Policy Think Tank REPORT

Community and Primary Health Care

22 July 2011 Melbourne

1. Background

This Community and Primary Health Care Policy Think Tank was the third in a series focussing on community and primary health care. Its purpose was to consider the role and operation of Medicare Locals and Community Health Services in the new environment created by the National Health Reforms (NHR).

The goals of the NHR are to create a unified national health and aged care system, improve transparency and accountability of funding, support more local responsiveness and integration, and ensure less bureaucracy. The national Health Reform Agreement was signed by all jurisdictions on 2 August, 2011.

The AHHA is *the voice of healthcare in Australia* and the only national organisation representing the health care sector across the continuum of care. The AHHA's key role, with the involvement of its members, is to develop and advocate for national policies which advance the performance of the healthcare sector for the benefit of all Australians. The Association is renowned for bringing together an exciting mix of leaders, thinkers and other stakeholders for stimulating discussion, development of policy and practical advocacy plans.

2. Facilitator and presenters

Associate Professor Paul Dugdale, Director, Chronic Disease Management Unit, ACT Health and Associate Professor, Public Health, ANU, facilitated the event.

Presenters were:

Australian Government overview of the national health reforms **Dr Tony Sherbon**, Deputy CEO - Health Reform Transition Office, Department of Health and Ageing, ACT
Implementing Medicare Locals – the first steps **Mr Terry Findlay**, Director, National Transition Project, AGPN, ACT
Collaboration at the local level – a perspective from community health **Ms Robbi Chaplin**, CEO, Inner South Community Health Service, Victoria
Networking across health service boundaries **Mr Mark Slattery**, Manager, Health Networks Branch, WA Health
Networking across large geographical areas **Dr Helen Chalmers**, Chief Operating Officer, Country Health SA
Australian Government perspectives on community and primary health care **Ms Jennie Roe**, Assistant Secretary of the Medicare Locals Implementation and Transition Branch, Department of Health and Ageing

3. Introduction

In the context of the reforms, the main issues discussed were:

i. **Financial incentives**: the capacity of funding systems to drive appropriate incentives for safe and cost-effective care and the impact of defining hospital services (in the context of the 'efficient price').

ii. **Capacity of local governance** at the level of Medicare Locals (MLs) and Local Hospital Networks (LHNs[1]) to understand community needs, particularly in the context of population health planning; and the associated need for better PHC data sets to ensure the effectiveness of the reforms in improving health outcomes and the consumer experience.

iii. **Integrating joint programs for chronic disease management** across LHN and ML organisational boundaries and the need for governments to provide support to the mix of community and primary healthcare services, including NGOs.

The impact of the reforms on workforce design, supply and curriculum development, including training and opportunities for clinical placements was raised on several occasions but not discussed in detail at this event.

4. Provider goodwill - Government support needed

4.1 Context

In terms of improving clinical services and consumer experience, the success of the reforms will depend on MLs and LHNs working together across boundaries to coordinate and integrate care for the chronically ill and aged. In doing so, they will need to engage with other services, such as community care and Non-Government Organisations. In this context, participants expressed genuine goodwill and 'great hopes' for the NHR. This reflects the views of AHHA members across the continuum.

4.2 Recommendation

It is essential that the Commonwealth and State governments cooperate in accepting responsibility for whole-of-system change management. They must provide clear leadership, guidance and information about the 'rule book' for the reforms (ie agreements, legislation, regulations etc) and especially in promoting and encouraging collaboration between national and local elements of the system.

Participants called on governments to:

- support local services, especially to foster leadership skills in culture change and organisational improvement as well as building capacity in service design and implementation of policy; and
- provide appropriate financial and other incentives such as relevant and robust performance indicators, built into the system to facilitate integrated services.

[1] Also called Local Health Districts and Local Health & Hospital Networks

5. Financial incentives

5.1 Context

The new Commonwealth-State financing arrangements are a central feature of the reforms. The discussions on this issue were complex and involved two main areas.

