Policy Issues Paper no. 12
December 1999

Context for the introduction of new MBS items

The 1999-2000 Federal Budget announced a range of measures worth $171 million that are intended to enhance the role of general practice in the primary health system. As part of this Enhanced Primary Care package (EPC), $110 million has been allocated to include new items on the Medicare Benefits Schedule for preventative health care and management. The items cover health assessments for non-indigenous Australians aged 75+ and for Aboriginal and Torres Strait Islander people aged 55+; care planning; and case conferencing. Some of the work covered by these items is the sort of work that has been carried out in a different (and far more expensive) way through the Co-ordinated Care Trials.

These new items may signal an important change in general practice, as they include some different ways of delivering and funding primary health services in a general practice setting and a possible change in emphasis in the GP role. This paper sets out some of the context for the introduction of the new MBS items.

Where have they come from?

Although the new items are being introduced as a result of negotiations by the Health Minister, Michael Wooldridge, with Senator Harradine, there have also been other influences that have helped lead to their introduction.

The negotiations between Wooldridge and Harradine aimed to get the legislation passed to allow the 31% rebates to private health insurance companies. The rationale was that the ageing population and rising incidence of chronic illnesses meant that Medicare could not cope with the demands on the public hospital system. Therefore, as well as encouraging take-up of private health options, measures were needed to prevent expensive hospital care. One of these measures was the introduction of MBS items to encourage GPs' care planning and co-ordination for those with complex needs.

GPs have long been aware of barriers to delivery of integrated care to patients. A survey of GPs conducted in 1991 found that there was significant dissatisfaction with the present system's failure to adequately reward GPs for involvement in preventive care and interactions with community health practitioners and hospitals.[1]

The funding system that splits funding responsibility for health care between three levels of government results in a complex system that is not only difficult to work in but also difficult to integrate. A fee-for-service structure for face-to-face consultations financially rewards quick throughput and does little to encourage long consultations or follow-up and planning work with other health providers. This problem has arisen particularly for GPs working with patients in areas such as mental health, aged care, domestic violence, child abuse and disability.

The Divisions' Program, which was set up largely to facilitate links between GPs and other health professionals was designed to help change the way GPs are able to work and recognised the barriers presented by the remuneration system. However, providing remuneration through

[1] R.M. Douglas, D.C. Saltman, 1991, *W(h)ither Australian General Practice?* National Centre for Epidemiology and Population Health (NCEPH), Discussion Paper Number 1. ANU: Canberra. p.11

divisions for a relatively small number of GPs to work in ways that are not remunerated through the usual payment structures can only have a limited effect. System-wide change is necessary if an increased GP role is to be achieved. GP groups, including divisions and their representative organisations have advocated for such system-wide change to allow GPs to fulfil a wider role.[2]

What's new ?

Some important precedents have been set in the descriptors for these items. The GP can be paid for work done on his/her behalf, and work GPs do outside of a face-to-face consultation with a patient is remunerated via the MBS for the first time. While some GPs may see the items as providing remuneration for work they already do, others will see them as constituting very new work.

Training program to support new items

The training that is being planned to support the introduction of the items will need to encompass a number of components, some of which may be achieved quite quickly, while others may be longer term activities. Components will include:

.

- information dissemination about the items, what they are for, who should be involved in plans and conferences, etc.
- information and training about any aspects of practice included in the items that some GPs are unfamiliar with – case conferences, instruments to use in care planning etc.
- education about what other health providers have to offer to a co-ordinated care approach
- education to other providers, to make them aware that GPs can now be paid for these activities and are likely to be available to participate in case conferences and care planning.

Of course, some rigorous evaluation will be necessary to ascertain not only how the items are being implemented, but to see if their implementation is providing any benefit to patient care.

The Minister has given responsibility for the implementation of the training to the General Practice Partnerships Advisory Council (GPPAC), which has set up the EPC Task Force to oversee the roll-out of the program. The Task Force decided that funding for the implementation strategy will be allocated to the SBOs. In Victoria, GPDV is consulting divisions to ascertain their preference for models of training. The initial response suggests that divisions generally prefer to run their own information and training sessions, using materials provided by GPDV and others. This is the model preferred by GPDV.[3]

Does using them mean addressing population health?

While some of what a GP does as part of these items may constitute activity related to population health, these items are likely to apply only to a small percentage of most GPs' practice populations. There are many other aspects of population health that are not addressed at all by participating, for example, in the occasional case conference. Other aspects may include, to name

---

[2] GPDV, 1998, *GP remuneration and integration*, submissions to Medicare Benefits Schedule Review Taskforce; Victorian Advisory Committee on General Practice, General Practice Financing Group.

[3] For more details, see GPDV's *EPC Update No. 1* (Dec 1999) and GPDV's *Draft Implementation Plan for Victorian Education & Training Program for the Enhanced Primary Care MBS Items* (Nov 1999).

only a few, establishing practice systems to identify particular groups of patients, recall systems, doing health promotion activities for people other than annual checks for those over 75, or 55.

As well as being inaccurate, making the term "population health" synonymous with "Enhanced Primary Care Package" (or "new MBS items") would be likely to result in confusion for everyone involved, including GPs.

Integration policies

The new items are a small part of a wider health policy picture that, both here and overseas, increasingly focuses on integration of the health system. Ways of involving Australian GPs in this have included the Co-ordinated Care Trials, the GP Strategy (including, but not limited to, the Divisions' Program) and now in Victoria, the redevelopment of the state-funded primary care system.

In the UK the Blair Government has developed Primary Care Groups composed of GPs and other health providers which hold the funds for all health services in a local area; [4] while in the US health funds have developed managed care arrangements. [5] The Australian strategy is quite different to both these overseas alternatives in that it is based on choices for GPs and choices for patients. Neither party is under any contractual obligation. Rather the Federal Government has provided incentives through the PIP and remuneration through the MBS to strengthen the GP role in medical case management.

Other parts of the service system have moved to case management as a means of planning the care of those with chronic, complex care needs rather than reactively responding to episodes of need. In some instances this has been more effective than others. However, the medical case management role of the GPs has been explicitly recognised previously only in the Coordinated Care Trials.

Conclusion

While some GPs may understandably feel overwhelmed in response to the continuing expansion of the general practice role, others are keen to have a central role in the care of the patient for whom they provide general health care. The level of take-up of the items among GPs remains to be seen, as does their usefulness to patients and the effect their introduction will have upon the work of divisions. There may be problems in their implementation and there may be a danger that publicising the items to GPs as an "enhanced primary care package" will suggest that general practice will have achieved integrated primary care if only GPs use these items (which do, after all, apply only to a small proportion of a GP's patients). Nevertheless, their existence is an important development in that for the first time, the Commonwealth has established an ongoing mechanism to pay GPs for a role in care planning and medical case management.

[4] Department of Health, 1998, Green Paper *Our Healthier Nation: a contract for health*, presented to UK Parliament February.
[5] Neelam Sekhri, 1999, "The case for USA-style managed care", *Global Health Reform*, Issue No. 1 April-May, p.6.