Draft AMSANT response to General Practice and Primary Care Clinical Committee

1 March 2019

AMSANT is the peak body of community controlled health services in the NT. Our members provide community controlled comprehensive primary health care from Darwin to the most remote area of the NT. Our sector is the larger of the two Aboriginal PHC providers (with the other provider being the Northern Territory government) and is growing including through expansion into areas serviced by government but also through delivering services in a wider range of areas including aged care and Social and Emotional wellbeing.

Principles

We agree that equity is important but believe it should extend beyond access to include distribution of resources so that funding is provided on the basis of need more than demand (as happens with the current fee for service Medicare system). We support partnering with individuals and families, but believe this can be strengthened to include partnering with communities and community governance where possible. We do not support the use of the term consumer in relation to Aboriginal and Torres Strait Islander people seeking primary health care services. This relates in part to the meaning of health for Aboriginal and Torres Strait Islander people which is not something that can be attained through consuming services.

Recommendations

Recommendations not in the inquiry

We will also respond to the other committee reports that are out for consultation – specifically the Aboriginal and Torres Strait Islander report- therefore recommendations specific to Indigenous health items will be addressed in that submission.

One major issue that has not been covered is higher Medicare rebates for remote and isolated communities. The cost of service provision is much higher in very remote areas and we believe this should be reflected in the Medicare schedule. This is largely due to the much higher cost of attracting and retaining workforce in these areas (where often housing needs to be provided and salaries need to be higher). Work undertaken in the NT to increase equity in per capita funding has made some assessment of the relativities between regional and very remote areas – this work could be reviewed and a loading added to Medicare rebates which would assist in reducing maldistribution of doctors and other health professionals in primary health care. Maldistribution of health professionals including doctors is a major barrier to improving rural and remote health outcomes.

There has been little expansion of Medicare items available to nurses and Aboriginal Health Practitioners registered to provide clinical services. although they will benefit from expansion of

telehealth items and case conferencing items. A general consult item for these health professionals should be considered given the need to move to a multidisciplinary team where work by all team members is equally valued- noting that much of the work currently done by general practitioners can be done equally well by other team members.

A higher rebate for consults where an interpreter is used would partly compensate for the practices time in arranging the interpreter but is unlikely to fund the true cost of interpreters particularly in very remote areas.

Responses to the Committee's recommendations

Recommendation 1. Move to a patient centred primary care model supporting GP stewardship
Partially agreed although important to also recognise the expanded role of nurses and AHPs in Aboriginal PHC. We would conceive of the stewardship as being led by primary health care rather than just general practitioners.

*Recommendation 2. : A new volunt**ary patient enrolment fee, and flexible access** linked to voluntary patient enrolment.*
Recommendation 3. Flexible access include non face to face access and some after hours or emergency services for enrolled patients. If the patient enrolment is not supported, flexible non face to face access should be made available to consumers facing difficulties obtaining access (remote, rural, disabled) as soon as possible including through new MBS items

AMSANT support a health care home concept but note that there is currently a pilot of this model of care which is currently being implemented and evaluated. In the NT, six ACCHSs are engaged in the national Health Care Home trial. We definitely agree that the enrolment fee must be weighted for complexity as is occurring in the health care homes trial to ensure this approach increases equitable distribution of resources, with the current level 3 complexity funding being approximately 2.5 times as high as the level 1 tier patients. This trial seems to have the weightings approximately right but it is inequitable that there is also not a remote loading for all patients including those in tier 1.

The high rates of multimorbidity and poverty for Aboriginal people in the NT mean that the majority of people are in the two highest tiers of complexity – therefore a weighting that was not appropriately scaled could increase inequity.

Of note, such an approach must also encompass adequate funding for prevention for those who are at high risk of chronic disease in order to delay or prevent progression into chronic disease. Also we do not want a two tiered system. The enrolment fee should be bulk billed (no cost to the patient) to ensure that doctors do not start charging higher enrolment fees (not bulkbilled) to patients who can afford it with others getting a lesser degree of service. This would erode the universalism of Medicare.

A key lesson from the current trial is that rushed implementation without addressing the complex system and technical challenges has delayed reform.

Another key issue is that maldistribution of health professionals could limit the success of the model. Higher bundled payments in remote and very remote areas would partly offset the high cost of recruiting and retaining health professionals in very remote and remote areas. It also needs to be noted that regional cities such as Darwin which are surrounded by very remote areas see a very high number of transient people from remote regions, who require significant care and often spend long periods of time in Darwin. Services in regional towns and cities who are seeing high proportions of people who are homeless and transient will also need additional funding.

