AMA

Improving care for patients with chronic and complex care needs

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The AMA recognises the need for more efficient arrangements to support the provision of well-coordinated multidisciplinary care to patients with chronic and complex disease. If access to coordinated multidisciplinary care is improved then patients will benefit, the number of avoidable hospital admissions can be reduced, and long-term savings to the health system will be generated.

In considering this issue, it is important to recognise that current MBS arrangements are meeting the needs of most patients. The Government's own draft Primary Care Strategy said in this regard that *supported by the Medicare Benefits Schedule (MBS), most Australians have good access to affordable services provided through general practice, have a choice of provider, and have been supported in their access to many specialist and diagnostic services*.

The AMA supports a comprehensive approach to the management of chronic and complex disease based on arrangements that:

- Provide GP-coordinated access for patients to services based on clinical need;
- Provide a patient's usual GP with the support they need to improve the care they can provide/organise for patients with chronic and complex disease;
- Support GPs to facilitate access for their patients to other members of a multi-disciplinary primary care team;
- Continue to ensure that funding follows the patient;
- Lead to better collaboration with existing service providers; and
- Simplify and enhance the existing MBS chronic disease arrangements.

Commonwealth Government's diabetes care funding proposal

The National Health and Hospitals Reform Commission (NHHRC), in its June 2009 Final Report, recognised the challenges of an ageing population and the increasing prevalence of chronic and complex disease. It recommended, among other measures, the introduction of voluntary enrolment for patients with chronic and complex disease – linked to pay for performance benchmarks and bundled payments for an enrolled patient's care.

The Government on 31 March 2010 announced a $436m funding package to support patients with diabetes. The proposal is disease specific and is significantly more limited in scope than that which was proposed by the NHHRC, although voluntary patient enrolment, pay for performance and bundled payments for an enrolled patient's care are still at the core of this proposal.

The Government failed to consult adequately with the medical profession in the development of its diabetes funding care proposal. While the Government has said it will work with the profession to implement the program, there are many areas of important detail that the Government should have already made clear in its policy announcement including:

- Will the payments made to practices for the care of an enrolled patient cover diabetes related care, or is the payment intended to cover all health care that a patient receives at a practice?
- What arrangements will be put in place for those patients that need more care than the Government has funded?
- Will patients be able to opt out of the program after they have enrolled?
- How does the new program impact on patients' access to the Medicare Safety Net arrangements?
- Will the program be open to all general practices, or only those that are accredited?
- Will practices be able to charge a fee for services delivered to enrolled patients?

- How will a patient's ongoing relationship with their usual GP be preserved, given that the financial responsibility for a patient's care will lie with the practice?
- Will proposed financial arrangements mean that practices will take greater responsibility for decisions about the delivery of patient care, potentially interfering with a GP's management of their patient?
- How will GPs be remunerated for the time that they spend with patients given that MBS access for enrolled patients will be removed?
- Will the payments made under the program vary according to the severity of a patient's diabetes and other conditions and, if so, how will this be calculated?
- Will payments made under the program be indexed over time and what formula will be used for this purpose?
- How will the money for allied health services be distributed and what services will qualify?
- Will other support services such as mobility aids qualify for support under the program?
- How will the higher costs of delivering multidisciplinary care in areas such as rural Australia be recognised?
- Will practices face extra red tape and will they need to negotiate fee arrangements with other health providers as part of managing an enrolled patient's care?
- How will patient data be managed securely, who will be responsible for determining the relevant performance criteria and who will monitor the performance of practices against this criteria?
- Will the Government seek to measure processes or patient outcomes?
- Will the Government provide incentives for patient compliance as part of the program?

The Government has also stated that it will move over time to include other chronic diseases in these arrangements, where this is clinically appropriate, and as early evidence from this initiative becomes available.

This statement highlights that, in many respects, the jury is still out when it comes to the question of whether this type of program will actually improve overall patient care. The AMA believes that the Government should not be experimenting with new models of patient care when significant gains can be made by improving existing systems and processes so that they provide GPs and their patients with the support they need.

The Government's proposal will limit access to care and undermine the doctor/patient relationship.

Current Medicare arrangements provide support to patients so that they can see a GP when they need to. MBS funding follows the patient and the rebate is directly linked to the provision of a service by a GP. Patients with chronic and complex disease can also access some allied health on referral from a GP in defined clinical circumstances. The Government only pays for the services that are delivered.

