

Central Australian Aboriginal Congress Aboriginal Corporation

Submission to the Medicare Benefits Schedule Review

Executive Summary

This submission to the Medicare Benefits Schedule (MBS) Review has been prepared by the Central Australian Aboriginal Congress (Congress).

Congress is the largest Aboriginal community-controlled health service (ACCHS) in the Northern Territory, providing a comprehensive, holistic and culturally-appropriate primary health care service to more than 13 000 Aboriginal people living in and nearby Alice Springs each year.

The MBS is a valuable, core component of how ACCHSs are financed and how they provide better access to health care for Aboriginal people. The adjustments to the MBS recommended in this submission have been identified as important to improving access to these services as a key component of closing the gap in health status between Aboriginal and non-Aboriginal Australia.

The Medicare Review Taskforce's proposed vision for the MBS:

Congress supports the Taskforce's proposed vision for the MBS that: *The MBS provides affordable universal access to best practice health services that represent value for the individual patient and the health system.*

Despite the original objectives of Medicare and the MBS to support universal access to health care, there remain major inequalities in health outcomes in Australia. The most obvious inequality is the gap in health outcomes between Aboriginal and non-Aboriginal Australians. Aboriginal people still experience a disease burden that is 2.3 times higher than non-Aboriginal people.¹ The MBS review is an opportunity to narrow the gap, and to use the MBS as a tool to improve access to quality primary health care, where it is needed the most. This would create value for patients and the health system.

Primary health care is better value for money.

Primary health care is an essential, cost-effective measure of ensuring healthy populations. International evidence shows that increased primary health care systems are associated with²:

- better health outcomes
- lower mortality rates, and
- lower overall national health care costs.

Primary health care should therefore be at the forefront of the health system. Health financing and investment needs to ensure populations that are vulnerable to poorer health outcomes have adequate access to affordable primary health care services, including an available and affordable primary health care workforce. For Aboriginal people and people living in rural and remote areas, Congress has identified the following changes to the MBS that would support improvements in primary health care:

1. Recognise the value of primary health care

Recommendation 1: *Increase MBS reimbursement rates for primary health care services so that they reflect the cost-effectiveness of primary health care within the health system and its contribution to population health outcomes especially the growing burden of chronic diseases such as diabetes.*

2. Reinvest revenue back into primary health care

Recommendation 2: Ensure income generated by state and territory governments through S19 (2) exemptions of the Health Insurance Act is reinvested back into in primary health care services rather than acute services or other government priorities. This always occurs with ACCHS and is another reason why this is the best practice service model for Aboriginal primary health care.

3. Rebalance the distribution of general practitioners (GPs)

Recommendation 3: Given the undersupply of GPs in areas of need, adjust the MBS to complement existing strategies that aim to address the inequitable, geographic maldistribution including:

- a. Introducing a two-tiered loading for MBS items based on a combination of remoteness and GP population ratios
- b. Regulating the number of provider numbers to achieve a more equal distribution of GPs.

4. Support Aboriginal health practitioners and nurses working in remote Aboriginal health services to provide basic services

Recommendation 4: Given the undersupply of GPs in remote areas:

- a. Support Aboriginal health practitioners and nurses in Aboriginal health services to provide basic services by introducing new item numbers so this workforce can claim in their own right, without direct GP supervision.
- b. Remove or increase annual caps for MBS items that allow Aboriginal health workers to provide follow-up services for health assessments and supporting chronic disease case management.

5. New Items to support the uptake of clinical technology in rural and remote primary health services.

Recommendation 5: Reduce the impact of distance and provide more timely services by introducing MBS items for services including:

- a. Point-of-care testing
- b. Telehealth items for S19 (2) exempt services areas.

6. Targeted cardiovascular risk assessments: A new item to closing the gap

Recommendation 6: In light of the vast gap in mortality and morbidity rates between Aboriginal and non-Aboriginal Australians due to cardiovascular disease, introduce an Aboriginal-specific MBS item for cardiovascular risk assessment.

7. Maintain Chronic Disease Items

Recommendation 7: Ensure the quality of ongoing care for people with complex, chronic conditions is maintained by continuing the existing Chronic Disease Management (CDM) Items until new financing mechanisms (e.g. bundled payments) are in place.

Context: Primary Health Care and the MBS.

Primary health care

The MBS supports the provision of primary health care services in Australia through rebates for a range of out-of-hospital services, which in general have a clinical focus. However the role and function of Primary Health Care (PHC) itself is much broader than the defined list of numbered descriptors of the MBS.

