



Feedback – MBS Schedule Review Taskforce consultation

March 2019



The Victorian and Tasmanian PHN Alliance is pleased to provide feedback on the Medicare Benefits Schedule (MBS) Review Taskforce Report.

Context and roles

The Alliance provides a platform for the Tasmanian and six Victorian Primary Health Networks (PHNs) to work together. The Alliance enables the PHNs to collectively achieve the best possible outcomes for local communities and organisations through leadership, collaboration, coordination and synergy across the jurisdiction. Points on PHNs are provided as an attachment as context.

Key points

The Alliance acknowledges that the recommendations seek to allow the MBS to deliver on interests in

- i. affordable and universal access;
- ii. best practice health services;
- iii. value for the individual patient; and
- iv. value for the health system.

These interests have framed the basis for Alliance feedback. The Alliance emphasises the following key points:

- **Support for implementation and change management will be extensive and phased over the longer term.** The approach to implementation planning must not be limited to workforce-oriented strategies (e.g. via professional bodies, peak bodies, and registered training organisations) in isolation; it requires broadening to include organisational strategies. The unit of analysis must be the general practice. PHNs apply this approach. The benefits of matrixed approaches which involve a breadth of parties to extend reach and coverage should occur within the context of a regional plan for implementation (e.g. aligned to PHN catchment boundaries) to foster a coordinated approach.
- **Value for the health system must be achieved through a coordinated national approach to recommendation implementation.** Several recommendations outlined in the Interim Report seek to realise improvements through [HealthPathways](#) development, adoption, and technology. A cost-effective approach may be facilitated through a formalised, collaborative and regional approach whereby the vision for care is incorporated into broadly nationally consistent pathways. Outputs of this type may mitigate issues of unwarranted clinical variation and potentially conflicting messages. This is considered essential to ensuring both a user-oriented approach for both general practitioners (GPs) and consumers who may traverse PHN catchment boundaries, and the Taskforce's focus on realising value. There may be implications for PHN schedules and resourcing commitment that may be required to support the efforts described in the recommendations.
- **The interface between primary and acute care must be strengthened.** There are a range of items in the recommendations of relevance to Local Hospital Networks (LHNs). It is important





to note that the Victorian public hospital system comprises over 200 public and private hospitals (including day procedure centres), which form 85 health services. The Victorian LHN model is directly comparable with that of other jurisdictions. The alignment between the six Victorian PHNs are not equivalent 'like for like'. For example, Murray PHN and Western Victoria PHN have 55 and 35 hospitals and health services respectively within local catchments.

Recommendations - Vision for the future

The Alliance supports the recommendations which enable a move to a patient-centred primary care model supporting GP stewardship. This includes the principles and elements identified in the Report.

The Alliance notes the following implementation considerations:

- **Implementation planning must be comprehensive and consumer and sector responsive.** PHNs acknowledge that general practice is highly heterogenous, and therefore there may be a high level of variation in progress toward the principles and elements. As part of the General Practice Support Function and Health Care Home initiative (through the formal trials at Primary Health Tasmania and South Eastern Melbourne PHN and other general efforts), PHNs have the experience and insight to undertake assessment of readiness to inform the development of tailored localised capability building and change management efforts which align to the general practice context and support preferences. This draws from experience to date, whereby PHNs engaged with approximately 88 per cent of general practices nationally in 2018.

Tailored approaches to PHN engagement with general practice may be conceptualised a low, medium and high levels of support. Below is an overview of PHN activities in general practice support as per the PHN Program Performance and Quality Framework:

Support (discrete and/or formal activities) is provided to general practices and other health care providers in a PHN region, either directly by the PHN or by a PHN commissioned service provider. Support may include one on one support, sharing information, facilitating access to or providing training, conducting workshops or disseminating education resources across any of the below focus areas:

General practice support – PHNs provide support to general practices in their region

Population health – PHNs support health care providers to improve identification and management of population health issues

Workforce – PHNs provide support to improve health workforce cultural appropriateness and identify and address clinical skill gaps. Health workforce broadly includes all persons working in the health sector within the PHN region