Where patients face significant out-of-pocket costs for out-of-hospital services, the Medicare Safety Net will pick up 80% of these costs once certain thresholds are reached.

In contrast, the Government's funding proposal will allow patients with diabetes to choose to opt out of their Medicare entitlement and enrol with a general practice in order to be eligible for a "bundle of care services". This represents the most fundamental change to Medicare since its inception.

The AMA believes that there are inherent weaknesses in the Government's approach, particularly when it is compared to the proven fee for service model that has operated so effectively in Australia. The Government's approach is based on capitation, which is used overseas in countries such as the United Kingdom. In particular, capitation:

- provides a perverse incentive for practices to maximise enrolments, which means that GPs will often spend less time with patients when compared with fee for service:
- may lead to poor compliance with recommended number of visits when compared to fee for service;
- can result in more hospital referrals (in direct contrast to stated Government aims) when compared to

fee for service;
- relies on a capped funding formula, which means that sicker patients may find it more difficult to access services once the funding cap is reached; and
- will place more burdensome red tape on general practice.

The Government also proposes to direct funding under the diabetes program to general practices, rather than the doctors that deliver the care to patients. This means that the financial responsibility for a patient's care will lie with the practice itself. A patient's control over their care will be diminished and practices may seek to interfere with clinical decisions made by GPs about the care of their patient for purely economic reasons. GPs will inevitably be forced to ration access to care for patients based on a budget set by the Government.

Outcomes-based payments

GPs are highly trained professionals who are accountable to their patients and work within established codes of professional conduct. GPs are the highest trained general health professional and assess/manage patients according to their overall health needs and not in relation to a single disease.

The Government proposes a system where practices will receive outcomes-based payments for the achievement of certain performance criteria.

Again, providing the money to the practice will potentially interfere with the doctor/patient relationship while "outcomes based payment" systems have inherent problems that are very difficult to solve including:

- performance incentives will drive activity regardless of whether or not it is in the patient's best interest;
- the attainment of performance targets can become the focus rather than the provision of quality care;
- arrangements that measure processes are not a measure of patient outcomes;
- performance targets can be open to data manipulation and gaming;
- it is unfair to hold GPs accountable for patient behaviours; and
- performance targets are often based on single disease protocols and do not take into account the needs of patients with multiple conditions.

The AMA has a comprehensive plan for patients with complex and chronic disease

Australia has a high-quality primary health care system, built on the solid foundation of the role of the GP. GPs could do more to provide access to multidisciplinary care and support services for patients with chronic and complex disease. However, existing chronic disease management arrangements are too limited, cumbersome, difficult for patients to access, and are wrapped up in red tape and bureaucracy.

To deliver real benefits for patients and maximise the impact of available funding, new arrangements need to be put in place that better support GPs to provide patients with chronic and complex disease with access to multidisciplinary care and essential support services. The Government's limited program for patients with diabetes will not achieve this goal.

The NHHRC suggested "An enhanced Medicare in the future"[1] that:

- Supplements medical services with a broad package of health services (allied health, nursing and other health professionals) to support complex and continuing care;
- In addition to personal individual consultations, encourages and supports team-based and multidisciplinary care;

1 Excerpts from National Health and Hospital Reform Commission Final Report June 2009 Table 4.1 An evolving Medicare

- Adds to current benefits as it pays for a mix of private and publicly delivered services (expanded to cover state-funded primary health care services, public hospital outpatient specialist services and selected allied health and other health professional services);
- Adds greater scope to support stronger focus on prevention, health promotion, early intervention and wellbeing, including supporting people in self-management;
- Supports a broader range of specified services by health professionals providing care within their defined scope of practice (and provided it is safe and cost-effective) and for innovative, collaborative care models within services;
- Supports the development of more integrated safety net arrangements that protect people from unaffordable costs; and
- Also pays for different types of services – email, telephone, telehealth (e.g. video conferencing) – that do not involve the physical presence of the patient. Payment for these services may be part of episodic payment or grant payments.

The AMA believes that there is a much simpler way of reforming the current system than proposed by the Government, which satisfies the intentions of the NHHRC goals as detailed above.