Key health institutions have sought to define primary health care, and agree upon certain principles. The 1978 World Health Organisation's (WHO) *Declaration of Alma Ata* takes a comprehensive view of primary health care, not just in terms of treatment of illness, but also including health promotion and disease prevention, promotion of community and individual self-reliance and participation, and intersectoral action to address what is now often described as the social determinants of health – issues such as economic inequality and poverty, housing, education, alcohol and other drug use and food supply which underlie the health of populations.³

The *Alma Ata Declaration* was informed by the development of Aboriginal community controlled health services (ACCHS) in Australia which began with Redfern in 1971. Congress soon followed in 1973. In fact, Aboriginal health leaders from the then National Aboriginal and Islander Health Organisation (NAIHO) were part of the Australian government delegation at Alma Ata and were able to ensure that the ACCHS model that they had already developed informed the Alma Ata declaration. Aboriginal people had a very holistic understanding of health which also informed the WHO view that health was much more than the absence of disease but was about the complete physical, social, cultural and emotional health and well-being of people.

Therefore, from their inception, ACCHS have always provide curative, promotive, preventive and rehabilitative health care to individuals to make them well, keep them well, as well as taken action at population level to address the broader underlying social determinants of ill health. This combination of both treating sick people and making them well and at the same time addressing the very conditions that have made them sick in the first place, is the hallmark of the "both/and" approach of comprehensive primary health care. ACCHSs have been the torch bearers of this approach in Australia.

Building on the Declaration of Alma Ata, the Australian Primary Health Care Research Institute defines PHC as: "Socially appropriate, universally accessible, scientifically sound first level care provided by a suitably trained workforce supported by integrated referral systems and in a way that gives priority to those most need, maximises community and individual self-reliance and participation and involves collaboration with other sectors. It includes health promotion; illness prevention; care of the sick; advocacy; and community development. This was a definition that was first developed in the Northern Territory by the Divisions of General Practice and ACCHS played a key role in its development.

Likewise, the National Primary Health Care Strategic Framework describes primary health care as the frontline of Australia's health care system. It recognises the role of the social determinants of health and need for partnerships with other sectors, and outlines a broad range of services including: health promotion, prevention and screening, early intervention, treatment and management.⁴

Comprehensive Primary Health Care in practise.

Congress functions within the framework of a comprehensive primary health care (CPHC) service, addressing health inequities, and aiming to close the gap between Aboriginal and non-Aboriginal people. The effectiveness of this model is due to the wide and innovative range of strategies that provide equity of access to culturally appropriate services and programs that are affordable and acceptable to the community,⁵ and holistically care for health and wellbeing of Aboriginal people.

Another key part of the progressive realisation of the CPHC vision, which has been leading the health improvement that has occurred in the Northern Territory, has been increasing iterations of what has become known as "core primary health care services" which translate the PHC norms and principles into the core outputs of Aboriginal primary health care practice including a range of clinical services, support services, social and preventative programs and policy and advocacy functions^{6,7}. There have been three iterations of the core primary health care services model with the most recent and comprehensive version produced in 2011 in which there are five service domains⁸:

1. Clinical Services
2. Health Promotion
3. Corporate Services and Information
4. Advocacy, Knowledge, Research, Policy and Planning
5. Community Engagement, Control and Cultural Safety

Defining core services is part of defining the progressive realisation of the right to health as the obligation on governments to ensure access to evidence-based services and programs according to need is made more explicit. Australia has the resources to ensure all of the services and programs outlined in this core services model are accessible through ACCHSs. This includes services and programs in areas such as early childhood, family support, alcohol and other drug treatment and aged and disability care along with the more familiar clinical, maternal and child health, chronic disease and other services. Resourcing all of the core services will enable CPHC to make its maximum contribution to Closing the Gap. Along with the development of these core services has been the corresponding development core primary health care indicators that enable each service to track its own progress in key areas and report this to their communities.

To illustrate the model, aside from clinical services, Congress provides early childhood learning services which are expected to impact on health outcomes. Congress is scaling up and developing these services, using an evidence-based approach that has demonstrable long term impacts on the development, educational, and health outcomes of disadvantaged children. Congress also plays a significant role in employing Aboriginal people and developing strong Aboriginal leadership, which contributes to the effectiveness of ACCHS and Closing the Gap.⁹

The role of the MBS in comprehensive primary health care.

ACCHS, including Congress did not have access to the MBS until 1 July 1996. Prior to this there was a complete reliance on grant funding and in 1994 there was only about \$53 million per year to fund ACCHSs. This was not sufficient to make up for the lack of access to the major primary health care funding source – the MBS which in that same year was worth \$6 billion.

Following the transfer of responsibility for Aboriginal health from the former Aboriginal and Torres Strait Islander Commission to the Commonwealth Department of Health (DoH) in 1995 there was a decision to commission research to determine the nature of funding for Aboriginal primary health care. John Deeble, who was, along with Richard Scotton, one of the architects of Medibank which became Medicare, was commissioned to undertake this research. Alarming, he found that for every \$1 of the MBS spent on non-Aboriginal people in Australia only 27 cents was being spent on Aboriginal people. This was in spite of the fact that they were at least three times as sick, based on Standard Mortality Ratios at the time. Deeble further found that for every dollar of the PBS spent on non-Aboriginal people only 21 cents was being spent on Aboriginal people. This lack of access to the MBS and Pharmaceutical Benefits Scheme (PBS) was nowhere near offset by the grants funding coming from the Commonwealth government for Aboriginal Primary Health Care.

