how often it is used, and whether it is used appropriately.

2011-12 BUDGET

	2011-12 $m	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	Total $m
Coordinated diabetes care – pilot	5.7	10.3	15.5	-	-	31.577
Better Access Initiative — rationalisation of GP mental health services	-50.1	-80.5	-85.4	-90.9	-98.9	-405.9
Expansion of Access to Allied Psychological Services	16.1	31.1	43.7	53.1	61.9	205.9
Continuation of incentives to improve access to after-hours care	-	?	?	-	-	49.9
Medicare Locals and AH services	16.7	33.8	-3.2	-2.3	-	45.1

Mental health reforms were a key focus of the 2011-12 Budget, but yet again from the GP / primary care perspective this was really fiddling with the Better Access program that had been the subject of considerable previous manipulation.

A two-tiered rebate for Mental Health Treatment Plans delivered by GPs was introduced. The Budget Papers stated that the aim was "to adjust the level of rebate to better reflect the time taken to deliver the service". It was estimated to deliver savings of **$405.0 million / 5 years.**

Further funding of **$205.9 million / 5 years** was provided to expand funding for the Access to Allied Psychological Services (ATAPS) program. The expansion, through Medicare Locals, was described as providing services to children and their families, Aboriginal and Torres Strait Islander people, and people from hard to reach locations with a particular focus on lower socioeconomic areas. Medicare Locals will coordinate services at a local level by integrating primary care services with other community based support for people with mental illness.

$45.1 million / 4 years was provided to bring forward the establishment date for 15 Medicare Locals to 1 January 2012 and to fast track reforms to AH GP services. Linked to this was funding of **$49.9 million / 2 years** from 2010-11 to extend incentives to general practices to support AH care. Tier 1 of the PIP AH Incentive, which had been due to terminate on 1 July 2011, was extended until 1 July 2013.

This Budget also saw the previously proposed Coordinated Diabetes Care program 'deferred' (at savings of **$448.4 million**) and in its place **$31.5 million / 4 years** was

[77] Department of Health and Ageing. National Health Reform. Progress and Delivery. 2011. Accessed at http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nhr-progress-delivery/$File/National%20Health%20Reform%20Progress%20and%20Delivery.pdf

provided to develop and implement a pilot program to trial the proposed design and patient outcomes of the original measure.

2012-13 BUDGET

	2011-12 $m	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	Total $m
General Practice Rural Incentives Program — additional funding		34.9	-	-	-	34.9
GP Super Clinics program — streamlining		-2.7	-13.8	-13.8	-13.8	-44.0
Aged care – Better healthcare connections		?	?	?	?	58.5
MH nurse incentive program	0.4	17.5				17.6
More effective targeting of PIP	-	-1.1	-30.9	-26.5	-24.9	- 83.5
Stronger Futures – Indigenous access to primary care in NT	-	58.5	nfp	nfp	nfp	254.4

The 2012-13 Budget implemented the Living Longer, Living Better suite of measures to begin to address needed aged care reforms. It's not clear how much of the $**58.5 million** provided through the Better Health Care Connections program in aged care will go specifically to GP / primary care as some of this is also for palliative and psycho-geriatric care and innovative ways of delivering health care services, including telehealth trials. However there are clearly some additional funds provided on top of the **$98.6 million / 5 years** provided in the 2010-11 Budget to support additional primary care services for older Australians in aged care. It is known that around **$9.9 million / 5 years** will go to a measure to support older Australians with complex health needs who could benefit from multidisciplinary care and coordination of treatment.

Uncommitted funding for GP SuperClinics for the provision of development, networking and other operational activities was cut on the assumption that these activities would be undertaken through the Medicare Local Network.

The Mental Health Nurse Incentive Program is modified yet again. In the Budget Papers this provision is described as providing 'additional funding' of **$17.6 million / 2 years**; while this is factually true, in that funds are provided for this program for 2011-12 and 2012-13, this is an ironic way to describe both limiting a program (what happens after June 2013?) and capping a program at existing service levels.

