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ahha australian healthcare & hospitals association

28 March 2019

Primary Care Consultation
Primary Care Reference Groups
Medicare Review Unit, Medical Benefits Division
Australian Government Department of Health

Sent via email: MBSReviews@health.gov.au

Re: Submission in response to the General Practice and Primary Care Clinical Committee Phase 2 Report

Dear Primary Care Consultation,

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to provide a submission in response to the General Practice and Primary Care Clinical Committee Phase 2 Report.

AHHA is Australia's national peak body for public hospitals and healthcare providers. Our membership includes state health departments, Local Hospital Networks (LHNs) and public hospitals, community health services, Primary Health Networks (PHNs) and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high-quality healthcare to benefit the whole community.

AHHA supports the Medicare Benefits Schedule (MBS) Review Taskforce's commitment to providing recommendations to the Minister for Health that will see the MBS deliver:

1. Affordable and universal access
2. Best practice health services
3. Value for the individual patient
4. Value for the health system

To achieve a healthy Australia supported by the best possible healthcare system, AHHA recommends Australia reorientate the healthcare system over the next 10 years by enabling outcomes-focused and value-based healthcare. This requires:

1. A nationally unified and regionally controlled health system that puts patients at the centre;
2. Performance information and reporting that is fit for purpose;
3. A health workforce that exists to serve and meet population health needs; and
4. Funding that is sustainable and appropriate to support a high-quality health system.

AHHA's *Healthy people, healthy systems* is a blueprint with a series of short, medium and long-term actions to achieve this goal. I have attached a copy of *Healthy people, healthy systems* along with this submission, and it is also available online at www.ahha.asn.au/Blueprint. Equally available are a series of Australian case studies, exemplify these recommended actions in practice.

We are committed to a strong primary care system which aims to reduce unnecessary and preventable hospitalisations, and includes a workforce where clinicians are funded and authorised to work to the top of their licence.

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While the recommendations from the General Practice and Primary Care Clinical Committee Phase 2 Report are broadly supported in principle for providing improved continuity of care and better management of chronic conditions, we also note that a number of recommendations would be associated with a significantly increased cost to the MBS. While the rationales provided to support the recommendations are generally *prima facie* tenable, evidence to support these recommendations has not been provided in many instances.

Changes to the MBS must improve continuity of care and management of chronic conditions, and must take into account the financial impacts for patients and clinicians providing services. Any changes associated with a significantly increased cost to the MBS must be supported by evidence.

AHHA therefore asserts that there must be a transparent independent review and evaluation within 12 to 24 months of any change to the MBS to ensure that the proposals are delivering value for money and improved patient care. This must also involve the collection of appropriate baseline data before a change is made to the MBS to ensure that this independent review and evaluation can be validly conducted.

AHHA also strongly encourages the Government to consider the merits of including a sunset clause on the costlier proposals made by the MBS Review Taskforce. This particularly relates to Recommendation 6 where, if the five-year annual average growth rate continues, this will over four years add $1.4 billion to MBS expenditure.

If the proposed recommendations do result in improved patient care where the benefits exceed the cost, then this would represent a valuable investment in the health of all Australians. However, where for example similar services are being provided but at a recommended significantly higher cost to the MBS, the evidence needs to be established that this represents value in patient care and to the health system.

AHHA submits the following with regards to the 18 recommendations made within the General Practice and Primary Care Clinical Committee Phase 2 Report.

1. Move to a patient-centred primary care model supporting GP stewardship

AHHA supports a patient-centred, team-based primary care model and acknowledges the leadership role played by general practitioners (GPs). However, AHHA stresses that any model of patient-centred primary care should not exist to support GPs as stewards but should exist to support patients to receive the right care, at the right place by the most appropriate service provider practising to the top of their licence. The MBS Review is an opportunity to examine how to develop the MBS funding model to better capitalise on the capacity of the total health workforce.