As a result of this data, it was no longer possible to claim that Aboriginal people were accessing primary health care in accordance to need. It was also decided that it was imperative that Aboriginal people were able to access the mainstream primary health care funding source – the MBS. This was to be in addition to grant funding, rather than instead of grant funding, as it was hoped that the combined funding (i.e. mixed mode funding) would enable the large gap in need for primary health care services to be addressed. Since July 1 1996, through exemptions from 19 (2) of the Health Insurance Act 1973, the MBS has been a core component of PHC funding for ACCHS. For Congress, in Alice Springs this amounts to more than \$4 million each year and, crucially, provides a funding mechanism for the 3000 visitors who utilise our town based service each year as these are not part of our core, per capita grant for primary health care.

The MBS has been a vital funding source for ACCHS in recent years. Grant funding has largely been capped such that the MBS has been the major source of growth funding as services, including Congress, have become more effective at appropriately accessing the MBS. This enables ACCHSs to access increased funds to meet increased need and more services in a dynamic way, without having to go through a budget appropriation process.

Access to essential services according to need has thus become more part of citizenship rights rather than requiring a “special” allocation which has previously been referred to as “welfare colonialism”. This has helped to de-politicise the funding of ACCHS as budget processes lead to a greater focus on the allocation of specific funds to Aboriginal people. This can create tensions with the wider Australian community, especially in a time of

fiscal restraint and in a context when many Australians have been wrongly led to believe that Aboriginal people get access to more than is warranted by their increased needs for services. The need for a funding mechanism to meet increasing demand for services is demonstrated by the reality that Congress has seen about a 10% growth in service utilisation as measured through "episodes of care". This has meant that Congress now provides more than 140 000 episodes of care each year whereas 10 years ago this was about 40 000.

For Congress and other ACCHSs, the MBS reimburses for services provided by eligible practitioners including general practitioners, nurses and allied health providers, for a range of services.¹⁰ These are generally consultations and procedural / therapeutic services, as well as diagnostic services.¹¹ In 2015, Medicare income was around 10 per cent of Congress' total annual income. This contributes to the existing services and plans for future growth including achieving Congress' strategic objectives and planned activities in prevention, clinical and social support services, continuous quality improvement, workforce, education and training, all of which contribute to closing the gap. The combination of MBS and total primary health care grant funding provides a level of funding that is closer to meeting the need for primary health care services as determined by the Northern Territory Aboriginal Health Forums Core Functions of Primary Health Care version 3 from 2011. There is still a need for additional primary health care funding in some areas.

Primary health care and health outcomes

While the gap in health outcomes has decreased in recent years, Aboriginal people still experience a disease burden that is 2.3 times higher than non-Aboriginal people.¹² In the Northern Territory the conditions that contribute most to the higher burden of disease for Aboriginal people are: cardiovascular diseases, mental and substance use disorders, injuries, kidney & urinary diseases, infectious diseases and endocrine disorders (which includes diabetes). Chronic diseases are responsible for more 70% of the gap in disease burden. This is worse in remote and very remote areas.¹³

Primary health care is associated with a more equitable distribution of health outcomes in populations.¹⁴ There is a demonstrated relationship between more or better primary care and improved health outcomes, including heart disease and stroke mortality, infant mortality, low birth weight, life expectancy, and self-rated health.¹⁵ There continues to be sound evidence that supports the link between strong primary care activities such as prevention, early intervention and comprehensive care and improved health outcomes for Aboriginal people.^{16, 17, 18}

Effective primary care also reduces the reliance of more expensive acute care, particularly for chronic conditions.¹⁹ A review of evidence shows that access to effective primary health care is strongly associated with the rates of hospitalisation for avoidable conditions i.e. admissions to hospital that could have potentially been prevented through the provision of appropriate non-hospital health services. Potentially Avoidable

Hospitalisations (PAHs) are an indicator of accessible and effective primary health care.²⁰ There are higher rates of avoidable hospitalisation when there is:

- Poorer self-reported access to medical care
- Higher costs for the consumer
- Lower ratios of GPs to population
- Increasing socioeconomic disadvantage
- Lower numbers of GP consultations
- Greater remoteness.

Primary health care should therefore be at the forefront of health system. Health financing and investment to ensure populations that are vulnerable to poorer health outcomes have adequate access to affordable primary care services, including an available and affordable primary care workforce. For Aboriginal people and people living in rural and remote areas, Congress has identified the following changes to the MBS that would support improvements in primary health care:

1. Recognise the value of primary health care

Recommendation 1

Increase MBS reimbursement rates for primary care services so that they reflect the cost-effectiveness of primary care within the health system and its contribution to population health outcomes especially through addressing the growing burden of chronic diseases such as diabetes.

