Primary care reform using a layered approach to the Medicare Benefits Scheme: unpredictable and unmeasured

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The time has come to review and reflect on where these reforms are meant to be leading

There is now a plethora of new Medicare Benefits Scheme (MBS) item numbers encompassing chronic disease management, diabetes annual cycle of care, asthma cycle of care, 45-year-old health check, health assessments for older people and refugees, general practitioner mental health care, pregnancy support counselling service, and domiciliary medication management reviews. The availability of these item numbers would appear to be logical, as they are linked to important national policy initiatives such as the National Chronic Disease Strategy,[1] Australian Better Health Initiative,[2] and the National Mental Health Strategy.[3] However, of increasing concern is that, with each budget cycle, another layer of new MBS item numbers is added. There is little clarification of what the final end point of these reforms will be. If the goal is a strong, robust and integrated primary care system[4] that will deliver improved outcomes for these patient groups, then using the rather crude tool of successive new MBS item numbers alone is unpredictable[5] and is likely to provide only part of the solution.

There is a paucity of published evidence that the new MBS item numbers have improved patient care. Some improvements in patients with diabetes have been noted,[6,7] and smaller studies have found positive changes in referrals to allied health professionals due to the use of care plans.[8] In a review of information technology and health, Georgeff cited evidence that "less than 14% of patients with chronic disease are placed on care plans" and less than 1% are followed to see if patients adhere to these plans.[9] In this issue of

the Journal (*page 100*), Hickie and McGorry query the geographical distribution of the uptake of the mental health items, the out-of-pocket expenses for patients referred, and the possible absence of focus on the highest risk groups.[10] They suggest that the uptake is in groups who were already accessing psychological support services.[10] Another study found further evidence regarding the lack of equity in use of health assessments.[11]

It is an indictment of the health bureaucracy that no systematic evaluation has been established to formally assess the effect of these new MBS items. Earlier evaluations for the original enhanced primary care item numbers[12] and asthma Service Incentive Payment (SIP) item number[13] have resulted in constructive innovations. If the overall aim is an integrated general practice that can manage the burgeoning number of patients with these conditions, then it is important to gather evidence to support this hypothesis. Over the period from July 2005 to June 2006, the number of health assessments claimed for was 285 861; care plans and case conferences, 1 234 703; GP diabetes, asthma and mental health items, 249 620; and the use of psychological strategies, 30 261.[14] This is about 2% of the 90 million patient consultations completed over this period. Yet we do not know the patient impact and cost-effectiveness of these activities. GPs are voting with their feet and continuing to focus on the core of general practice — the consultation. Red tape, GP workforce shortages and the paucity of trained allied health professionals have been regularly cited as causing the lack of uptake of these items.[15] Jurisdictional differences between state, territory and federal governments also continue to surface as key barriers for evidence-based health policy.

Also in this issue of the Journal (*page 104*), Harris and Zwar outline concerns with chronic illness,[16] arguing that these new chronic disease items are only part of a fully functional chronic disease model. The complete model would include:[17]

- clinical information systems that measure quality of care;
- actively implemented decision support and guidelines;
- ongoing information management and data exchange;
- integrated chronic condition self-management programs;
- appropriate finance systems;
- practice-based teams; and
- community and consumer linkages.

The only elements being fully supported by the new MBS items are the final two. The principal policy response seems to be to add new MBS item numbers and then hope that Australian general practice can adapt and deliver the required outcomes. There are no regular programs to consult on or support the development of the other elements.

The way forward

The time has come to halt this approach to the MBS and review and reflect on where these reforms are meant to be leading. We need a better system. Following are some of the elements this system should include.

Developing an articulated vision for general practice and primary care

The reforms[1-3] that underpin these new MBS items require more than item numbers. A vision that is accepted by all groups, with agreed goals, effective leadership and alignment across all governments and local non-government providers, is vital if these reforms are to deliver the desired outcomes.

Methods of increased accountability that foster quality and accessibility for all groups

Models that "reward practices for delivering clinical and organisational quality", such as in the United Kingdom,[18] need exploring. Since 2004, general practices in the UK have been given the opportunity to receive extra funding for achieving a range of specific standards in clinical areas (eg, stroke, diabetes, and asthma), practice organisation (eg, information for patients), patient experience, and additional services.[18] In a similar way, Australian general practices should be financially rewarded with extra payments for reaching agreed practice-based targets for health assessments, diabetes SIP, and GP chronic disease items. This model would need to be supported by ongoing practice-based audits, which could be implemented by the Divisions of General Practice.

Supporting longer consultations

A debate is required about whether a financial model that rewards GPs for spending more time with the patients would achieve as much as the plethora of new item numbers.[19]

Improving the infrastructure to foster the use of shared e-health records

It has been calculated that $1.5 billion could be saved by "improved knowledge sharing and care plan management".[9] Providing financial incentives to all GPs and allied health providers to foster the use of shared records with the electronic delivery of referrals and discharge summaries is a logical initial first step.[9]

Improving the flexibility of delivery of chronic disease programs

Funding self-management programs,[20] and allowing other allied health groups to instigate multidisciplinary care plans and establish the primary care teams in partnership with general practice are other options.

The health priorities that underpin the MBS item evolution will not disappear. They will only increase and we have a pressing need to find solutions that will provide sustainable and acceptable solutions. But the time to gather evidence for effectiveness and efficacy is long overdue.

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