Constructing quality health policy

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With recent attempts by the government to introduce changes to Medicare, it is important for those of us working within the system to revisit the evidence regarding delivery of primary care, in order to provide an evidence-based position. Countering ill-advised policies with clear evidence to the contrary is most consistent with our identity as health professionals trained within a scientific tradition.

It is rare that a single piece of research will cause a revolution and, often, it takes years of gradual accumulation of evidence for a position to be accepted. Building on earlier research, there is now a clear consensus that a strong primary care system is linked with better health outcomes. How to best deliver this care is a crucial question that remains and one major aspect of this question is how delivery of primary care should be financed.

Fee for service, capitation, salary, and incentive payments have all been examined and continue to be the subject of trials. Each study serves as an additional building block in developing a strong evidence base. For example, one study found that capitation is associated with better blood pressure control in the management of hypertension when compared with fee for service.[1] Other studies have found that diabetes care is improved in the setting of particular models of delivery.[2]

Complicating the issue is the fact that primary care involves the provision of both acute and chronic care. A method of delivery that may work well for acute presentations may not be appropriate for the management of chronic diseases and vice versa.

In addition, even when there is clear evidence and consensus regarding an intervention, there remains the problem of implementation. For example, the early initiation of insulin in the treatment of type 2 diabetes (T2DM) is supported by international guidelines; however, there are many barriers that can result in delayed initiation, particularly in the primary care setting. This gap between evidence and practice is the subject of translational research that seeks to bridge the gap, and is an area of increasing priority.[3]

In this issue, Wong and Tabet[4] cover the introduction of insulin in the patient with T2DM, a chronic disease of great significance that has been targeted as a health priority.[5] It serves as a good example for delivery of care in chronic disease, and interventions to optimise management and prevent its development are the subject of multiple studies. Deed et al[6] review dietary recommendations for the prevention of diabetes and as an essential management consideration. Davoren[7] provides a guideline for navigating the maze of available hypoglycaemic agents. Finally, Cohen[8] describes the latest evidence for the use of insulin pump therapy and continuous glucose monitoring, technology that is rapidly heading towards closed loop systems and the 'artificial pancreas'.

Comparison and collaboration with other health systems will be essential in determining the best practice delivery of primary healthcare. Fortunately, the information revolution has exponentially facilitated the sharing of knowledge, such that we are all in a position to mutually benefit from the experience of overseas colleagues in primary care. Careful and considered research into existing and new models for delivery of primary healthcare at home and overseas will result in the gradual accumulation of high-quality evidence, which should serve as the basis for quality health policy.

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