There is still a heavy reliance on more expensive and highly specialised acute care in major metropolitan hospitals, rather than the redirection of resources towards high quality primary care, population health initiatives and preventative care.²¹ A major workforce analysis by the Department of Health conclude that this is both unaffordable in terms of escalating future cost, and unfavourable to optimum patient care, particularly for those with chronic conditions. A very recent report has pointed to the probably impact that inequitable access to primary health care has on unnecessary and avoidable hospitalisations which are far too prevalent in certain parts of Australia.²² A well-funded, evidence-based primary health care system can reduce the human and economic cost of these avoidable hospitalisations.

Contributing to the imbalance between acute and primary care is the significant variation and imbalance between medical specialty incomes. Procedural specialties, such as gastroenterology and ophthalmology, typically earn much higher incomes than GPs and other 'generalists' such as general physicians, psychiatrists and paediatricians, who earn the least of the medical specialties.²³ This does not sufficiently recognise the value and higher contribution of primary health care and generalist services to the health system and reinforces a disproportionate use and supply of specialist services.

The MBS could be used to strengthen primary health care by increasing reimbursement rates for the primary care and community-based providers of these services to reflect this value. A strong primary care system, adequately reimbursed will reduce the escalating demand for acute care and associated costs.

2. Reinvest revenue back into primary health care

Recommendation 2

Ensure income generated by state and territory governments through S19 (2) exemptions of the Health Insurance Act is reinvested back into primary health care services rather than acute services or other government priorities. This always occurs with ACCHS and is another reason why this is the best practice service model for Aboriginal primary health care.

Exemptions from Section 19 (2) of the Health Insurance Act 1973 allow salaried health professionals to claim MBS items. S19 (2) exemptions occur in ACCHSs and for state and territory government employed primary care doctors who are working primarily in Aboriginal health in rural and remote areas of need (e.g. populations under 7000). In principle, funds generated by S19 (2) exemptions must be used to enhance primary health care in the Aboriginal community in which they are generated. The benefits actually belong to the patients and should be spent in ways that clearly benefit the very patients from whom the benefits are derived in a transparent and accountable manner.

One of the key strengths of the MBS is the funding is generated at the locus of the doctor / patient consultation and is not normally able to be used as a defacto grant in terms of Commonwealth state funding arrangements. A major concern for Aboriginal communities that do not have the benefit of their own ACCHS is that the Medicare money that is generated through the care they receive can simply be used to enable cost shifting between Commonwealth and state and territory governments with no net gain in PHC services.

For example, the previous CLP government in the NT in the 2015/16 financial year reduced the funding into PHC by \$6 million and told all of their District Medical Officers to generate an additional \$6 million in MBS to make up for the funding cut. This does not lead to doctors who are motivated to even use the MBS properly and this partly explains why the utilisation of the MBS is so much lower for NT government health services compared with ACCHS. It is an abuse of the principle of the 19 (2) exemption and should not be allowed to continue.

All ACCHSs currently report on the expenditure that the exemption generates which is reinvested back into comprehensive primary care services. This is transparent and accountable to their members through the audited statements at the AGM and to the Commonwealth DoH. There is no mechanism in place to ensure state and territory health departments report on 19 (2) generated funds in the same way and there is a lack of transparency on how these funds are spent. Originally there was a requirement for state and territory government to report each year to the Aboriginal Health Planning Forum about the MBS they had generated and what the funds were being used for, but this has not happened for more than a decade.

It is recommended that all S19 (2) exempt service areas are required to report to the Commonwealth Department of Health, on S19 (2) generated income to ensure that the income is invested in primary care services rather than acute services. Failure to comply should lead to the removal of the 19 (2) exemption.

3. Rebalance the distribution of general practitioners

Recommendation 3

Given the undersupply of GPs in areas of need, adjust the MBS to complement existing strategies that aim to address the inequitable, geographic maldistribution including:

- c. Introducing a two-tiered loading for MBS items based on a combination of remoteness and GP population ratios*
- d. Regulating the number of provider numbers to achieve a more equal distribution of GPs.*

Areas of need are underserved by GPs and are determined by the medical boards through the Australian Health Professionals Registration Authority (AHPRA).

Higher ratios of general practitioners to populations are associated with better health outcomes particularly for disadvantaged populations.²⁴ The most recent report on Australia's medical workforce by the Australian Institute of Health and Welfare (AIHW) indicates that GPs numbers rose minimally from 109 per 100,000 population in 2008 to 114 in 2009, 2012 and 2015.²⁵ The data show the supply of GPs was the highest in *Remote/Very remote* areas in 2015 at 136 FTE per 100,000 population compared with the national rate of 112. The report prompted the Assistant Minister for Rural Health to comment that "the geographic spread of doctors between city and country has greatly improved" and that "...access to GPs in regional areas is now comparable to access in metropolitan areas."²⁶