Consideration must also be given to how funding for value and outcomes can be achieved either through the MBS or alternative funding arrangements to support more the effective and efficient provision and coordination of patient-centred and team-based primary care services. Services provided in this manner are a critical component of a comprehensive health system which can improve health outcomes and reduce overall healthcare costs and out-of-pocket expenses.

Reforming payment models in relation to the care and support needed in the community should form part of a modern and responsive health system. This was a key finding at the AHHA's

September 2015 think tank on health funding[1] and from AHHA's paper on the role of bundled payments in Australian primary healthcare[2].

Patient-centred and team-based primary care should assist in providing continuity of care, coordinated services and a team-based approach according to the needs and wishes of the patients. This should build on the efforts of Primary Health Networks (PHNs) who are already developing such services in their areas. The diversity of the environments in which PHNs operate requires flexibility and innovation in organisational structure and the ability to develop effective partnerships, particularly if they are to be effective in commissioning regional services that target local needs.

While AHHA welcomed the Commonwealth Government's Health Care Homes program when first announced, AHHA urged the Government to provide the trial sites with the funding and resources needed to succeed in delivering transformational change to the primary care system and to the care of all patients.

Recommended by the Primary Healthcare Advisory Group to deliver continuity of care through coordinated services and a team-based approach according to the needs and wishes of the patients, the stated objectives of the Health Care Homes program cannot be achieved with inadequate funding that does not reflect the complexity of enrolled patients.

An expanded and appropriately funded Health Care Homes model would be a way forward, based on a population health approach with all patients having access to the Health Care Home model, not just those with chronic conditions. Appropriate funding is required that properly reflects patient care complexity, and funding needs to explicitly incorporate non-GP primary healthcare services when needed (beyond the limits of the MBS disease program) and be weighted for remoteness.

AHHA supports in principle the 12 principles for Australian primary care (Report from the General Practice and Primary Care Clinical Committee: Phase 2, p 29) put forward by the Committee, which closely align with the shared principles put forward by AHHA in 2017[3] for coordinated and efficient care that is patient-centred, flexible and tailored to local needs and the capacity of the local workforce. Without agreed shared principles, the capacity to achieve substantial system change and acceptance from funders, providers and patients will be compromised.

2. Introduce a new voluntary patient enrolment fee

AHHA acknowledges having a regular GP is beneficial for patient outcomes, patient experience and value to the system. AHHA supports in principle the concept of patient enrolment to build continuity of care under the proviso that enrolment does not inappropriately hinder patient access to other GPs, general practices or other appropriate healthcare professionals, nor increase costs to the patient, should they wish to seek service provision from an alternate provider.

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[1] Australian Healthcare and Hospitals Association (AHHA) 2015, *Think tank on Sustainable Funding of Public* Hospitals, Australian Healthcare and Hospitals Association, Canberra, https://ahha.asn.au/think-tank-sustainable-funding-public-hospitals-0.

[2] Dawda P 2015, *Bundled payments: Their role in Australian primary health* care, Australian Healthcare and Hospitals Association, Canberra, https://ahha.asn.au/sites/default/files/docs/policy-issue/bundled_payments_role_in_australian_primary_health_care_0.pdf.

[3] Thurecht L, Woolcock K, Silk K, Partel K and Verhoeven A 2017, *Health Care Homes: Principles and enablers for their Implementation in Australia*, Deeble Institute for Health Policy Research, Australian Healthcare and Hospitals Association, Canberra, https://ahha.asn.au/publication/health-policy-issue-briefs/deeble-issues-brief-no-21-health-care-homes-principles-and.

It is our view that voluntary patient enrolment will work most effectively in practices where the best-practice principles we identified for implementation of Health Care Homes, including team-based care, are applied[4].

Any application of an enrolment fee must include public policy consultation and consideration of matters including:

- the quantum of the fee
- who will bear the cost of the fee, and if it is the patient, whether it will be means-tested
- who will receive the fee (for example the GP, the practice or the team of health service providers providing primary care services to the patient)
- how a patient's location and health status will affect the fee
- the scope of services to be included, and whether the patient will be eligible to access services outside of the practice in which they are enrolled without financial penalty
- how issues of equity and access will be considered, and
- how item numbers will be removed or changed as a result of the fee being instituted.

