GRATTAN Institute

Primary care policy needs more than just unfreezing rebates

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Presentation to
University of Melbourne Department of General Practice
Research Matters Seminar
June 2019

Context of primary care policy

- Changing epidemiology
- Changing technology
- Non-viability/not-fit-for purpose of GP (in rural) in this new context

- Weak evidence base for possible reform strategies (vs what others are doing)
- Changing trust
- Lack of consensus (or clarity) about reform directions

Meso structure options :

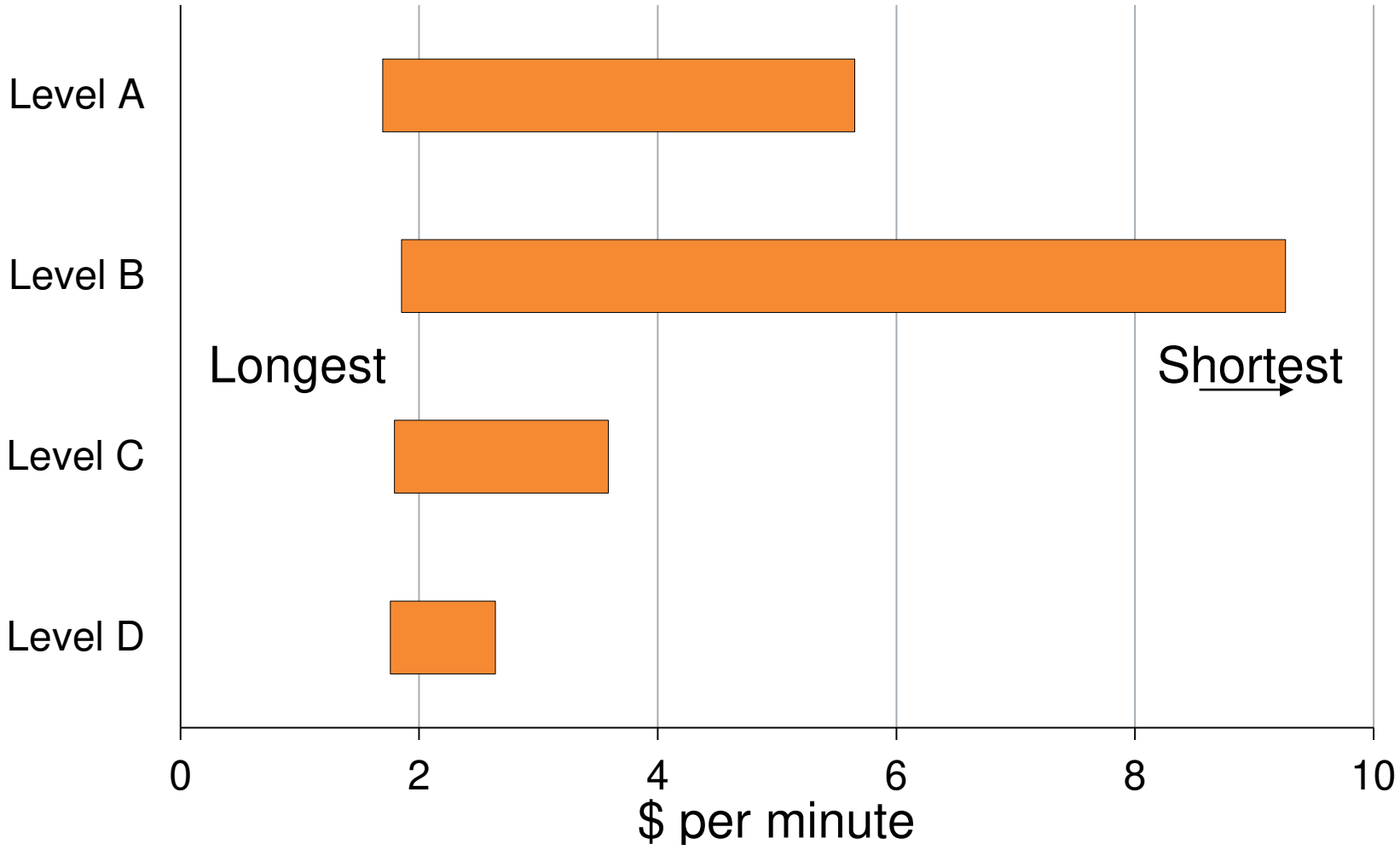
- Independent GP practices supported by PHNs
- Independent team practices part of weak or tight networks (supported by PHNs or rural local hospitals)
- Corporates

Australia's current (Commonwealth) primary care policy and funding

- rewards short consultations,
- delivered by disparate general practitioners,
- unevenly distributed across Australia,
- unsupported by good, tailored guidance,
- disconnected from specialist medical,allied health, psychologist and social worker support,
- with care commonly focusing on presenting problems,
- delivered face-to-face,
- mostly patient initiated, with prevention framed (essentially ineffectively) as a 'life style' issue,
- disconnected from other local community support service,
- with little information collected centrally about patterns of care,
- at a total cost of around $26 billion* (2017-18), 75 % of which is met by taxpayers