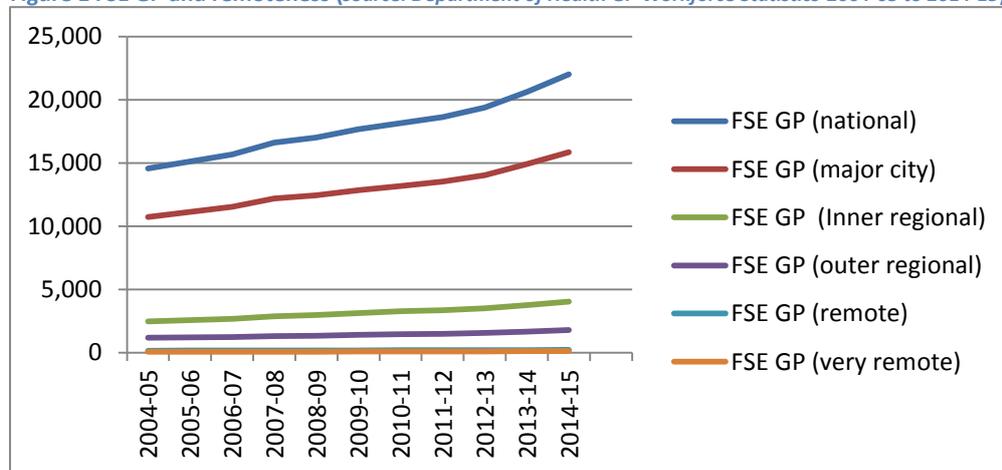
The report however, should be read with some caution. The AIHW notes that the numbers do not necessarily imply remote and very remote populations are better off in terms of access to GP services and that this may reflect different service delivery models and higher levels of demand in some areas. Additionally, the AIHW have calculated the supply of GPs as 'full-time equivalent' (FTE) practitioners working based on the total hours worked reported by medical practitioners who are registered with the Medical Board of Australia and who have undertaken a voluntary Medical Workforce Survey.

Conversely the Commonwealth DoH now looks at GP workforce data using the Full Service Equivalent (FSE) as a measure of workforce activity.²⁷ FSE supersedes and replaces the previously used FTE. The DoH notes that workforce activity is more meaningful than simple headcounts when monitoring the availability of medical practitioners, as not all practitioners work standard hours. FSE was developed to provide a robust estimate of workforce activity in Medicare. Hence, Congress views this data as more reliable when looking at GP services that are available in the bush.

According to the DoH FSE data, GP availability in metropolitan areas is currently 92 per 100,000 population while it is 80 per 100,000 in outer regional, remote and very remote

areas. Additionally, a sharp rise in the availability of GPs in metropolitan and inner regional towns has occurred between 2004/5 and 2014/15, compared with rural and remote areas (Figure 1).

Figure 1 FSE GP and remoteness (source: Department of Health GP Workforce Statistics-2004-05 to 2014-15)



The DoH acknowledges that the geographic maldistribution of GPs means "...inadequate or non-existent service provision in some rural and remote areas, and to populations of extreme disadvantage, most particularly the Aboriginal and Torres Strait Islander communities and some outer metropolitan communities."²⁸ Many incentives and levers are in place to improve the balance of the medical workforce towards areas of need, including the General Practice Rural Incentives Programme, and exemptions on the moratorium for providers numbers for International Medical Graduates (IMGs) who work in areas of need.^{29,30} These are insufficient as distribution is still very inequitable.

Optimal number of GPs per population is subject to debate. Compounding the issue is the changing health needs of all Australians, including the ageing population and rising rates of long-term conditions. None-the-less, lower ratios of GPs to population are linked to higher rates of avoidable hospitalisations and poorer health outcomes. ^{31,32} Given the poorer health outcomes in rural and remote areas, and the significant gap between Aboriginal and non-Aboriginal people, there is a need for more GP services in the bush.

GPs continue to be attracted to cities and are concentrated in metropolitan areas.

GP numbers have increased by 47 per cent in over ten years.³³ According to a recent analysis by the Australian Population Research Institute, an increase in the numbers of IMGs has significantly contributed to the current number of GPs.³⁴ The number of IMGs have more than doubled in ten years. Higher numbers will be compounded by the increase in the number of medical school training places and the expected rise in number of new Australian Trained Doctors.

The purpose of promoting IMGs was to fill roles in underserved areas, including rural and remote areas. However IMGs are shifting to metropolitan areas within the total head count in major cities doubling in ten years to 8550 while rural and remote area overseas

trained doctor numbers rose to 2426.³⁵ This is creating greater inequity in access to GPs in Australia such that the populations with the highest levels of illness have the least access to GPs. There is no need to have an argument about the ideal ration of GP to population as the public policy goal should be to ensure that whatever number of GPs are currently working in Australia they need to be distributed in a manner which ensure that sickest people have increased and not decreased access. This is especially the case as different countries have very different absolute GP population ratios without much discernable difference in health outcomes. The best way to achieve maximum efficiency in the health system is to ensure unequal access for unequal need or in other words health equity. Unfortunately, the Inverse Care Law is alive and well within Australia's current Medicare system.

