

Report on the Community and Primary Health Care Policy Think Tank



Held in Canberra, 11 May 2012

Facilitator: Paul Dugdale

Prue Power AM
Executive Director, Australian Healthcare & Hospitals Association

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Primary care reform

Introduction

The Community and Primary Care Policy Think Tank held on 11 May 2012 in Canberra was the fourth in a series focusing on community and primary health care, as implementation of National Health Reform proceeds apace.

The National Health Reform agenda is designed to tackle challenges to our health system posed by the ageing population, the growing burden of chronic and preventable disease, and rising health care costs. The delivery of high quality primary and community health care is central to addressing each of these challenges, as the national health reforms will not achieve their stated objectives if they are focused solely on the acute care sector. The Commonwealth Government acknowledges this, emphasising the importance of “shifting the centre of gravity from hospitals towards primary care”.¹

It has been a busy time since in health reform since the last Community and Primary Care Policy Think Tank held in July 2011:

- The National Health Reform Agreement was signed by all jurisdictions on 2 August, 2011;
- The National Health Performance Authority (NHPA) and Independent Hospital Pricing Authority (IHPA) are now up and running;
- The national roll out of Medicare Locals is well underway: 62 of these organisations have been announced, of which around 40 are already up and running, with the remainder to be operational from July 2012;
- GP Super Clinics continue to be constructed around the country, and hundreds of primary care practices and clinics are expanding or being upgraded as a result of Primary Care Infrastructure Grants awarded by the Commonwealth Government; and
- The announcement of continued funding for the national e-health program in the 2012 federal budget means personally controlled electronic health records (PCEHRs) will roll out from July 2012.

The Primary and Community Care Network Think Tank

In this context, the Policy Think Tank, jointly hosted by the Australian Healthcare and Hospitals Association (AHHA) and the National Primary and Community Health Network, brought together researchers, community and primary health care providers, and national representative bodies to discuss national health reform implementation and its implications for community and primary health care.

The AHHA is the nation’s ‘voice of public healthcare’. It is the only national organisation representing the public and not-for-profit health sectors, across the continuum of care including area, regional and district health services, hospitals, community and primary health centres, aged and extended care facilities. The National Primary and Community Health Network is a coalition of government representatives, peak bodies and others interested in sharing information on primary health care and the important role it plays in the Australian health system.

The participants at the Policy Think Tank discussed a wide-ranging set of issues, including:

¹ For example, see The Hon Julia Gillard MP, Prime Minister, and The Hon Nicola Roxon MP, Minister for Health and Ageing, ‘Medicare Locals to Deliver Home Grown Health Solutions’, Media release, 25 August 2011 (<http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr11-nr-nr160.htm>).

- How do we ensure that innovation continues in primary health care when the majority of the focus continues to be on the acute sector?
- How do we identify and address the perverse incentives while recognizing the value of positive incentives to deliver desired outcomes?
- How is community health defined and is it different to similar community based services delivered by others?
- How are different jurisdictions responding to the changing funding environment?

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

The speakers and the topics they addressed were:

- Robert Wells – Director Australian Primary Health Care Research Institute ANU: *Structure of Community and PHC service delivery under the National Health Reform: is anyone accountable?*
- Walter Kmet – CEO Western Sydney Medicare Local NSW: *Medicare Local perspective*
- Lyn Morgain – CEO Western Region Health Centre VIC: *Community health perspective*
- Rod Wilson – Health Consultant: *GP Super Clinics*
- David Butt – Deputy Secretary Department of Health & Ageing (PHC Reform): *Commonwealth perspective*
- Ross O’Donoghue – Acting Deputy Director General Corporate and Strategy ACT Health Directorate: *State Perspective*

Key themes and issues

Accountability – who is accountable to whom?

The national health reform agreement creates important new accountability arrangements for governments and health services, with important implications for primary and community health care providers, and for the integration between these services and those provided by the acute care sector.

The new organisations created by the national health reform agreement include Local Hospital (or Health) Networks to coordinate local hospital services, and regional primary health care organisations called Medicare Locals to coordinate and fill gaps in primary health care services provided in local communities. In being responsible for filling gaps in local primary health care services, Medicare Locals will have some capacity to purchase services. This is a significant development, in that it creates organisations with responsibility for population-wide health for the first time.

