

Challenges in primary care policy

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The recent federal election barely discussed primary care and to the extent it did, the ‘solution’ was only about unfreezing the Medicare Benefits Schedule (MBS) rebate. Readers of this journal know this is obviously not the sole answer. But why is primary care reform so hard?

The context of primary care policy is important. The changing epidemiology is well established – decreased emphasis on acute, episodic illnesses and an increased emphasis on caring for people with multiple chronic conditions, including mental illness.

Broader social factors are also at play. To some extent we live in a post-trust society, with the medical profession, and general practice in particular, not immune from the impact of declining trust in authority figures. Changing technology, and the advent of ‘Dr Google’, increasingly shape contemporary patient–provider interactions.

These factors don’t necessarily make reform hard, they are simply factors which need to be recognised and addressed. There are three other contextual factors which do contribute to making the reformer’s task hard.

First is the weak evidence base. There is a broad international consensus that fee-for-service is not the best way of remunerating GPs in the context of the increased prevalence of chronic disease. But the evidence to demonstrate this, and the superiority of any alternative, is very weak indeed. In the absence of such evidence, it is easy for those who benefit from current funding arrangements to challenge any new policy.

Second, there is a lack of consensus about the preferred policy directions. This is partly due to the weak evidence base, and partly due to the reality that any change will involve some people or groups who will lose. Building consensus of clear, desired directions will be hard, but must be an early step in the policy process.

But choices about policy directions are not simple and obvious. For example, there is consensus that the current state of the MBS rewarding short consultations is undesirable. But what is the desired future state? Is it rewarding long consultations? Increasing long consultations is primarily an intermediate goal to something else, such as reducing potentially avoidable hospitalisations or emergency department visits, or maybe even improving self-rated health. What should a new policy reward?

Similarly, the current state of care by multiple GPs is also seen as needing change, but again, what should be the aim? Continuity of care by an identifiable, single GP? Or continuity of care by a primary care team with good internal communication? What little research evidence there is suggests the former leads to better care, possibly because of lack of examples of the latter or it may be insufficient research.

Consensus does not mean papering over differences or casting a veil of vagueness over the topic by use of feel-good words such as ‘patient-centred care’. It does mean doing the hard yards of identifying each of the dimensions of the desired future state and clarifying what the actual preferred vision is for each dimension.

Building consensus for change will be harder than building a coalition against change, but without clarity of direction we will continue to have policy paralysis.

Third, we have path dependency. Options for the future are partly shaped by where we are now. Australia has a primarily fee-for-service private system for general practice, allied health, and mental health services in the community. Nurses’ roles in outreach are undervalued. Policy needs to recognise that reality and work out how to change from that state to the new vision, perhaps incrementally, perhaps with demonstration projects, but all designed to move towards the desired end.

So what does this mean for readers of, and contributors to, this journal? One of the weaknesses I have identified is the weak evidence base. One solution is that designers of all evaluation studies and trials need to think about the policy context. Does the write-up of the paper make it clear what the intervention really was? Can a reader implement the intervention without having to contact the authors? If the intervention does work, what are the barriers to scaling it up? Does it rely on zealots, or was it personality independent? Does policy or funding need to change to promote widespread implementation and, if funding change is necessary, how do we know the intervention is worth it (cost-effective)?

Good evidence is not enough, of course, but without it, as I have argued, policy changes will be that much harder.

Conflicts of interest

The author declares no conflicts of interest.