The MBS Review Taskforce has also not described how a patient enrolment fee would impact on existing MBS items for episodic care. AHHA contends that a more holistic view of the issue of continuity of patient care should be focussed on what should be paid for the provision of a package of care, rather than a simple increase in income to general practice.

AHHA is also concerned with the implicit suggestion that in the absence of an enrolment fee GPs do not have a role in maintaining patients' My Health Record for the care that they provide. AHHA also notes that discussion of Recommendation 2 does not state that the intended patient enrolment fee be voluntary.

Finally, AHHA agrees that general practice should be supported to enact, "data driven improvements in quality of care, and in referral and prescribing practices leading to potential downstream savings from preventable hospitalisations" (Report from the General Practice and Primary Care Clinical Committee: Phase 2, page 31). AHHA expects that the Taskforce would also agree that this data driven improvement in care would be most effectively maximised by contributing data to be used to inform population health more broadly through contributing data to a national minimum data set for primary care.

AHHA contends that further information on a patient enrolment fee be made available to the sector and public to understand the full operation and impact of this significant proposed change.

3. Introduce flexible access linked to voluntary patient enrolment

AHHA is unable to support a patient enrolment fee without greater detail as noted above.

AHHA supports flexible access to medical care including non-face-to-face access to be made available as soon as possible (eg telephone, email, videoconsulting, telehealth, etc.) for consumers facing difficulties in accessing face-to-face consultations (eg remote, rural, disabled).

4. Combine GP Management Plans (GPMPs) and Team Care Arrangements (TCAs) and strengthen GPMPs

Proactive healthcare is critical to patient outcomes.

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[4] ibid

AHHA supports the reduction of administrative burden and low value care while increasing patient engagement in their own care planning. AHHA notes the majority of GPMPs and TCAs are currently claimed together.

A comprehensive team-based approach to healthcare is integral to being able to provide patient-centred care. A comprehensive team-based approach should:

- be accountable for a large majority of the physical and mental health needs of a patient, including transitions in care
- provide preventive, chronic and acute care
- provide care in a culturally respectful and sensitive manner
- be interdisciplinary, including community-based organisations, mental health, specialist care teams, aged care, disability and other clinicians and professionals where appropriate
- ensure members of the care team understand, respect and utilise the diverse roles and responsibilities of each member, with the services being provided being collectively greater than the sum of their parts
- have an initial patient contact point that is known by the patient.

5. Link allied health items to GPMPs

AHHA supports this recommendation as a vital component of the holistic management of a patient's chronic disease.

6. Equalise the rebate for GPMPs and GPMP reviews

While AHHA agrees with, "longitudinal care and reviewing and updating the plan by the patient's usual GP is important in optimising patient outcomes from CDM planning" (Report from the General Practice and Primary Care Clinical Committee: Phase 2, page 43), no evidence is provided to justify a doubling of the cost and remuneration of providing this service. Furthermore, the Taskforce report shows that the annual average growth in services for item 732 is 16.2%, demonstrating that general practice is able to provide this service with the current funding level.

It is noted that if the five-year annual average growth rate continues, this proposal will over four years add $1.4 billion to MBS expenditure and income to general practice. For such a significant increase in public funding to be justified, the evidence needs to be established that this represents value in patient care and to the health system.

If this recommendation is accepted, there must be a transparent independent review and evaluation within 12 to 24 months of any change to the MBS to ensure that the proposals are delivering value for money and improved patient care in the manner contended by the MBS Review Taskforce. This must also involve the collection of appropriate baseline data before a change is made to the MBS to ensure that this independent review and evaluation can be validly conducted.

If this recommendation is implemented, AHHA also strongly encourages the Government to consider the merits of including a sunset clause on the proposal given the substantial cost and presently uncertain cost-benefit justification.

7. Increase access to care facilitation services for patients

AHHA supports improving access to care facilitation services, such as a system coordinator role, for PHNs with additional resources provided.