The national health reform agreement also sets up two new national bodies, the National Health Performance Authority (NHPA) and the Independent Hospital Pricing Authority (IHPA). The IHPA is responsible for setting the national ‘efficient price’ for the provision of hospital services. The NHPA will publish information on agreed performance indicators for hospitals, through the My Hospitals website. The NHPA will also publish ‘Healthy Communities’ reports, providing information on population health and access to primary health care services in Medicare Local catchment areas.

Keynote presenter Robert Wells described a ‘new approach’ to accountability reflected in these arrangements, in particular the separation of responsibility for policy, payments or funding, and reporting performance information.

Will they work to improve transparency, and ultimately performance? Participants at the Think Tank described some confusion in the sector about the new arrangements, and who exactly is accountable under the new arrangements to whom and for what. For example, who is accountable to whom for population health plans and their quality – are Medicare Locals accountable to the Department of Health and Ageing, the NHPA, local communities, or all of the above?

Public and transparent reporting of performance and other information (including on health outcomes) is a proven way of reducing variation in performance between different providers. This is one of the objectives of the new accountability arrangements established under the national reform agreement. These new arrangements are still in the early days of implementation, and will continue to be refined over time along with the datasets and performance measurements that they rely on.

Integration and coordination of care – opportunities and risks presented by the reforms

Participants at the Policy Think Tank heard about and discussed both the opportunities and risks presented by the national health reform for improving integration and coordination of care.

Opportunities

CEO of the Western Sydney Medicare Local (Wentwest), Walter Kmet, described the work WentWest is doing in response to the national reforms: building organisational capacity to be able to provide more integrated and coordinated services, including by identifying the health needs of the Western Sydney community, and delivering programs and facilitating services which respond to these needs.

Despite some challenges, in particular those inherent in the ‘start-up’ phase of implementing the reforms (such as balancing development of capabilities in a new organisation with the pursuit of outcomes), Mr Kmet spoke about the importance both of establishing a strong working relationship with the Local Hospital Network, and of being accountable to the local community – and the enormous opportunities for improving services, and ultimately health outcomes for the community, if these foundation stones are in place.

Risks

For the community health care sector, the national health reform agreement provides significant opportunities for better integration with primary health care service providers, but also some risks of unintended consequences if the changes are not managed well.

Lyn Morgain, CEO of the Western Region Community Health Centre in Victoria spoke about the Victorian community health sector’s support for the reform objectives, but also about the importance of ensuring that lessons learned from community health over decades are brought into the current reform process. For example, Ms Morgain spoke about the importance of community and primary health care services working extensively with partners beyond the health sector, including housing, employment, transport, immigration, justice and other social services, to achieve good outcomes.

There has been some ‘decoupling’ between health and these sectors over the last few years, but for disadvantaged and hard to reach groups in particular, a sustained, cross sectoral, multi-disciplinary approach is critically important, as is ensuring that the views and concerns of consumers are properly incorporated into the design and delivery of programs and services. The current reform process, for all its opportunities, risks not being able to deliver

on its objectives of improving care for people with chronic and complex health problems, and the important health and social equity dimensions inherent in these objectives, if these issues are not taken into account in implementation.

Innovation

The opportunity for innovation in local and regional service delivery is one of the most important opportunities created by the establishment of new organisations like Medicare Locals and the rollout of new programs such as GP Super Clinics. These policies and programs provide the opportunity for trying out things that meet local needs, but which won't necessarily work on a national scale.

Almost by definition, mistakes will be made along the way through this process and things will be tried which ultimately might not work, but it is important that these programs provide opportunity for innovation and creativity in local service delivery, including innovative new partnerships at local level, so we can find out what does work and develop new models of service delivery and best practice.

Better integration and coordination through financing reform?

Will the new accountability and financing arrangements introduced by the reforms, and in particular the new pricing arrangements for acute services, promote better integration and coordination of care – especially between the primary and acute care sectors?

There was lively discussion during the Policy Think Tank on this topic. Some participants held the view that there is nothing in the new funding arrangements in and of themselves that will promote better integration and coordination of care, and in fact that there is risk of perverse incentives and outcomes in the current arrangements. Others took the view that the reform environment – in particular through the establishment of Medicare Locals as primary health care organisations with population health responsibilities, along with other reforms such as the rollout of e-health records – create the conditions in which better integration and coordination is positively enabled. Better integration and coordination will not happen overnight, but it is likely to be realised over the medium and long term. Local partnerships and innovative ways of maximising opportunities created by the existing structures will be critical in this process.