$83.5 million / 4 years in savings are taken from several Practice Incentives Programs (PIP). The savings were achieved by:

- A requirement for General Practices to participate in the Personally Controlled Electronic Health Record (PCEHR) System to receive the eHealth PIP incentive;

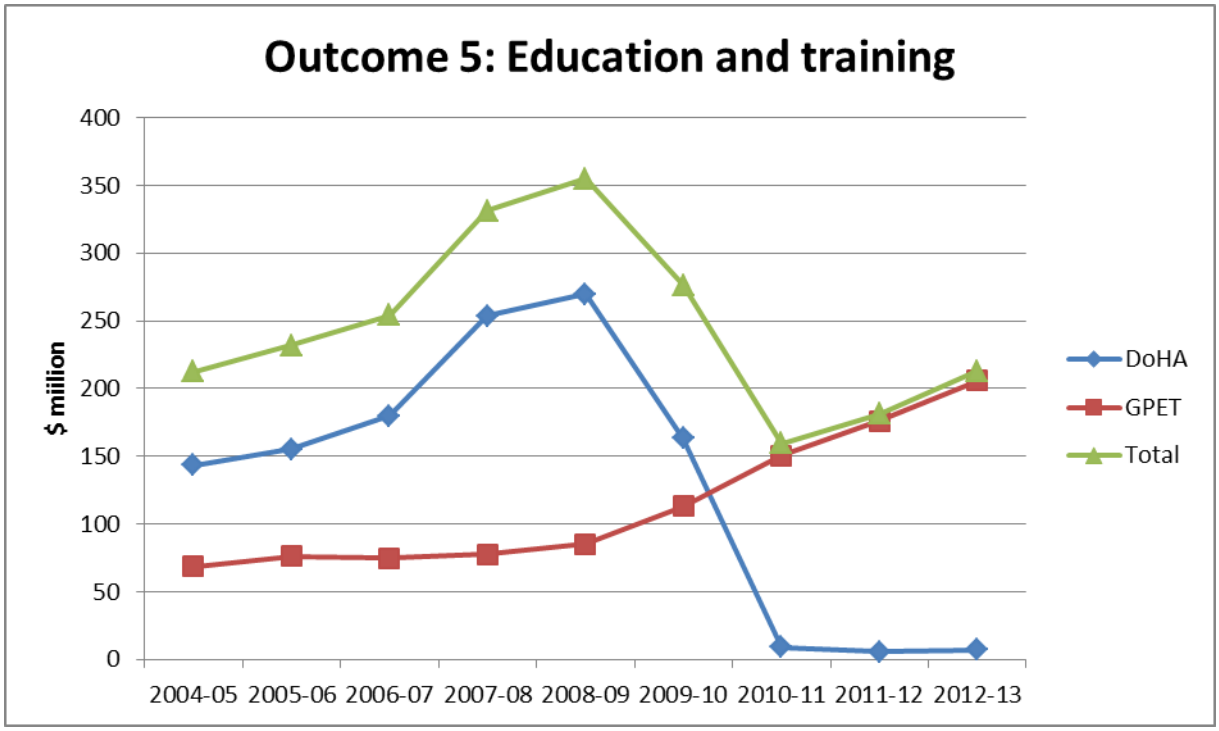
- Increasing the targets for General Practices to receive incentives for the PIP Cervical Screening Incentive, from 65% to 70 % of eligible female patients;
- Increasing the targets for General Practices to receive incentives for the PIP Diabetes Incentive, from 40% to 50% of eligible diabetics; and
- Discontinuing the GP Immunisation Incentives Scheme, in light of requirements introduced on FTB A supplements in the 2011-12 MYEFO.

It is clear that the Government is phasing out PIP payments. By my estimate close to **$400 million** has been cut from PIP payments since 2008 (not including e-health incentives), and the 2011-12 Budget Papers show PIP spending declining 18% over the forward estimates. The 2008-09 Budget alone cut a total of **$227.8 million / 4 years** from GP PIP programs. The 2009-10 budget cut a further **$25.8 million / 5 years** from PIP payments in the name of 'quality and administrative improvements' and in the 2010-11 Budget **$23.5 million / 4 years** was taken from the cervical cancer PIP. This year's Budget provides funding (none of it new funding) to the General Practice Rural Incentives Program but for only one additional year and these funds are reallocated **- $18.2 million** is redirected from Health Workforce Australia and **$16.7 million** from other, unspecified health workforce capacity program.