This could include:

- educating patients and carers about and encouraging the use of case conferencing where appropriate—both prior to and at the point of hospital discharge, as well as in the community—to ensure that care is integrated across all domains; and
- providing data to GPs on carefully selected metrics that measure their requesting, referring and prescribing behaviours, compared to a benchmark of their peers; and encouraging GP training organisations and PHNs to take greater responsibility for promoting and developing stewardship and leadership.

AHHA also notes that there are a range of ways that care facilitation services could be provided to patients, and flexible options should be available to meet the needs of individual patients.

8. Activate and engage patients in their own care planning

AHHA supports this recommendation. This approach to care should see a partnership between a patient and their team of healthcare providers, families and carers. Key characteristics include:

- healthcare should be whole-person oriented, and should acknowledge and support cultural and social needs
- understanding and respecting patients' preferences, values, goals, experiences and expectations
- patients should be engaged as partners in care planning and design
- patients should be supported as partners at the centre of the care team, with recognition of the role their families and carers play in their care
- patients and their carers should receive adequate information to enable informed consent to the proposed course of treatment, interventions and any related costs.

In addition to active and engaged patients in their own care planning, patients must be also be genuinely engaged in co-designing services and how the entire health system functions across hospitals, primary health care and prevention activities[5].

9. Rebate participation in case conferencing for non-GP health professionals

AHHA supports improving access to multi-disciplinary team-based care and case conferencing as part of effective chronic disease management, and ensuring that the patient is engaged in their own care planning. AHHA equally supports enabling non-doctor health practitioners to claim an MBS item for participation in a case conference as a means to facilitate greater inter-disciplinary involvement in case conferences.

10. Build the evidence base for Health Assessments and ensure that the content of Health Assessments conforms to appropriate clinical practice guidelines

AHHA supports establishment of processes to collect evidence on and measure the effectiveness of Health Assessments with a focus on at-risk populations. This should include data aggregated at the

[5] Dawda P 2015, *Bundled payments: Their role in Australian primary health* care, Australian Healthcare and Hospitals Association, Canberra, https://ahha.asn.au/sites/default/files/docs/policy-issue/bundled_payments_role_in_australian_primary_health_care_0.pdf.

PHN level based on existing groups eligible for Health Assessments, and should influence commissioning studies to establish evidence for Health Assessments for identified at-risk groups.

11. Delete Health Assessments less than 30 minutes and expand the at-risk groups who are eligible for Health Assessments

AHHA is unable to support recommendations based on the use of a patient enrolment fee without greater detail as noted above. Upcoding practices are not supported until evidence becomes available to support the practice.

12. Link Medication Management Reviews (MMRs) to GPMPs and reduce the schedule fee

In principle, AHHA supports this recommendation. However, the eligibility criteria for MMRs not only includes patients who have a chronic medical condition, but also those with complex medication regimens. Specifying that MMRs be claimed only in conjunction with GPMPs, which are restricted to patients with chronic medical conditions, will limit MMRs being provided to the latter group of patients.

Further consideration would need to be given to patients who have complex medication regimens and would benefit from an MMR, but who do not meet the definition of having a chronic medical condition. It must be ensured that these patients are not disadvantaged and that GPs are supported to participate in MMRs for people with complex medication regimens but who do not have a chronic medical condition. A review is recommended in the first instance.

AHHA supports appropriately trained allied health professionals to assist with information gathering that would allow an accredited pharmacist to complete the MMR without being physically present, for use in very remote communities where timely access to an accredited pharmacist is not feasible.

13. Increase the rebate for home visits for patients with a GPMP

AHHA supports this recommendation in principle, while noting that the quantum of the increase in the schedule fee has not been specified.

14. Introduce a 6 minute minimum time for a Level B consultation item

AHHA supports this recommendation, and in particular notes the existing descriptor for Level A MBS items.

15. Introduce a new Level E consultation item at 60 minutes or more

AHHA supports this recommendation in principle. However, it is noted the wording on the recommended level of remuneration is vague and open to interpretation. AHHA recommends that where, “the new schedule fee should have the same per-minute rate as a Level D consultation” that this be calculated on the basis of the current average length of time for Level D consultations.

