



Access to Health Care for People with Diabetes: Variation in the Use of Primary Care Services for Diabetes Management According to Country of Birth and Geography among Older Australians

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Australian's generally have access to a high class health care system administered by the Australian Government Department of Human Services through Medicare [1]. Under Medicare claims for medical, specialist, diagnostic and other health care services and pharmaceutical products are subsidised according to claims for specific Medicare Items as defined by the funding schedules. Medical care provided by general practitioners (GPs) is charged as a fee for service and are frequently 'bulked billed' so that there are no out of pocket costs for patients. This model of funding has limitations for the ongoing treatment and management of patients with chronic and complex care needs such as diabetes. A number of specific financial incentive payments to enhance the quality of care for these patients have been introduced in recent years including the Practice Incentive Program (PIP) and Chronic Disease Management (CDM) Medicare Items. PIP payments support accredited general practices and GPs to implement best practice processes of care, enhance practice capacity for management of patients with chronic and complex care needs, and improve patient outcomes [2]. CDM Items are designed to encourage multidisciplinary and team care arrangements involving the GP and other health care professionals [3]. They include payments for the preparation and review of multidisciplinary GP Management plans (GPMP) and establishing Team Care Arrangements (TCA).

Implementation of these incentives was a theoretical approach backed by evidence from a number of large international studies that have demonstrated the positive benefits of aspects of diabetes care and value of multidisciplinary care. For example, intensive treatment and control of hyperglycaemia, high blood pressure, and of lifestyle changes have been shown to prevent or delay of onset of diabetes-related cardiovascular complications [4-7]. Research, such as that of Ciccone and others has also demonstrated the importance of multidisciplinary care teams and care co-ordinators to ensure implementation of care processes [8]. Research findings such as these form the basis of the development of international and national guidelines for the management of diabetes in general practice and investment in their dissemination [9,10].

More recently translational and applied research based on linked administrative data collections is demonstrating associations between GP CDM incentive payments and improved health outcomes such as reduced hospitalisation [11]. A previous study using the Sax Institute's 45 and Up Study and linked to Medicare and hospital admission data found high rates of admission (33.0%) among diabetic participants in the year following their recruitment [11,12]. The study explored these CDM Items and found that participants who usually saw the same GP (adjusted Incidence Rate Ratio (aIRR): 0.92 (95% CI: 0.89–0.96), or had a Medicare claim for completion of an annual cycle of diabetes care (aIRR: 0.77 (0.74–0.80)) were less likely to be admitted. This research provided evidence for the importance of the patient/provider relationship. It reported that claims for review of GPMP/TCA arrangements and not simply their preparation were associated with reductions in hospitalisation (aIRR: 0.92 (95% CI: 0.89–0.96)). Does this evidence reflect better care or enhanced relationships that provide alternatives to hospitalisation? Further research is needed to unpack the nature of these associations.

One of the underpinning principles of Australia's universal health care system is an assumption of equal access to health care. Tran and her colleagues explore access to CDM Medicare Items for diabetes care for culturally and linguistically diverse (CALD) communities in Australia [13]. Using country of birth as a proxy for CALD status she was able to demonstrate considerable variation in access to a number of CDM Medicare Items for CALD communities even though all seven CALD groups studied had a greater number of claims for GP attendance than Australian born participants. Tran's results suggest that GP propensity to implement CDM Items such as GPMP/TCA and participant uptake of these is variable. Explanations for these differences are likely to be complex and may have cultural as well as patient and practitioner causes. For CALD patients access to culturally appropriate services, language barriers and perceptions of the role of health care are known to influence the services accessed. We know from our centres' work that patients are known to prefer GPs from their own cultural background. These practitioners may have their own perceptions about modes of practice and attitudes to multidisciplinary care that impact on their capacity to engage with other health professionals in multi-disciplinary care. These results suggest a need for new research to better understand the training needs for GPs who provide care to patients from CALD backgrounds to improve appropriate access to CDM items.

These are important issues for diabetes care in multicultural countries such as Australia. In recent years interest in improving diabetes care has been driven by recognition of the public health burden of the disease and the rapidly increasing prevalence [14]. Ensuring universal access is key performance indicator for health services. A number of new initiatives are being introduced to better identify patients with particular care needs and ensure their access to high quality integrated multidisciplinary care. Data linkage studies such as those mentioned above provide a cost effective means of evaluating changes in practice over time.

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