First, the conversation focused on the new Commonwealth-State financing arrangements, in particular the 'efficient price' for hospital services. This 'price' is not yet defined pending the establishment of the Independent Hospital Pricing Authority (IHPA) which will have this task and will set the value[2].

Second, while not being deterred by the emphasis on increasing productivity, participants agreed that financial instruments need to be finely-tuned in order to drive incentives towards delivery of cost-effective care in the most appropriate settings - while also ensuring quality and safety of care. It was acknowledged that traditional funding mechanisms, such as fee-for-service, are unlikely to provide adequate incentives for multi-professional team care involving a range of services.

5.2 Recommendation

Participants strongly believed that traditional funding mechanisms, such as episode-based fee-for-service and discrete program funding, are unlikely to provide adequate incentives to promote coordinated and integrated care arrangements provided by multi-professional teams across a range of services (eg between hospitals, GPs community and home based care).

They recommended that the Commonwealth Government introduce a new system of blended payments, comprising fee-for-service and incentive funding components, to foster integrated or 'bundled' models of care that will be provided by a range of providers across sectors and boundaries.

6. Local governance

6.1 Context

The COAG Agreement commits LHNs and MLs to work together to bring about more integrated care and coordinated pathways for patients. Building collaborative relationships between LHNs, MLs and other health, community and aged care services is an essential first step in the long journey of health system reform. This was emphasised by numerous speakers and participants.

A focus on prevention in primary health care is a central feature of the NHR. The newly established MLs[3] will co-ordinate primary health care within a defined area including responding to service gaps, an initial focus being on after-hours

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[2] The subsequent NHR Agreement (Clauses A9-A26) reflects the recommendations of the Think Tank which called for process around the definition of 'hospital care' to be sufficiently flexible to encompass new models of care that present innovative alternatives to in-patient care as they arise.

[3] Funding for MLs is $477 million over four years (from July 2011) and the first 19 commenced operation on 1 July 2011

services[4]. MLs will work with GPs, private allied health and nursing services, NGO provided primary care and State government funded community health services.

6.2 Recommendation
Despite varying governance structures, it will be essential that LHN and ML boundaries do not limit services and flows or hinder current programme based relationships.

Think Tank participants recommended that LHN and ML jointly funded and operated clinical governance arrangements be established to manage and coordinate the care of patients needing integrated services, including maintenance of networked arrangements. Lead Clinician Groups would be involved in such arrangements.

7. Community Health Services and non-government sector

7.1 Context
A Community Health Service has the potential to facilitate the delivery of important elements of an integrated care approach, recognising that 70% of health and well-being occurs outside the formal health system. However, participants noted that the potential contribution of the Community Health and NGO sectors in the new system remain relatively unexplored, demonstrating the lack of attention on integrating these services.

7.2 Recommendation
Think Tank participants recommended more attention be given to mechanisms to integrate the Community Health and NGO sectors.

There are at least two ways in which this could be addressed:
- the ML could commission services from the CHS; and/or
- the Independent Hospital Pricing Authority could be enabled to cost non-hospital services as part of an efficient price approach to integrated care.

8. Population health planning

8.1 Context
The COAG Heads of Agreement (Clause 60) recognises the *"need for effective integration across Commonwealth and State funded healthcare services"* and a key enabler for this will be integrated approaches to population health planning, including alignment of relevant LHN and ML activities. The Australian General Practice Network (AGPN) also expects a key function of Medicare Locals will be the planning and ensuring the provision of services to meet population health needs. These planning activities should take an asset or strengths based approach in order to identify capacity for action which will vary between localities.

8.2 Recommendation
Participants recommended that both levels of government support joint population health planning between LHNs and MLs, underpinned by a focus on social determinants of health. Such planning has the potential to reduce duplication and overlap in local service provision.

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[4] The Coordinated Care for Diabetes pilot commenced from July 2011, and the findings of the pilot will help inform future policy considerations regarding arrangements for chronic disease management in the primary care setting.