Aged care – PHNs provide support to health care providers on identifying and managing health issues of older people (those 65 years and older), including support for at home care





Digital health – PHNs provide support to health care providers to adopt digital health systems and technologies. Digital health systems and technologies describe the use of digital technology to improve the delivery of health care for providers and patients

Support may occur at the following levels:

- high – targeted, tailored support to a general practice, health care provider or individual health care professional to assist in the change of a behaviour or approach. (e.g. supporting accreditation or adopting new digital health systems)
- moderate – broad based support to a general practice, health care provider or health care professional or several general practices and/or health care providers to raise awareness and knowledge. (e.g. information sessions on using My Health Record or cultural awareness training)
- low – general interactions where information may be shared (e.g. PHN representation at forums or workshops on the issue of aged care health issues etc.).¹

It is also noted that State Governments have a role in reform implementation. For example, the Victorian Government fund health services which deliver MBS funded services, including several community health services that offer general practice and privately funded services.

- **Quality improvement is the foundation for high performing primary care.** Quality improvement systems are a precursor to practice and GP readiness for patient enrollment. This includes the way workforce, funding, and organisational capability are optimised to foster patient safety and quality. The efforts of the Australian Commission on Safety and Quality in Health Care toward patient safety and quality improvement in primary care are noted.² The Alliance submission to a Commission consultation is publicly available.³
- **The vision for the future must become the intended standard or benchmark for consumer expectations.** Consumer and community engagement are foundational to the PHN approach.^{4,5} Given that several recommendations in the vision represent a significant variation from the status quo, there is need for comprehensive consumer and community health literacy strategies. Health literacy has been identified as an issue and/or regional health priority for PHNs through the population health needs assessment process. Health literacy approaches are consistent with the evidence for patient activation as a concept and measure which has been applied in the United Kingdom National Health Service (NHS) to support patient and system/commissioning activities.⁶

¹ http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Performance_Framework

² <https://www.safetyandquality.gov.au/publications/consultation-paper-patient-safety-and-quality-improvement-in-primary-care/>

³ <https://www.safetyandquality.gov.au/wp-content/uploads/2018/06/Primary-care-consultation-Victorian-PHN-Alliance.pdf>

⁴ <https://www.murrayphn.org.au/healthvoices>

⁵ <https://www.gphn.org.au/populationhealthplanning/community-engagement/>

⁶ <https://www.england.nhs.uk/ourwork/patient-participation/self-care/patient-activation/pa-fags/>





Recommendations - Voluntary patient enrolment, case facilitation, and engaging patients in their own care

The Alliance supports the recommendations which support voluntary patient enrolment, and holistic, flexible and longitudinal care models for enrolled populations and patients.

The Alliance notes the following implementation considerations:

- **There is support for recognition of the unique issues with enrolment in selected geographical areas.** This includes patients in rural and remote areas, mobile populations, and those living along State/Territory borders. There is a need for appropriate flexibility in future models given issues of patient flow and workforce constraints (e.g. models of care issues that arise from GP workforce supply and access to and level of the schedule fees for non-vocationally recognised doctors via the Rural Other Medical Practitioners or ROMPS program). The importance of flexible models of care that are co-designed with consumers within communities, are integrated in a broader rural health workforce strategy, and maximise available financial incentives and policy levers are paramount. PHNs currently undertake model of care redesign and co-design as part of core business, including proactively seeking to examine issues associated with primary care coverage and viability.
- **Organisationally focused afterhours efforts must be nested in a broader regional approach to afterhours capacity.** PHNs have a role in developing a strategic vision for afterhours primary health care for local catchments, implementation of innovative and locally-tailored solutions for afterhours services, and the conduct of work to address gaps in afterhours service provision. Consequently, there is the potential to consider how PHN general practice support, digital health functions, and sector intelligence generated, may be closely coupled with practice and GP uptake of patient enrollment. For example, there is the potential for the implementation of patient enrollment by practices to be actively supported and promoted by PHNs, to ensure there is a net positive contribution to afterhours access for local communities. This is particularly relevant for regional, rural and remote communities. The challenges of addressing these gaps in rural areas are a result of workforce constraints, the influence of incentive payments, and other drivers which can inadvertently divert provider capacity and inevitably patient demand to LHN emergency departments and urgent care centres.
- **The notion of access to care facilitation services for patients is acknowledged as having merit.** Details were supplied in the Report that included the intent of supporting care navigation and the workforce types placed to deliver this role. However, precise definition and details of the following are required to support more detailed assessment of:
 - i) the details, complete list of services, or offerings as defined under the term care facilitation, and
 - ii) how blended PHN block funded and MBS funded models would work in a coordinated manner.