Participants discussed the impact of the national efficient price for hospital services, which will be set by the IHPA, and its impact on services provided by the community and primary health care sectors. There is some concern in the sector that if the efficient price is too generous, it will provide incentives for states to move services which would be better provided in community settings back into hospitals. However, states will need still be funding the majority of the cost of any services provided in hospital settings (as the Commonwealth will contribute 40 per cent of the efficient cost) so even a generous 'efficient price' will not necessarily incentivise the provision of more services in hospitals. It is also important that the new pricing arrangements provide incentives for service providers to tackle the 'hard' services, through, for example, appropriate loadings and weightings for complex cases.

In the context of discussion about the opportunities and risks inherent in the new financing arrangements, participants discussed the importance of continuing to pursue reforms to existing funding models in the long term, including reforms which better incentivise coordinated patient pathways between different providers and settings – such as capitation funding in primary care. The outcomes of the diabetes care pilot currently underway may provide a catalyst for discussion about further funding reform in future.

Key outcomes and next steps

1. National Primary Health Care Strategic Framework

The National Health Reform agreement calls for the Commonwealth to work with states and territories on system-wide policy and state-wide planning for GP and primary health care services, including through the development of a National Primary Health Care Strategic Framework by December 2012. At the same time, state-specific plans for primary health care will be developed, which are to be completed by July 2013.

Participants discussed these processes and the best ways to influence them in order to address the various issues and concerns discussed during the Policy Think Tank. In particular, participants discussed the importance of how primary health care is defined in these policy frameworks, especially as it relates to allocation of resources within the primary and community health system under the new funding arrangements. Participants also discussed the importance of new funding arrangements recognising community-based services (and their cost weights) appropriately.

Action

- *AHHA will find out in more detail where the processes to develop the National Primary Health Care Strategic Framework and bilateral primary care plans are up to, to determine where the best points of influence for AHHA and member bodies will be.*
- *AHHA should also consider calling on COAG to guarantee funding for primary and community-based services care grows at least as quickly as funding for acute services.*

2. Learning from best practice

In discussing the enormous opportunities presented by the reforms, participants discussed the importance of being able to learn from others about what works and what doesn't especially as Medicare Locals are being rolled out, and about examples of best practice. In fostering an environment where best practice is shared, there is also opportunity for the best performing organisations to work with and mentor newer organisations as they come online.

Action

- *AHHA will work with the Australian Medicare Locals Alliance (AMLA) to identify best practice models of Medicare Local collaboration across sectors and innovative service delivery, and work with other partners such as the National Primary and Community Health Network to disseminate this knowledge and information.*

3. Future funding reform

As noted above, participants discussed the importance of continuing to pursue reforms to existing funding models in the long term. Development of new funding models, such as capitation funding and blended payments, should incorporate, for example, weighting for factors such as socio-economic status in order to provide more flexibility (and resources) for dealing with people with complex needs. There was also discussion about the need for review of existing financial incentives such that funding is more strongly weighted towards and provides incentives for prevention and primary health care, in order to achieve the National Health Reform Agreement's objective of promoting and rewarding 'allocative efficiency' across the primary, preventative, acute and other sectors.

Action

- *AHHA will work with members, partner organisations and government to identify opportunities for further development of new funding models in primary and community health care – including through mechanisms such as the development of the National Primary Health Care Strategic Framework, and using mechanisms already in place such as the Diabetes Coordinated Care trial as catalysts for advocating for further change.*

4. A new AHHA Network

In order to pursue the actions outlined above, Think Tank participants discussed the establishment of an AHHA Network of members.

Action

- *AHHA will establish a new Network of members, which will compliment but not duplicate the work of the existing National Primary and Community Health Network.*

Conclusions

During this phase of implementing the reforms, there is a real sense in the sector of getting on with the job of making the reforms work. This sentiment was on display at the Policy Think Tank, where participants exchanged ideas and discussed the possibilities and opportunities presented by the reforms for improving patient services, and the coordination and integration between them.

At the same time there is recognition that reform does not happen overnight: it is slow, sometimes painfully so, and it is still relatively early days in the implementation of the national health reform agreement.

There are also some concerns in the sector about some aspects of the reforms, and a lack of clarity about how particular aspects of the reform will work. In some cases, this clarity will only come over time as the reforms continue to roll out. In other cases further clarity needs to be sought from government, to ensure the national health reform process delivers on its objective of a better integrated, more coordinated, high quality and sustainable health care system for the future.

Prue Power AM

Chief Executive Officer, Australian Healthcare & Hospitals Association