Increased supply and competition between GPs in metropolitan areas is contributing to high rates of bulk billing which have increased from 68 per cent to 84 per cent over ten years.³⁶ Bulk billing is used to achieve a competitive advantage by reducing costs to the consumer, and incomes are generated by high volume and high rates of service. This is not the way that primary health care can make a difference in chronic disease management and in the prevention of avoidable hospitalisations. This is a very inefficient form of practice and leads to 10 minute medicine without the major outcomes that quality primary health care can achieve. Because of the knowledge imbalance between patients and their GPs it is also relatively easy in areas of high competition to ask patients to come back for unnecessary consultations to maintain income. This is a well described phenomenon in the literature and is known as Supplier Induced Demand or SID. This has become the business model of some corporatised general practice services. It could be argued that rather than addressing the distribution of GPs in rural and remote areas IMGs are being used to increase the profit of these businesses.

Use the MBS to attract GPs to rural and remote areas of need

Rural and remote areas cannot compete with highly populated areas and the ability to generate income through high volume servicing and SID. However, the MBS could be used as a financial incentive to attract GPs to areas of undersupply. It is suggested to load MBS items in rural and remote areas of need to attract GPs to a higher income stream, complementing existing financial incentives and other non-financial incentives. For example, where the GP population ratio falls below 1 in 800, an Area of Need (AoN) could be determined and a 20% loading could be applied to all MBS items. The Australian Health Practitioner Regulation Agency could notify the Health Insurance Commission of the AoN it has determined and all GPs with provider numbers in that AoN would automatically receive the loading. The AoN could just be in Aboriginal health and not in mainstream general practice within the one town and in this case it would be the ACCHS only that has been granted AoN status and not the entire town.

In addition to covering the additional cost of providing services in remote areas, where a GP service is being provided in a RAMA 6 (remote centre) location there could be a 10% loading. In a RAMA 7 location, a 20% loading in addition to the loading based on GP population ratios could be applied. GP ratios per population would need to be decided upon, alongside rural classifications.

Use the MBS as a non-financial incentive to steer GPs to areas of relative undersupply

Consideration could also be given to the geographic restriction of provider numbers within areas where the supply is well above the national average.³⁷ Restricting access to the MBS will deter GPs from moving to areas that already have sufficient supply to ensure that reasonable GP population ratios are achieved across Australia as this will make the MBS much more efficient and effective as GPs would be distributed to work where they are most needed.

Provider numbers have previously been used as a lever to influence the location of IMGs for instance, by exempting those who work in rural areas from the 10 year moratorium on provider numbers. Restricting provider numbers in this way is constitutional because it is not directing doctors to where they must work but simply advising that there are some areas of Australia where they cannot work while leaving open many other possible workplaces. Former Federal Health Minister, Michael Wooldrige, had high level legal advice that such a restriction on provider numbers would not breach the Australian constitution and could not be considered a form of "civil conscription". There need to be a balance of financial and non-financial incentives to address the current inequity in the distribution of GPs in Australia which makes the MBS far less efficient than it would otherwise be.

4. Support Aboriginal health practitioners and nurses working in remote Aboriginal health services to provide basic services

Recommendation 4

Given the undersupply of GPs in remote areas:

- a. Support Aboriginal health practitioners and nurses in Aboriginal health services to provide basic services by introducing new item numbers so this workforce can claim in their own right, without direct GP supervision.*
- b. Removed or increase annual caps for MBS items that allow Aboriginal health workers to provide follow-up services for health assessments and supporting chronic disease case management.*

New items for basic services provided by AHPs and RNs

A high quality Aboriginal workforce is important to ensure the system is able to meet the health needs of Aboriginal communities: they are able to bring together professional training with community and cultural understanding to improve patient care and increase cultural safety across the organisation in which they work.³⁸ Additionally, a workforce 'for' Aboriginal peoples means qualified and professional staff (whether Aboriginal or not) being able to address the specific health and wellbeing needs of Aboriginal people.

Up to two-thirds of all PHC episodes of care in remote PHC services are provided by Aboriginal Practitioners (AHP) and Registered Nurses (RN). However, the MBS reimburses a restricted range of episodes of care provided by AHPs and RNs (see Table 1).

Currently, MBS services provided by AHPs and RNs in these settings must have an initial on-site review by a medical professional. This is a major disadvantage to remote areas that have limited ready access to GPs and means that Aboriginal people living in remote areas do not access the MBS benefits they are entitled to as citizens. The loss of income constrains potential income that could be reinvested back into comprehensive primary care.