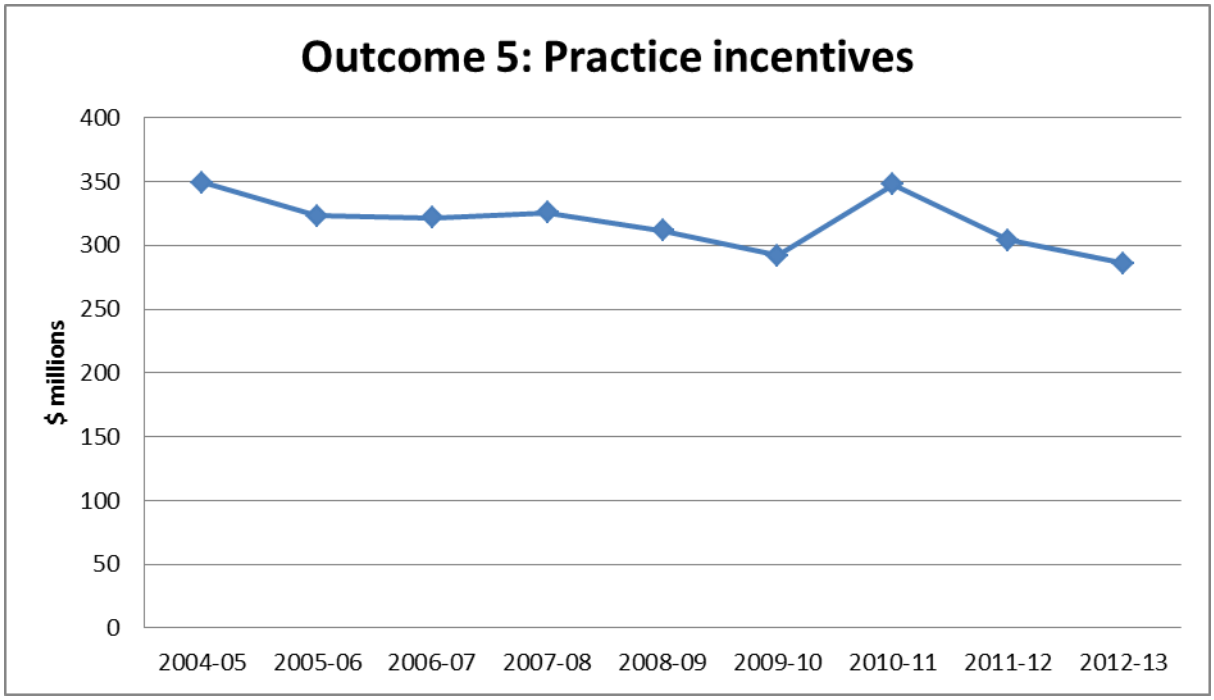
The main 2012–13 Budget initiative in Indigenous affairs is the new Stronger Futures in the Northern Territory package which, if the legislation presently before the Parliament is passed and negotiations with the Northern Territory Government proceed as expected, will replace the NP on Closing the Gap in the Northern Territory. The Stronger Futures cross-portfolio package provides **$254.4 million / 4 years ($713.5 / 10 years**) for better primary health care, and better access to allied health services.

