RACGP | Aboriginal and Torres Strait Islander Health

Background

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to provide additional feedback to the Medicare Benefits Schedule (MBS) Review Taskforce, following the teleconference held between RACGP Aboriginal and Torres Strait Islander Health (the Faculty) and Professor Bruce Robinson, Chair of the MBS Review Taskforce on 26 June 2019.

Please refer to our earlier submission for a more detailed response to the recommendations outlined in the Aboriginal and Torres Strait Islander Reference Group report.

As requested, this submission provides feedback regarding:

- models of primary healthcare and funding requirements
- possible enhancements to care delivery outside of the MBS
- the recently introduced heart health assessment (items 699)
- the scope of the review as it relates to Aboriginal and Torres Strait Islander health.

Models of primary healthcare and funding requirements

In 2013-14, primary healthcare expenditure on medical services, including the MBS, was $271 per Aboriginal and Torres Strait Islander person compared with $302 per non-Indigenous person.[1] This is a difference of about 11 percent. Such an outcome may be in part due to Aboriginal and Torres Strait Islander people not accessing services, but it could also indicate the range of services accessed are provided through means other than MBS-funded services.

Aboriginal and Torres Strait Islander people are more likely to have long and complex general practitioner (GP) consultations,[1] which require service providers to have excellent clinical skills, cultural understanding and an awareness of the historical and psychosocial context which influences health outcomes. In this context, the complexity, skill and time required to deliver high-quality healthcare is not always recognised through the current Medicare structure or MBS rebate values.

Our best understanding of the difference between mainstream practices and Aboriginal Community Controlled Health Organisations (ACCHOs) and Aboriginal Medical Services (AMSs), in terms of MBS generated income is through the Majellan model.[2] It was found that the hourly billing rate for its Aboriginal and Torres Strait Islander clinic was 76% the rate for its mainstream practice. This suggests that ACCHOs and AMSs may make up to 25% less than other practices, without accounting for the other services that are provided, such as transportation and time spent following up for patients who do not attend in person.

Comprehensive primary healthcare encompasses a range of services, such as access to acute healthcare, population health programs (e.g. screening, immunisation), health promotion, chronic disease prevention and management, social and emotional wellbeing services, which is delivered through a multidisciplinary team. It reflects what is accepted and valued by Aboriginal and Torres Strait Islander people in their healthcare. Mainstream general practices, ACCHOs and AMSs all need to be better supported to deliver this kind of care.

In addition to the above, there are other examples where alternate funding could be used to support the delivery of healthcare including:

- increasing core funding for ACCHOs, to support the sustainable delivery of high-quality, comprehensive, culturally appropriate primary healthcare services. Core funding is not expected to increase with the roll-out of a new funding allocation model from 1 July 2020. A focus on increasing MBS billing in the sector will not necessarily make up the shortfall for each organisation, to be able to provide the wide range of high-quality services to patients

- re-orienting the Practice Incentives Program Indigenous Health Incentive (PIP-IHI) program to incentivise the delivery of high-quality chronic disease care, and to recognise the complexity and skill required to deliver Aboriginal and Torres Strait Islander primary healthcare through a quality-based payment structure

  As one of the only mechanisms to fund mainstream practices to provide services for Aboriginal and Torres Strait Islander people, outside of the fee-for-service model, the PIP-IHI requires reform. See related RACGP submission for more information

- further research and consideration of alternate funding mechanisms to support health professionals who do not have formal registration bodies, such as traditional healers, and environmental health workers to recognise their role within the health system

- investing in the growth and sustainability of the workforce, particularly Aboriginal and Torres Strait Islander Health Workers and Practitioners, to support their entry into mainstream settings.

Taking this approach goes some of the way to addressing the shortfall in MBS funding, and facilitates the provision of services and a culturally responsive environment, not supported through the MBS, yet essential to high-quality, comprehensive primary healthcare delivery.

Heart health assessment

The RACGP notes the opportunity to provide feedback on the implementation of the heart health assessment (item 699), over the next two years. Uptake of the services delivered through this item may not present a full picture of what is happening on the ground, as Aboriginal and Torres Strait Islander people may access heart healthcare via other means, such as the health assessment (item 715). The implications for access to care, and what is accepted and valued by patients should be considered in the evaluation of the item's implementation.

Eligibility criteria for both of these items may create barriers to accessing appropriate healthcare. For example, in the case where a heart health assessment is billed, this may limit a patient from seeking a subsequent health assessment within a certain timeframe. As such, de-coupling eligibility for these items (715 and 699) should be considered, as it also should in the case of the proposed introduction of a prison release health assessment (through items 703, 705 and 707).

There are important lessons to be taken from the introduction of the heart health assessment that should be reflected in the implementation of the recommendations made by the MBS Review Taskforce. Primarily, the need for appropriate consultation to consider the effects for different population cohorts, and reasonable timeframes for implementation.

Scope of review

The Aboriginal and Torres Strait Islander Reference Group has considered a limited range of MBS items. However, Aboriginal and Torres Strait Islander people seek a wide-range of services that are eligible for MBS rebates.

Suggested changes across the broad range of items under the Taskforce's consideration should look at the potential impacts and benefits for the health and wellbeing of Aboriginal and Torres Strait Islander people and the sustainability of ACCHOs and AMSs.

The RACGP looks forward to hearing about the final recommendations and outcomes from the Taskforce. If you have any questions or comments regarding this submission, please contact Ms Leanne Bird, Faculty Manager – RACGP Aboriginal and Torres Strait Islander Health, via email on leanne.bird@racgp.org.au or on (03) 8699 0313.

References

[1] Australian Health Ministers' Advisory Council, 2017, Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report, AHMAC, Canberra.

[2] Johansen R P, Hill P. 2011. Indigenous health: A role for private genera practice. Australian Family Physician. 40:1.