The Department have supported various care facilitation and navigation models such as those for diabetes⁷ and mental health;⁸ however, these models vary such that it is not possible to assume the details of the care facilitation model implied in the Report. It is noted that models

⁷ <http://www.health.gov.au/internet/main/publishing.nsf/Content/eval-rep-dcp>

⁸ <https://blogs.unimelb.edu.au/phn-lead-site-project/>





of care facilitation which include blended payment models may need to move beyond provider and practice incentives (e.g. as understood through the Standardised Whole Patient Equivalent or SWPE and Workforce Incentive Program or WIP).

- **Coordinated approaches for patients moving between settings is essential.** A range of recommendations relating to care provision for patients post discharge from hospital, post release from prison, or as residents of aged care facilities have been outlined. There will be a need for a lead entity to be working collaboratively with partner services. For example, LHNs must define, plan and implement appropriate and timely arrangements to facilitate care transfer to a GP. Sustainable processes and system-based solutions are required which must be integrated as part of better practice hospital discharge planning processes. Similar tenets apply for people planned for release from prison. In the absence of this, there will be limited proactive mechanisms for GPs to engage with patients (and use MBS items as intended). The PHNs have embarked on a range of sector integration initiatives, including engagement with justice and correctional services to support a coordinated approach at points of transition.
- **Aligned with the evidence and policy mandate in support of carers within a patient's model of care, the Alliance highlights the interest in ensuring the contribution of carers is actively integrated in the holistic models of care where appropriate and agreed by the patient.** The contribution of carers may extend beyond the provision of copies of plans and conference summaries, and outside formal multidisciplinary case conference arrangements, health assessments and medication reviews. For example, the Victorian PHNs have a partnered with Carers Victoria to examine opportunities to enhance carer role recognition, carer contributions, and the identification of carer health needs within general practice. This is being undertaken within the context of the Victorian Carer Strategy 2018-11.⁹

Recommendations – Changes to chronic disease management item numbers and health assessments

The Alliance supports the recommendations to enhance chronic disease management item numbers and changes to health assessments.

- **Multidisciplinary team case conferencing should align with other models of secondary consultation and co-consultation.** There are a suite of specialist support and advisory structures (which may be commissioned by PHNs or State/Commonwealth Governments) to enhance capacity, including but not limited to areas such as psychiatry,¹⁰ addiction medicine and pharmacotherapy.^{11,12} These activities have been coupled by other models of co-consultation, such as those involving specialist paediatricians¹³ and non-dispensing

⁹ <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/victorian-carer-strategy-2018-2022>

¹⁰ <https://www.emphn.org.au/news-events/news/new-psychiatric-consultation-and-advice-service-to-help-providers-manage-patients-with-mental-health-issues>

¹¹ <https://www.gphn.org.au/resources/pharmacotherapy/addiction-medicine-specialist-secondary-consultations/>

¹² <https://www.turningpoint.org.au/about-us/news/safescript-gp-clinical-advisory-service>

¹³ <https://nwmpnhn.org.au/news/study-bringing-specialist-primary-care-together-better-child-health/>





pharmacists¹⁴ in general practice. These models are funded outside of the MBS, and incentives must be leveraged to integrate and facilitate a broader multidisciplinary approach.