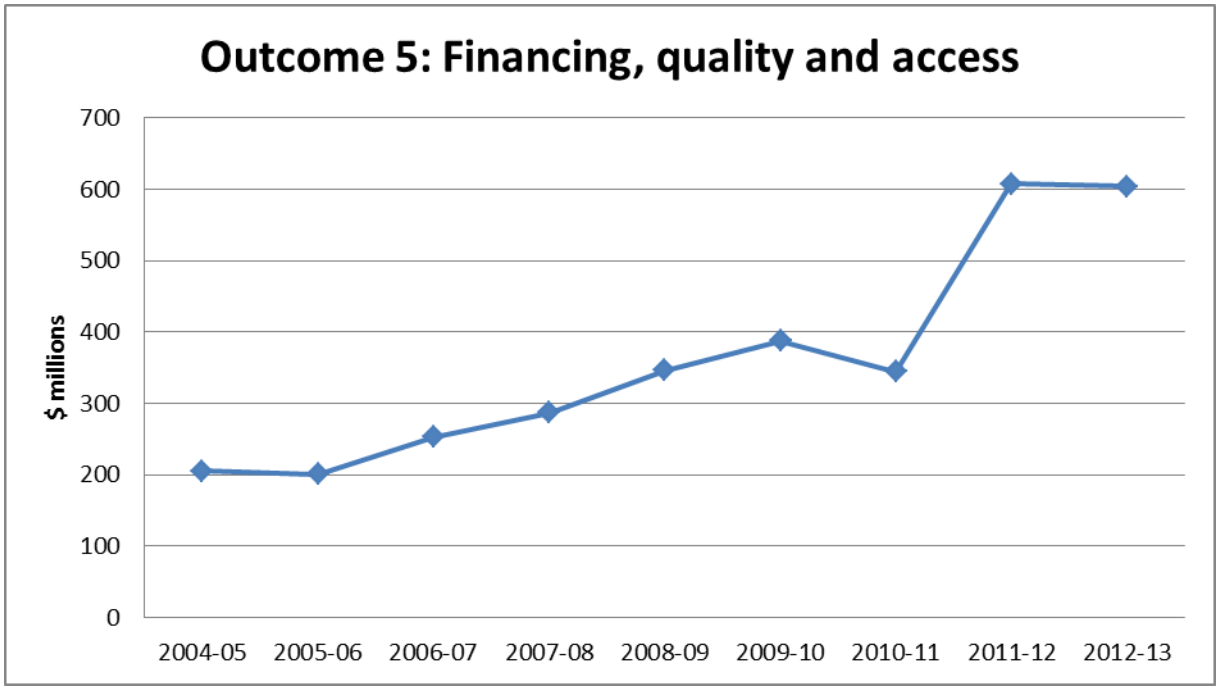
Tracking Primary Care Funding through Portfolio Budget Statements

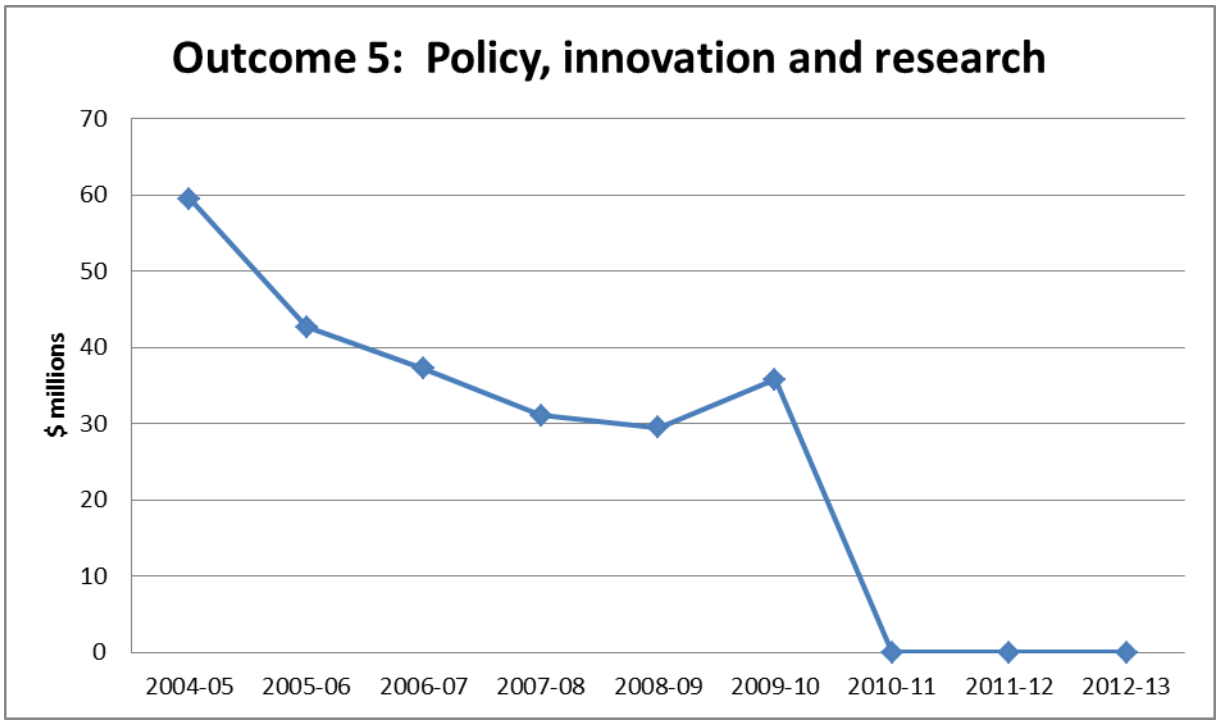
2005-06 was the first year that Primary Care had its own Outcome in DoHA Portfolio Budget Statements. Limited tracking of broad categories of funding is possible from this time period. However this is not very informative as it is clear that what is included in this outcome has changed over time and that there are primary care measures in other outcomes.