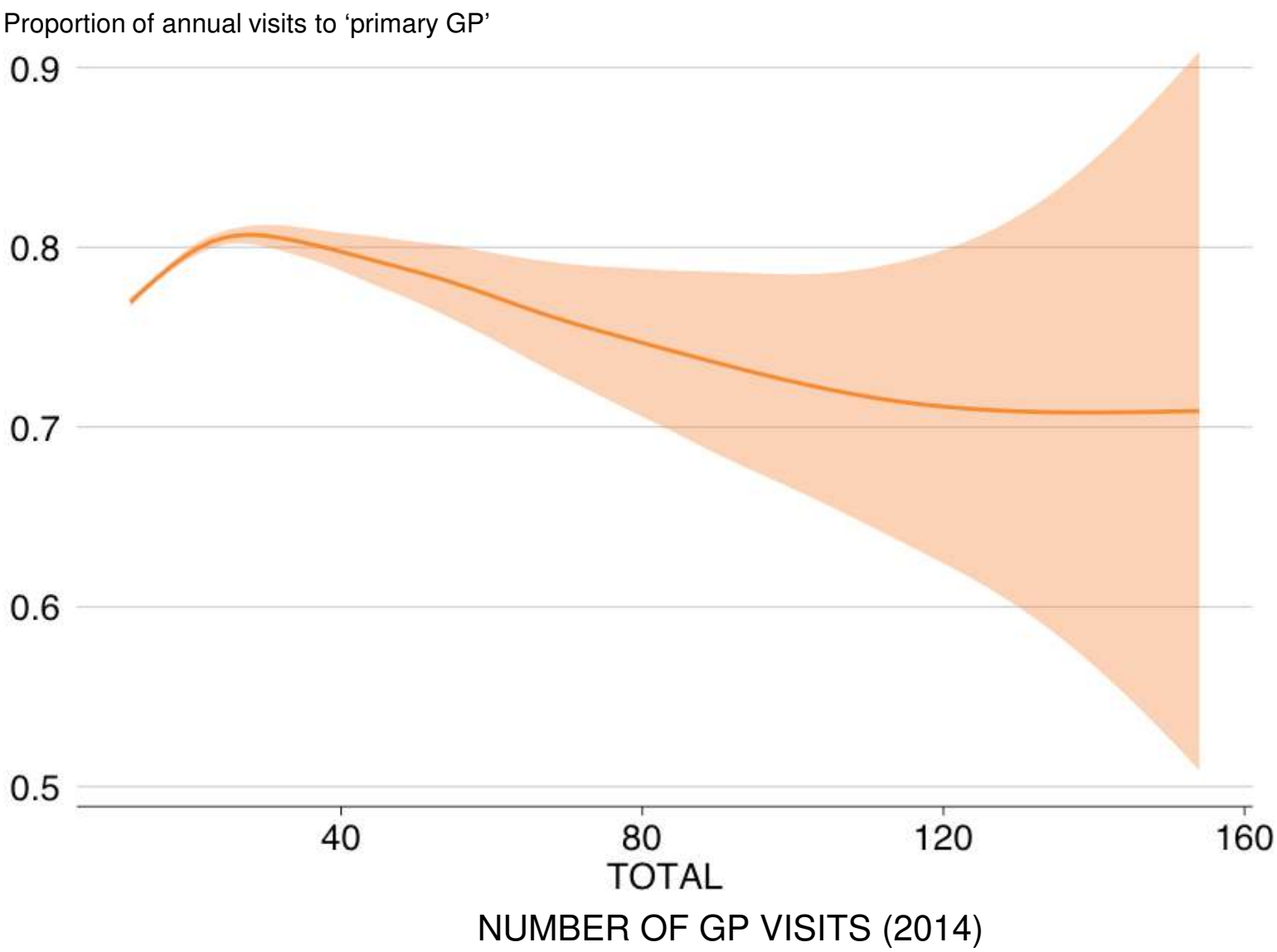
* unreferred medical ($12 b), community health, other allied health ; not including diagnostics generated

Shorter consultations are most remunerative



Notes: Assumed length ranges: Level A (3-10 minutes); Level B (4-20); Level C (20-40); Level D (40-60). Indicative only. Figures do not include income other than Level A, B, C and D MBS rebates (e.g. excludes out-of-pocket payments, practice incentive payments). Does not include time spent on indirect care (e.g. care coordination) or administration. Does not include proposed $5 cut to services for general patients

Many high users (>10 visits per year) see other GPs



Current state	Desired state
rewards short consultations	• Long consultations • Reducing potentially avoidable hospitalisations • Improving Patient Reported Outcome Measures or self-assessed health
delivered by disparate general practitioners	• Continuity with identifiable, single GP • Continuity with team practice
unevenly distributed across Australia	• More even distribution of (Australian trained) GPs • More even distribution of primary care teams
unsupported by good, tailored guidance	• Easy GP access to decision support software • Easy patient and GP access to decision support software
disconnected from specialist medical,allied health, psychologist and social worker support,	• All practices > 5 GPs (? All networks of practices) have employed allied health etc staff (vs contractual links) • All practices > 5 GPs (?networks) have sessional cardiologist, endocrinologist, general physician *(Role of GP voluntary networks, PHNs)*
delivered face-to-face	X% of GP interactions digitally Y% health care advice by endorsed AI
with little information collected centrally about patterns of care	Same range of data as with hospitals, but including more social determinants of health data