The model has its limitations however, in providing a care to highly mobile Aboriginal populations as it may discourage service providers from providing comprehensive health care to people who have signed up as a health care home patient in another location. This is important given the high burden of disease borne by Aboriginal people and the fact that they may spend significant period s of time in two or more communities over a 12 month period and may indeed consider that they have two "homes". This will need to be evaluated in the Health care Homes trial with mechanisms instituted to ensure that service providers outside of the patient's home are not discouraged from providing the full range of care.

Recommendations 4 and 5.
Combine GP Management Plans (GPMPs) and referrals for Team Care Arrangements (TCAs) into one MBS item, with a minimum of 40 minutes contact time with usual GP and other health professionals, with upload to MyHealth Record when possible (record exists, patient consent), and link allied health items to GPMPs. Some conditions such as alcohol dependence and morbid obesity should be excluded.

Agreed but rebate should be increased if this includes allied health referrals. It needs to be clear that the whole contact time should be inclusive of the team including the general practitioner but also other team members.

AMSANT believes the recommendations from what is excluded from chronic conditions need review. Alcohol and drug dependence should meet the criteria for a chronic condition and be included. We disagree that alcohol dependence is simply a " personal choice or behavioural issue" - this is over simplifying a complex issue with most experts now agreeing that taking a moralistic blaming approach to drug and alcohol problems is counterproductive. Alcohol and other drug abuse is often a response to very significant personal and intergenerational trauma and poverty in Aboriginal people and in other population cohorts who are disadvantaged and marginalised. Alcohol and drug dependence could be included if it was impacting on a patients physical health. Morbid obesity should be considered as at this level, it can have very serious ramifications for individuals.

AMSANT suggests the addition of non-dispensing pharmacists to items 813XX (Group M11) and for other Aboriginal and Torres Strait Islander Chronic Disease Management follow-up allied health items. Pharmacists are the only major allied health professional with a role in chronic disease who are excluded from these items. Including them would assist with embedding pharmacists in ACCHSs multidisciplinary teams, which is consistent with evidence on the role of pharmacists and the national reviews, including the 2017 Indigenous Pharmacy Programs Review.

Recommendation ***6.*** *Rebate for GPMP reviews increased to same level as GPMP; if changes, upload to MyHealth Record when possible*

Agreed- but perhaps this does not need to be overseen by a GP each time. Perhaps a lower (but still significant) rebate could be paid for a GPMP review signed off by a nurse or AHP and a higher one if signed off by the GP (noting that other team members would have done some of the work).

Recommendation 7: Increase funding for care coordination through either

- *New fee-for-service funding for care facilitation under the current set of items available for allied health appointments, for patients with a GPMP o*
- *Block funding for care facilitation, outside the MBS*
- *Additional resources for PHNs to provide care facilitation services, outside the MBS*

Agreed in principle

Block funding direct to ACCHSS (and not through the PHNs) would be more effective and equitable with more of the money hitting the ground than if it is channelled through the PHNs (where more of it will be used in administration). Currently, COAG funding provides care coordination for Aboriginal people with chronic disease, but the funding is not sufficient to reach all ACCHSs. Care coordination funding should be funded equitably (noting the higher burden of complex chronic disease in disadvantaged populations).
Care coordination should be provided within the health service – it will cause service fragmentation to provide care coordination as a separate service outside of general practice/ACCHSs.

Recommendation 8. Develop mechanisms to active and engage patients in their own care planning including assessment and support of patient health literacy

Agreed- ACCHSs should be resourced to do this locally, providing opportunities for employment for Aboriginal and Torres Strait Islander Health practitioners as well as other Aboriginal staff without AHPRA (Australian Health Practitioner Regulation Agency) registration.

Recommendation 9. Inviting patient to case conference and provide summary to patient-

Agreed but need interpreter support which is not available in Aboriginal primary health care without the service incurring unacceptable costs. This is inequitable given that there is now good access to free phone interpreters and on site interpreters for CALD people who do not speak English well - this needs to be rectified perhaps through national funding for Aboriginal interpreters.

Not all patients and families will wish to attend the case conference and so it should be allowed to proceed as long as a summary is sent to the client.