Table 1 Extant MBS items for AHPs and RNs

MBS item	Descriptor	Cost
10988*	Immunisation	12.00
10989*	Wound care	12.00
10987	Health Check follow-up	24.00
10997	Chronic Disease review	12.00
10983	Telehealth support	32.40
73802	Haemoglobin check	3.95
73806	Pregnancy test	8.70
11700	Electrocardiograph	26.60
74991	Bulk billing incentive – pathology service	9.10
10991	Bulk billing incentive – client service	9.25

The primary health care model in remote areas is built upon an expanded multidisciplinary workforce provided by AHPs, RNs, Aboriginal Health Workers, nurse practitioners etc who work as a team, within a defined scope of practice underpinned by standard treatment protocols and a robust Continuous Quality Improvement program. This is a task-sharing model and the GP remains part of this team and maintains oversight of activities.

Given there is an undersupply of GPs in rural and remote areas, new item numbers should be created so this workforce can claim in their own right, without direct GP supervision to provide basic, core primary health care services.

Self-management support and case management by AHPs

A vital role in improving Aboriginal health outcomes is in supporting health literacy, self-management (including medication adherence) and assisting in the case management of patients with complex comorbidities. MBS Item 10987 allows Aboriginal people who have received any MBS health assessment item to access Medicare rebates for follow up services provided by a practice nurse or an Aboriginal health practitioner. Likewise, patients with either a GP Management Plan or Team Care Arrangement can also receive monitoring and support services from a practice nurse or Aboriginal health practitioner on behalf of the GP (MBS item 10997).

These items are capped at 10 and 5 services per calendar year respectively. Patients have variable needs and abilities to take on complex therapeutic regimens – particularly in a cross-cultural setting. However it makes little sense to limit AHP participation to a small number of episodes of care and the cap could be raised to 25 services (fortnightly) a year or be removed altogether.

Similarly, it is also recommended that the eligibility of MBS items 10987 & 10997 be expanded to group sessions to reward AHP led interventions such as smoking cessation or chronic conditions self-management support groups. Again, such an approach reduces substantially the need for additional grant funding for these core services.

5. New Items to support the uptake of clinical technology in rural and remote primary health services.

Recommendation 5

Reduce the impact of distance and provide more timely services by introducing MBS items for services including:

- a. Point-of-care testing*
- b. Telehealth items for S19 (2) exempt services areas.*

Access to primary health care is an essential, cost-effective measure of ensuring healthy populations and a crucial factor for reducing health disparities.^{39,40} Higher proportions of Aboriginal and Torres Strait Islander people live in rural and remote regions, making access to primary care services a major challenge.⁴¹

A number of innovations are circumventing remoteness and increasing access to primary care. These include point of care testing and telehealth.

Introduce new Point-of-Care testing items

Long distances between health centres and local laboratories means the turnaround time between pathology sample collection and receipt of result can be many days. Additionally, recalling patients living in remote communities for follow-up can be also difficult.

Point-of-care (POC) pathology testing has been introduced to reduce time between pathology collection and consultation with a doctor. POC testing provides onsite, rapid pathology results and diagnostics leading to timely initiation of appropriate therapy and/or facilitation of linkages to care and referral. For example, time from HbA1c sampling to follow up consultation in remote settings has been reduced from 24 days to same day consultation with the doctor.⁴²

Point-of-care pathology testing is particularly useful in remote areas that do not have easy access to a laboratory and is simple enough to be used in remote primary care clinics. This is improving the management of both chronic and acute conditions. For example, when a patient is commencing blood thinning medications they are required to have multiple standard presentations and multiple blood tests in a short space of time. Furthermore, point-of-care testing may be used as an effective screening tool in standard consultations.

Congress recommends new point-of-care testing item numbers be introduced for existing POC tests for ACCHS, especially in very remote areas, but also in all areas as some Aboriginal patients will not access these tests if they are not done at the time of

presentation. Based on clinical services frequently provided using POC testing in ACCHS, several items are suggested in Table 2 below.

Table 2 Possible new item numbers

Point of care service	Estimated Cost per service*
International normalised ratio (INR) (iStat)	\$23.76
Troponin (iStat)	\$39.64
Blood Gas (iStat)	\$16.88
Electrolytes and Creatinine (iStat)	\$20.88
Digital Retinal photography for diabetic retinopathy	\$50.00

Allow for telehealth items in S19 (2) exempt services

Telehealth is making primary and specialist care more accessible to people in rural and remote areas. Technological innovations are improving the range of services that can be provided without requiring patients to travel a long distance. Video consultations are used for diagnostic purposes in a wide range of areas.

Telehealth is well suited to some specialties and circumstances, particularly those that may not require a physical examination, such as psychiatry and radiology.⁴³ For instance, a review examining the evidence on telehealth models in Australia and overseas found no significant difference or same outcomes in psychiatric consultations, and that patient satisfaction is higher.⁴⁴

Despite this, telehealth is yet to achieve its full potential and consultations comprise less than 1 per cent of total consultations.⁴⁵ The uptake of telehealth in rural and remote communities has been slow with only 31 per cent of the population living in regional and rural areas receiving a very small proportion of services.^{46,47}

Another contributing factor is that the MBS does not recognise telehealth services sufficiently to increase uptake.^{48,49} Additionally, telehealth items are not applied in services exempt from Section 19(2) of the *Health Insurance Act 1973*. S19(2) exemptions allow salaried health professionals to claim MBS items, which is often the case for Aboriginal Medical Services and many rural and remote services. Telehealth items should be created for GPs and other health professionals working in these areas.