- **There is benefit in a coordinated approach to enhancing and applying the evidence for better use of health assessments.** The evidence for health assessment in the general population or other populations as outlined in the Report is noted. As such, there is a need to ensure that there are coordinated and consistent key messages among health promotion charities whom support general screening of selected risk assessment tools. The PHNs as a national network support knowledge management and information sharing for collective benefit, and there is value in a structured use of quantitative data, qualitative data and research evidence in building understanding of the relevance for new at-risk groups.
- **The implementation of MBS schedule reform should be integrated with the advancement of efforts in support of quality use of medicines.** There are a suite of parties and programs that have a role in quality use of medicines. Efforts towards formalising activities, investment (including how activities are managed through PHN funding schedules), and measures of success in relation to these functions is considered essential for longer term sustainability of Australian quality use of medicines interests not otherwise limited to the Grant Program and Commonwealth Government funded NPS MedicineWise activities. Furthermore, the introduction of a nationally consistent mandated real-time prescription monitoring system is an important development worthy of reference.¹⁵ Drawing from the Tasmanian and Victoria experience, there is benefit in proactive consideration of how system MBS reform, workflow integration and clinical capability is matched to support better practice prescribing and dispensing. The Victorian PHNs have partnered with the Victorian Department of Health and Human Services to support primary care training and HealthPathways development as part of the statewide implementation of SafeScript.^{16, 17}
- **There is an established evidence base for social prescribing whereby patients, including those with chronic diseases, benefit with GP referral and linkage to non-medical options and other community based supports.**¹⁸ Several PHNs are exploring the potential of social prescribing in the Australian context.¹⁹ There is potential to consider how these learnings and further cost-effectiveness research may provide a case for inclusion in chronic disease and comprehensive preventative health plans, consistent with a holistic understanding of health and wellbeing. The value of social prescribing may have particular benefit in rural communities that have a higher proportion of aged persons and experience of experience transport and service access issues which bear influence on social connectedness.

It is also noted that the committee reference to a 2012 study of patient behaviours whereby “92% of Australians always attend the same practice; however, many see multiple GPs within that practice” is relatively dated, and contemporary and ongoing review of patient practices and preferences should continue.

¹⁴ <https://nwmpnh.org.au/news/pharmacists-gps-join-forces-improve-patient-care/>

¹⁵ <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2017-hunt071.htm>

¹⁶ <https://vtphna.org.au/safescript/>

¹⁷ <https://www2.health.vic.gov.au/public-health/drugs-and-poisons/safescript>

¹⁸ <https://www.kingsfund.org.uk/publications/social-prescribing>

¹⁹ For example, Gippsland PHN, Western Victoria PHN and North Western Melbourne PHN – NWMPHN details at: <https://nwmpnh.org.au/commissioned-activity/social-prescribing/>





Other recommendations

The Alliance supports the recommendations which foster enhanced role definition (Recommendation 17) and increased access to telehealth services (Recommendation 18).

The Alliance notes the following implementation considerations:

- **Telehealth must be adequately maximised to support all patients, but priority should be given to those in rural areas and/or experiencing barriers to accessing services.** Anecdotal reports of community members choosing to go without care due to the travel time required to attend medical appointments are common. Qualitative data and analysis of ambulatory care sensitive hospitalisation data provide insight into the impact of models of care that may not adequately engage telehealth to maximum reach.

In line with this, digital health is a national PHN priority. PHNs have recently undertaken a national program of work to support My Health Record awareness, education, readiness and support.²⁰ This occurred within the context of other digital health capability building efforts undertaken by PHNs, including but not limited to support for secure messaging, eReferral and telehealth. Consequently, PHNs have insight into the precursors and conditions conducive to establishing and maintaining viable digital health delivery systems within general practice, of which MBS reform will assist but not represent the sole solution. As an example, PHNs have commissioned telehealth offerings that have demonstrated impact, including on afterhours capacity as shown in the vignette below.

My Emergency Dr is an app that facilitates a video consultation with an Australian-registered specialist emergency doctor within minutes when a person's usual GP isn't available after-hours. The doctors are experts in making rapid, accurate assessments of all medical emergencies and assess the situation via the built-in video on a smartphone or tablet.