They urged governments to resource activities that would support the development of more effective skills to undertake this joint effort. They emphasised that this must be supported by the provision of clinically relevant datasets at the local level.

9. Indicators and Data

9.1 Context

There is a need for a nationally coordinated and supported approach to data collection at the ML level that goes beyond indicators and that will support health service planning, policy development and performance monitoring.

This will include a nationally consistent set of core performance indicators to assist with local planning and service improvement as well as national benchmarking and performance assessment. It is important, though, that these indicators are supported by by a strong data collection infrastructure that is appropriately resourced and collects a wide range of relevant information.

Policy Think Tank participants expressed great concern regarding the poor state of primary health care data which limits the ability of any organisation, whether ML, DoHA or Performance Authority, to access the data they require to make sensible judgements relating to performance, particularly reporting on and interpreting the proposed indicators. The data just doesn't exist or is so patchy and non-standardised as to be useless, particularly at the level of MLs. There was also a lot of concern about the fact that the indicators so far proposed are to a great degree outside the ability of the MLs to influence.

Policy Think Tank participants also discussed the emerging need to ensure linkages between providers of social care and health care in order to support consumers with complex needs receiving services from both sectors. Just as indicators and datasets will need to reflect cross-boundary care with in health they will also need to reflect cross-sectoral care.

It is also important that all data on service provision and expenditure is available by remoteness (using the ASGC-RA system) so that actual access to services and health expenditure in rural and remote communities can be measured.

9.2 Recommendation

Think Tank participants recommended that:

- all governments, as a matter of urgency, cooperate with each other and with PHC and community services to develop relevant primary health care data sets, standardized across Australia. This will enable collection of data to measure performance and provide information to the National Health Performance Authority.

- data and performance indicator sets be shared by LHNs and MLs to facilitate joint service planning and integration of services, and to avoid reporting that echoes the silos of the health system;

- performance measures need to focus on improving the outcomes for people with chronic diseases such as diabetes, where good outcomes depend on effective working relationships across many health providers;

- national performance agencies explicitly measure how well health services are performing in providing integrated care and whether they are collaborating with other health services;

- performance agencies use data to encourage best practice and innovation (the 'carrot-approach'). Data feedback provided to health services must be clinically meaningful to inform patient care practices and foster service improvement within a learning environment. This will also encourage purposeful data collections by practitioners and is key to improving quality of care.

10. Evaluation of the reforms

10.1 Context

The National Health Reforms must include systematic evaluation procedures for collecting, analyzing, and using relevant information to satisfy the sector that the intended effects of the reforms are being achieved, including their effectiveness and efficiency.

10.2 Recommendation

An overall evaluation plan and processes would add great value to the implementation of the NHR, not as a conventional academic evaluation, but as a means of ensuring that the system 'learns and applies' as it goes – akin to a Continuous Quality Improvement approach.

11. Conclusions

The essential mission of the Reforms is to improve healthcare by devolving responsibilities for services to local hospitals, community and primary care settings through new MLs and LHNs.

Healthcare providers and clinicians are genuinely keen to make the reforms work on the ground. They know they can improve patient care by better coordinating services between hospitals and community/primary care settings.

The discussion at this Community and Primary Health Care Policy Think Tank highlighted the good-will among providers and the potential that exists to deliver improved healthcare; but, equally, it identifies the importance of the implementation processes and the creation of the right incentives.

Now that the Agreement is signed, it is essential that all governments support their local health services to implement the Reforms.

But the scale of organisational and attitudinal change required for successful implementation cannot be under-estimated. Governments must demonstrate their commitment to the Reforms through their quality of leadership and the tone and behaviours of their own bureaucracies.

Finally, the concept of Consumer / Patient Centred Care should underpin the reforms and their implementation. The challenge for any healthcare system is to genuinely place the consumer at the 'centre' with all of the system players seeing that as their unifying purpose.

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Australian Healthcare & Hospitals Association
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