This includes the following items:

- phone/video consultation for GPs providing advice to remote primary health care teams.
- Follow-up structured therapeutic sessions delivered by psychologists after an initial face to face consultation. Exemptions should also be made where the initial consultation was not required to be face-to-face in areas where this was not possible.

- Some specialist services such as dermatology and psychiatry should also be eligible in remote areas.

It is important to also consider:

- familiarity of specialists with both the health system locally and the cultural and social context of people
- the need for physical examination which requires specialist expertise and therefore precludes telehealth -for instance obstetrics and gynaecology has limited capacity for telehealth given need for physical examination, ultrasound and colposcopy
- upskilling and support which can occur with specialist outreach visits to communities as well as two way learning- this may not occur to the same extent in telehealth consultations.

An alternative to the creation of a new Telehealth item(s) is to enable Telehealth episodes of care to be claimed as standard consultation items. For example:

- Permit GPs working in 19(2) exempt PHC settings to claim standard consultation items (MBS: 3, 23, 36, 44) for Telehealth episodes of care.
- Permit GPs working in 19(2) Telehealth PHC settings to claim case conferencing items (MBS: 735, 739, 743) for Telehealth episodes of care.
- Permit RN/AHP working in 19(2) exempt PHC settings to claim telemedicine item (MBS: 10983) for consultation by telephone or videoconferencing with the supervising GP.

6. Targeted cardiovascular risk assessments: A new item to closing the gap

Recommendation 6

In light of the vast gap in mortality and morbidity rates between Aboriginal and non-Aboriginal Australians due to cardiovascular disease, introduce an Aboriginal-specific MBS item for cardiovascular risk assessment.

Increase the uptake of cost-effective, targeted preventative measures such as cardiovascular risk assessments, will address significant disparities between Aboriginal and non-Aboriginal populations. Along with injuries, cardiovascular disease is the leading contributor to the gap in fatal burden between Aboriginal and non-Aboriginal Australians.⁵⁰ Aboriginal Australians also have a hospital admission rate for heart disease that is more than twice that of non- Aboriginal Australians.⁵¹

Addressing this disparity is key to reducing Aboriginal mortality in the future and reducing the gap. The identification of risk, preventative measures and early management of cardio-vascular disease can prevent more acute complications, including avoidable hospitalisations.

Cardiovascular risk is assessed within Aboriginal -specific health checks (item 715), though is not mandatory. To encourage uptake of cardiovascular risk assessments it is recommended that an Aboriginal -specific MBS item is created for cardiovascular risk assessment. This could be triggered through the Aboriginal -specific health check for 20

years and over (as per Central Australian Rural Practitioner's Association guidelines for Aboriginal people). An indicative cost for the item would be around \$30.

7 Maintain Chronic Disease Items

Recommendation 7

Ensure the quality of ongoing care for people with complex, chronic conditions is maintained by continuing the existing Chronic Disease Management (CDM) Items until new financing mechanisms (e.g. bundled payments) are in place.

One of the key issues identified in the Professional Services Review Annual Report 2014–15 52 was the misuse of identified Chronic Disease Management (CDM) items (e.g. GP Management Plans and Team Care Arrangements) by GPs, a trend that has increased from 2013/14. These items understandably will have a high level of scrutiny in the MBS Review. It is understood that there is strong advocacy amongst some GPs to remove CDM items and replace them with increased payments on standard items.

ACCHSs, with their commitment to comprehensive models of primary health care, have been shown to play a significant role in facilitating care planning for Aboriginal and Torres Strait Islander clients: for example in 2010-11 over 90% of such services reported providing care planning and 80% reported facilitated shared care arrangements for the management of people with chronic conditions⁵³.

There is a need to maintain the existing CDM items in the short term, until new measures are in place to support ongoing, multidisciplinary care. If care planning is removed as a specific item and it is assumed to occur as part of routine care there will be a loss of quality care as care plans as they are meant to be developed will become less frequent. For people with complex care needs, including Aboriginal and Torres Strait Islander clients, the health system is already difficult to navigate.

It is recommended that CDM items are maintained until new financing arrangements to support complex long term care are in place. The outcomes of the Commonwealth Government's trial of Health Care Homes will provide new direction on financing ongoing coordination, management and support of people with chronic conditions i.e. quarterly bundled payments rather than fee-for-service payments. It would be very premature to remove these items prior to the outcome of these trials.

As a short-term measure to control the reported misuse of CDM items, the Taskforce could recommend a requirement that GPs spend a minimum of 30 minutes with the patient to claim a care plan preparation item be introduced. This could be audited to ensure compliance is being achieved.

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