It is possible that this graph does not include all the funding spent on GP education and training but it is not possible to assess the extent of any additional funds.


Outcome 5: Practice incentives
$ millions
400
350
300
250
200
150
100
50
0
2004-05
2005-06
2006-07
2007-08
2008-09
2009-10
2010-11
2011-12
2012-13


Outcome 5: Financing, quality and access
$ millions
700
600
500
400
300
200
100
0
2004-05
2005-06
2006-07
2007-08
2008-09
2009-10
2010-11
2011-12
2012-13


Outcome 5: Policy, innovation and research
$ millions
70
60
50
40
30
20
10
0
2004-05
2005-06
2006-07
2007-08
2008-09
2009-10
2010-11
2011-12
2012-13

Flexible Funds

In 2011 the Federal Government consolidated a large number of health and ageing programs within eighteen larger, flexible Funds. Several of these funds apply to GP and primary care.

PRACTICE INCENTIVES FOR GENERAL PRACTICES FUND

- Medicare Plus - Aged Care Access Initiative - GP Component
- Practice Incentives Program - Cervical Cancer Screening Incentives
- Practice Incentives Program - Closing The Gap - PIP Indigenous Health
- Practice Incentives Program - Integrated National Diabetes Program PIP
- Practice Incentives Program - Procedural GP Incentive
- Practice Incentives Program - After Hours, Asthma, eHealth, Quality Prescribing and Teaching Incentives, and Rural Loading.
- General Practice Immunisation Incentive

HEALTH WORKFORCE FUND

- General Practice training
- Specialist medical training
- Nursing, midwifery and allied health workforce training
- Telehealth – (for the training of health professionals)
- The recruitment, retention and support of Overseas Trained Doctors (OTDs)
- The Aboriginal and Torres Strait Islander health workforce through the provision of education, training and mentoring
- Health workforce locum schemes
- Increased number of, and levels of support to, health professionals working in regional, rural and remote Australia
- The development and regulation of the health workforce

REGIONALLY TAILORED PRIMARY HEALTH CARE INITIATIVES THROUGH MEDICARE LOCALS FUND

- Primary Health Care Organisations – Medicare Locals.
- Improve Access to After-hours Care - Funding to Medicare Locals to ensure availability of face-to-face after hours services.
- General Practice After Hours Program.
- Workforce Support for Rural GPs Program.

- Rural GP Locum Program.
- Rural Primary Health Services Program.
- Medicare Plus Better Aged Care Residents (Aged Care Access Initiative) – Allied Health component.
- Primary Health Care Organisation Support – Improving Access to General Practice and Primary Health Care Services for Older Australians.

ABORIGINAL AND TORRES STRAIT ISLANDER CHRONIC DISEASE FUND

- Indigenous Chronic Disease Package
- National Action to Reduce Indigenous Smoking Rates
- Helping Indigenous Australians Reduce Their Risk of Chronic Disease
- Local Indigenous Community Campaigns to Promote Better Health
- Subsidising PBS Medicine Co-payments
- Supporting Primary Care Providers to Coordinate Chronic Disease Management - Care Coordination and Supplementary Services Measure
- Improving Indigenous Participation in Health Care Through Chronic Disease Self Management
- Increasing Specialist and Allied Health Follow-up Care
- Monitoring and Evaluation
- Workforce Education and Training
- Expanding the Outreach and Service Capacity of Indigenous Health Organisations
- Engaging Divisions of General Practice to Improve Indigenous Access to Mainstream Primary Care
- Attracting More People to Work in Indigenous Health
- Clinical Practice Guidelines – Primary Health Care Resource
- Rheumatic Fever Strategy - National Coordination Unit
- Closing the Gap: Improving Eye and Ear Health Services for Indigenous Australians for Better Education and Employment Outcomes – training of Aboriginal Health Workers in ear health and monitoring and screening

THE CHRONIC DISEASE PREVENTION AND SERVICE IMPROVEMENT FUND

The programs consolidated under this fund are not specified.