Since the implementation of the initiative in July 2018, patients have provided overwhelmingly positive feedback for the service with calls to the service growing at a rapid rate. Approximately 88.29% of all patients were managed in situ during January and 61.22% of survey respondents said they would have gone to the emergency department or called 000 for an ambulance if they had not called My Emergency Dr.

The highest number of calls were from residents in Yarra Ranges and Whittlesea LGAs (target areas) who have limited access to afterhours services, resulting in many residents attending hospital for afterhours care.²¹

²⁰ <https://vtphna.org.au/my-health-record-expansion/>

²¹ <https://www.emphn.org.au/what-we-do/after-hours/my-emergency-dr>





The Victorian and Tasmanian PHN Alliance look forward to supporting the implementation of reform toward a patient-centred primary care model supporting GP stewardship.

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Supplemental detail: Context for response

Primary Health Networks

The objectives of Primary Health Networks (PHNs) are to increase the efficiency and effectiveness of medical services and improve coordination of care to ensure patients receive the right care, in the right place, at the right time. PHNs apply a regional perspective to examining and supporting:

- the health workforce
- organisational processes
- networked systems of care.

PHNs are change agents for health improvement at the 'meso' or middle layer of the Australian primary care system, acting as a conduit between individual providers/services and State, Territory and Commonwealth Governments. PHNs provide a nationally consistent infrastructure for solutions design and implementation support at the local level. Central to this are inclusive and participatory methods involving consumers and providers to design and achieve change. PHNs achieve objectives by:

- Understanding the health care needs of their PHN communities through analysis, planning in collaboration with clinical and community/consumer advisory groups (and other consumer engagement and co-design mechanisms), while maximising value and efficiency.
- Providing practice support services so that GPs are better placed to provide care to patients subsidised through the MBS and Pharmaceutical Benefits Scheme and help patients to avoid having to go to emergency departments or being admitted to hospital for conditions that can be effectively managed outside of hospitals.
- Supporting general practices in attaining the highest standards in safety and quality through showcasing and disseminating evidence of best practice. This includes aggregating and reporting data to support continuous improvement.
- Assisting general practices in understanding and making meaningful use of digital health systems, to streamline the flow of relevant patient information across the local health provider community.
- Working with other funders of services and purchasing or commissioning health and medical/clinical services for local groups most in need.

The Victorian and Tasmanian PHNs support the primary care services using system levers in a range of ways.

- **As an improvement partner** – PHN provider and whole-of-organisational support for quality improvement efforts. PHNs are one of several primary care service improvement partners, which is reflective of inter-organisational or networked approaches to patient safety and quality. Victorian and Tasmanian PHN contributions include:
 - Facilitating all general practice staff to have access to meaningful data analytical capability using their own data, and supporting data integrity





- Collaborative approaches to change implementation, involving clinical support and networking
- Delivery of continuous professional development training for the primary care workforce including GPs, nurse/nurse practitioners, allied health and pharmacy.
- **As a commissioner** – PHNs commission primary care services in areas of community need and operate consistent with the relevant clinical governance policies and protocols. This includes commissioning of the following:
 - General practice and community pharmacies for the provision of afterhours support
 - Providers to assist Aboriginal and Torres Strait Islander people access primary care services and better manage their complex and chronic health needs through care coordination and outreach support
 - Alcohol and other drug services
 - Mental health stepped care models, utilising a diverse mental health workforce, including allied health professionals, mental health nurses, and other workforce structures.

This **dual role** creates a unique contribution to system capacity to advance safety and quality within primary care.

- **As an improvement partner**, PHNs have an active role in supporting the clinical and non-clinical workforce to build individual skills and expertise and to implement systems of care.
- **As a commissioner**, PHNs have a role in developing and shaping primary care services to deliver evidence-based models of care across a geographical area. These services are understood as ‘the market’ in economic terms, and the task of procuring primary care services cannot occur in isolation of market development to mitigate the risk of market failure. PHNs have a lead role in working alongside primary care services and fostering a market which can meet expectations in relation to a suite of measures of effectiveness, including safety and quality expectations (e.g. scope of practice, clinical supervision and workforce credentialing).