GP Management Plans

GP Management Plan (GPMP) arrangements in the MBS provide a structured approach to caring for patients with chronic and complex disease, although presently they do not provide patients with access to allied health and other support services. To provide access to allied health services GPs must also prepare a team care arrangement, which involves additional red tape.

We know that early intervention helps to improve health outcomes and in this regard initial access to a limited number of multidisciplinary and other support services through GPMPs could yield significant benefits for patients. The GPMP pathway could also provide access to medically appropriate preventive health services for individuals at high risk, eg developmental delay in children.

The AMA believes that GPMP arrangements should be simplified and reformed so that they provide "automatic" access to a predetermined number of GP referred services. On referral from a patient's usual GP, GPMP arrangements should provide patients with access to:

- Five funded visits to allied health services per annum[2];
- Parenting programs for children at risk; and
- Selected home aids including home safety, mobility aids, vital call, diabetes equipment, continence aids and therapeutic appliances.

In relation to the latter, we believe that it would be possible for Medicare Australia to contract with relevant suppliers for the provision of these services.

The existing GP Management Plan Review item in the MBS should be retained and enhanced so that it includes the option to provide access to extra clinically relevant allied health services beyond the threshold set out above.

Patients that need more support

For patients with chronic and complex disease that need greater support than can be provided through a GPMP, we need a new program administered through Medicare Australia that will provide these patients with streamlined access to a range of services relevant to their clinical needs.

[2] Noting that private providers, community health centres or public hospitals could provide these services

The AMA proposes an overhaul of the existing MBS Team Care Arrangement (TCA) item. Under the AMA model, the existing TCA item would essentially be transformed into an assessment item for entry into the new program. In this model the current requirement for the GP to consult with other care providers would be removed. It is burdensome and does not accord with accepted medical practice. When patients are referred by GPs to other specialists, they are not subject to the same level of prescription and red tape.

The AMA accepts that strict eligibility guidelines would need to be developed to govern access to the program, including the requirement for the patient to already have a current GPMP in place. Patients would only be eligible to access the program where they were assessed by their usual GP as requiring additional support beyond what was available through a GPMP.

This program should be used, in relation to relevant conditions, to open up funded access to the following:

- GP-referred allied health and nursing services;
- A broader range of home aids, ramps for disability, home safety, mobility aids, wheel chairs and vital call;
- Transport services to assist with access to medical or allied health care;
- An enhanced safety net for medications;
- Dressings; and
- Education programs.

The program would retain a review mechanism similar to existing MBS review items in order to assess a patient's progress and ongoing eligibility for this extra support.

Why is this program better?

The AMA proposal is a comprehensive plan to address the needs of patients with chronic and complex disease, not a disease-specific proposal as put forward by the Government. The AMA's proposal:

- Ensures that patients do not lose their entitlement to a Medicare rebate;
- Ensures funding arrangements do not interfere in the doctor/patient relationship;
- Means patients would have more choice and greater control over decisions about their health care;
- Provides patients with multiple conditions with improved access to GP coordinated care services;
- Seeks to enhance proven existing arrangements so that they work better for patients;
- Provides access to a broad range of allied health and other support services;
- Does not require the establishment of new bureaucracies in general practice;
- Respects the professionalism of GPs and the comprehensive care that they provide to patients;
- Reduces the red tape burden on GPs; and
- Is both clinically and cost effective.

Most importantly, patients will receive care in accordance with their clinical needs rather than a predetermined budget set by governments that are not in the position to understand the care needs of individual patients.

The role of Primary Health Care Organisations

There is strong evidence to show that patients benefit significantly when their care is coordinated by their usual GP. Placing a bureaucracy such as a PHCO between patients and their usual GP will not improve primary health care delivery. The AMA has not supported the introduction of PHCOs, although we note that the Government has announced their introduction.

In this context, the AMA believes that the activities of PHCOs should be to support and complement general practice. GPs must have responsibility for planning and managing their patients' care and the introduction of PHCOs must not lead to restrictions on patients' access to a GP or their choice of a GP or other medical practitioner. There must be no restriction or change in patients' access to their Medicare rebate entitlement to see their GP.

PHCOs will be most effective if they work on improving population health planning at the local level and organise allied health services in areas of unmet need so that GPs can provide patients with access to such services.

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