*Recommendation 10. New rebate for participation in case conferencing for non-GP health professional**s** (Aboriginal Health Practitioners, allied health, nurse practitioners)*

Agreed and we strongly agree with the inclusion of Aboriginal health Practitioners. In addition, remote area nurses and potentially practice nurses should be added to the list of health professionals able to attend and receive rebates for case conferences not involving GPs. Nurse practitioners are still relatively uncommon in remote Australia and in Aboriginal primary health care

but remote area nurses have an expanded scope of practice that is similar to primary health care nurse practitioners.

Recommendation 10. Set up processes to gather evidence on the effectiveness of Health assessments with a focus on at risk populations, and commission studies on evidence for health assessments for new at risk groups.
We agree that this check needs to be evidence based but also that the evidence base needs to be localised to what is appropriate in that region. We will go into more detail in the Aboriginal and Torres Strait Islander working group review but believe an overly prescriptive approach can lead to a tick box check up mentality that is not holistic or patient centred.

AMSANT strongly supports health check ups for released prisoners and children in out of home care. These will only improve care substantially if services are available to these cohorts in a range of areas such as SEWB/trauma counselling, alcohol and other drug counselling and for children in out of home care- cultural support, developmental services and counselling. If these services are not available, the key challenges will go unaddressed.

Prisoners should be eligible for a check up with every release from custody. Those cycling in and out of custody frequently are most likely to benefit from integrated holistic support.

Recommendation 11. Delete Health Assessments less than 30 minutes (MBS 701) and expand the at-risk groups who are eligible for Health Assessments: Children in out-of-home care (annually), prisoners on discharge from prison (once following each episode of imprisonment for six or more months), home visits for over 75 with a safety risk (annually)

Agreed, although not as relevant for Aboriginal primary health care. The 30 minute limit should be a team limit –e.g. a nurse/AHP should be able to do the bulk of health assessments.

Recommendation 12. Link Medication Management Reviews (MMRs) to GPMPs and reduce the schedule fee. Allow allied health clinicians to gather information for use by a MMR review in remote settings where a pharmacist cannot easily be present.

Agree with allowing other health professionals to be involved in remote settings so that a pharmacist does not have to be on site. Agree to include allied health involvement but also should include nurses/AHPs who are the most common health professional in remote settings and dispense and supply medications to patients

Reducing the fee for GP involvement. Do not agree with major reduction for any of these items as long as the GP has a discussion with the pharmacist before and after the MMR. MMRs conducted without substantial GP involvement are not likely to be very useful as the GP is the prescriber and also knows the patients social and family circumstances better than the pharmacist in most instance. If GPs are involved in discussing the results of the MMR with the pharmacist, it seems more likely that the MMR will result in useful changes.

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

Agreed

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

Recommendation 15.Introduce a new Level E consultation item at 60 minutes or more
Agreed- consults are particularly complex in Aboriginal health. Furthermore, emergencies particularly in remote settings may well last more than sixty minutes

AMSANT also recommends introduction of a level F consultation of >120 minutes particularly for emergency consultations in MM6 and MM7 where retrieval services may take hours to arrive.

Recommendation 16. Increase access to primary health care in Residential Aged Care Facilities through restructuring fees – "flag fall" fee plus per patient fee

Agreed. It is unfair that the consultation fee is progressively reduced the more patients are seen. Nursing home visits are often complex with time often required outside of the visit to talk to families and nursing home staff. GPs need to be adequately reimbursed for this.

Recommendation 17. Modernize language in respect to nurses
AMSANT agrees and believes remote areas nurses should also be recognised as a distinct group with extended skills – despite not being nurse practitioners, they have an extended scope of practice (as do AHPs in remote areas).

Recommendation 18 Expand telehealth items available to medical specialists to include GPs so that GPs can provide direct to patient telehealth services, and add items for GPs to provide telehealth consultations to support Nurse Practitioners and Aboriginal and Torres Strait Islander Health Practitioners consulting with patients in remote and rural settings (similar to items which currently exist to reimburse other specialists)

Agreed. There has been a huge gap caused by not having GPs being able to claim for telehealth services. The highest need for rural and remote patients is access to GPs. In specialist consults, claims by GPs should also be accepted even if the specialist does not claim. It is frustrating that primary health care misses out on these rebates because they are not claimed at the other end. There is considerable time and effort required to organise telehealth and it is a disincentive not to be adequately reimbursed for this time.

The telehealth item should *be extended to remote areas nurses* – and not just nurse practitioners. Nurse practitioners make up only a minority of nurses in remote Aboriginal PHC with most being remote areas nurses who also have an extended scope of practice (e.g. can dispense medication according to the CARPA manual).