16. Increase access to primary health care in Residential Aged Care Facilities

Access to primary care by older Australians living in residential aged care facilities or for those unable to leave their home is often challenging. An increasing number of GPs are choosing not to provide services to people living in residential aged care and many are no longer doing home visits to older people living in the community.

Many people, upon entering residential aged care find that their GP is no longer able to continue providing them with healthcare, disrupting their continuity of care.

Current fee-for-service models limit innovative modalities of care provision, restricting the use of flexible and potentially more efficient methods of providing primary care services, e.g. follow up telephone conversations or video consultations. While it is recognised that the MBS Review Taskforce have provided recommendations for reforms in this area—to date these recommendations have been limited to care provided by GPs and nurse practitioners.

Better access to responsive, appropriate, high-quality and safe primary care and general practice services is needed for many people receiving aged care services.

Primary care available to those receiving aged care services should align with the quality of care available to other Australians.

Access to clinically appropriate, high-quality and safe primary care must be available to people receiving aged care services when required. This may involve inreach/outreach models to enhance access to care.

Changes to MBS items provided by primary healthcare providers to allow flexible access including non face-to-face consultations (e.g. telephone, videoconsultations, etc.) are needed to improve access and responsiveness.

AHHA rejects a “flag fall” payment implemented in isolation unless evidence is provided in support of the need of this payment and details on the payment’s quantum is specified.

17. Update language across the MBS to better reflect the role of registered and enrolled nurses

AHHA supports this recommendation.

18. Amend the specialist consultation telehealth items to make clear that GPs are able to claim the items

AHHA supports flexible access including non-face-to-face access (for example: telephone, email, videoconsulting, telehealth, etc.) for consumers facing difficulties in accessing face-to-face consultations (for example: remote, rural, disabled) be made available as soon as possible.

Conclusion

There is a clear need for an ongoing and transparent review of MBS items to ensure they are evidence-based, fit-for-purpose, reflect contemporary medical practice and offer value for money.

Changes to the MBS must improve continuity of care and management of chronic conditions, and must take into account the financial impacts for patients and clinicians providing services. Any changes associated with a significantly increased cost to the MBS must be supported by evidence.

AHHA supports the establishment of sunset clauses to remove the necessity of exhaustive review processes every few decades and to strengthen the ongoing sustainability of the Medicare Benefits Scheme, as well as rapid reviews to allow the Medicare Services Advisory Committee to speed up some applications to add new services to the MBS.

Reforming payment models in relation to the care and support needed in the community should form part of a modern and responsive health system.

Collaboration between general practice, local hospitals and health networks (public and private) can support population health planning and reduction of inequities in health service access and health outcomes. We support the role of Primary Health Networks in facilitating this collaboration, and note the key role general practice and the broader primary health workforce must play in shaping collaboration.

Collaboration should include opportunities to pool funding, particularly to address preventable hospitalisations and to promote innovative models of care. AHHA has made a number of recommendations regarding health system governance in our *Healthy people, healthy systems* blueprint, available online at www.ahha.asn.au/Blueprint.

While primary care and greater system integration are part of the solution to better patient care, we must also acknowledge and address health and social inequalities, better utilise data and technology, promote better engagement between clinicians and patients, increase attention on transitions of care, focus more on advanced care planning and shift the system toward value-based care that is focused on patient outcomes.

Reducing preventable hospitalisations in order to improve health outcomes and reduce unnecessary healthcare system costs is a longstanding concern, and finding solutions will require effort, investment, research and system redesign. General practitioners must be engaged in this redesign, together with patients, other primary health providers, the acute care sector and policy makers.

Achieving and evaluating these goals will take both time and investment, and will challenge existing models of care and practices to enable all care providers to work to the top of their licence.

Sincerely,

Alison Verhoeven
Chief Executive
Australian Healthcare and Hospitals Association

Attachment: *Healthy people, healthy systems*