Australian Healthcare & Hospitals Association

Submission on the
National Primary Health Care Strategic Framework

October 2012

1. Background

The Australian Healthcare & Hospitals Association (AHHA) welcomes the opportunity to provide feedback on the National Primary Health Care Strategic Framework.

The Australian Health & Hospitals Association is the peak body and advocate for the Australian public healthcare and not-for-profit sectors. Our membership includes state health departments, Local Hospital Networks and public hospitals, community health services, Medicare Locals and primary healthcare providers, universities, and individual health professionals and academics. We are uniquely placed to be an independent, national voice for universally accessible, high quality healthcare.

The AHHA is a strong supporter of national health reform, and recognizes the importance of a strong, effective and sustainable primary health care sector to the health of all Australians.

2. Introduction

It is critical to ensure effective alignment between primary care and other sectors of the health care system to address fragmentation and a lack of coordination. This requires a strong emphasis on navigation, coordination, advocacy, and community / consumer engagement.

It also requires serious consideration of alternative funding arrangements and allocation of resources including a mix of block or grant and activity funding arrangements and tying expenditure to enrolled populations and identified targets where necessary.

It is essential to ensure consistency of approach across States and Territories in the proposed bi-lateral plans if the new arrangements are not to further entrench disparities of health outcomes across the nation.

There must also be a concerted effort to ensure Medicare Locals meet uniform performance targets with regard to the health status of the populations they serve.

3. Scope and Vision Priorities and Actions

Scope

The intended Scope of the draft Framework is appropriate; however, it could be enhanced by a clearer statement of the definition of primary health care as various meanings can be applied depending on the context of the discussion, leading to unnecessary debate and confusion.

The narrative under the heading of Primary Health Care in Australia commencing on page 6 describes a primary health care system which encompasses public and private sectors, involves a range of providers and recognizes consumers and communities as key partners, as well as the importance of prevention.

This philosophy is not consistently reflected in the document. There is limited demonstration of engagement with the private and non-government sector in the Action statements. Similarly there is minimal recognition of the role that government agencies, other than health agencies, play in influencing the health of the population.

The Priorities and Action are GP-centric and tend to ignore the significant role of other clinicians.

Vision

A strong, responsive and sustainable primary health care system that improves health care for all Australians, especially those who currently experience inequitable health outcomes, by keeping people healthy, preventing illness and reducing their need for hospital services.

The vision for Australia's primary health care system should be of a system that improves health outcomes rather than just the provision of health care. Addressing the social determinates of health will significantly improve the health of Australians, particularly those currently bearing a burden of disease and illness. Much of the work required in this area is the responsibility of agencies other than in the health sector. The need to engage with these groups should be acknowledged in the vision statement.

Similarly the pivotal role of consumers and communities as key partners should be acknowledged and integrated into the vision and the actions which should follow.

The following amendment to the Vision is suggested:

A strong, responsive and sustainable primary health care system that improves health for all Australians, especially those who currently experience inequitable health outcomes, by engaging consumers, communities, government, non-government and private agency providers to coordinate effective and efficient health promotion and illness prevention and management strategies.

4. Priorities and Actions

The AHHA is supportive of the identified priority areas with the following suggested amendments to the Action items.

Strategic Outcome 1: Build a consumer-focused integrated primary health care system

Subject to the following comments, it will be critical to build a more explicit consumer role into all the elements of Strategic Outcome 1 to ensure the development of a genuine consumer focused integrated primary health care system.

1.1 Establish formal planning and engagement protocols between Medicare Locals and Local Hospital Networks, to ensure that, in partnership with consumers and other providers, they develop joint service plans, work together and co-operate in ensuring the delivery of services that achieve the best outcomes for individuals and the wider community.

Coordination between Medicare Locals and Local Hospital Networks is critical to optimizing the patient journey through the health system. This will, however, not be without significant challenges due to the variation between jurisdictions in the number and size of MLs and LHNs and the governance structures and associated level of responsibility within each ML and LHN.

1.2 Identify high risk population groups and develop evidence based health care interventions for them

Nil comment

1.3 Work together, and with Medicare Locals, to examine innovative care coordination and/or case management arrangements for people with complex chronic conditions that focus on secondary and tertiary prevention, improve health outcomes and literacy and reduce avoidable hospitalisations.

Examining existing arrangements is a somewhat limited approach and should be strengthened eg "…identify and support the implementation of…"

Utilisation of avoidable hospital admissions as a performance indicator is one of a number of measures that could be used eg PBS and MBS utilisation. A broader term such as '…reduce health resource utilization…" could be considered.

1.4 Examine ways to manage more complex, urgent cases within the community by facilitating the development of integrated and ambulatory extended hour clinics in areas where sufficient demand is identified.

Nil comment

1.5 Develop and promote innovative 'pathways through care' models which support more integrated and seamless care for consumers.

Significant reform of the current Activity Based Funding and National Hospital Pricing Framework would be required to achieve the intent of this action area. The current model reinforces the boundaries and silos around hospital based care delivery and has limited capacity to support integrated care particularly for chronic conditions. Reform of the funding model to allow bundling care and associated funding across sectors will be necessary to achieve the desired "pathways through care'.

The proposed leadership by the National Lead Clinician's Group will be an important factor in encouraging information sharing and innovation. The ability of the NLCG to facilitate a bottom-up approach is yet to be tested.

1.6 Building upon the National Primary Health Care Strategy, promote discussion on funding models that include incentives for a focus on the health of the population, promote safety and quality and reduce preventable hospitalisations, including primary and secondary prevention, screening, early intervention and chronic disease management.

The use of Medicare and the MBS to drive practice change and support integrated care has had varied success. As indicated above the capacity to coordinate care across funding streams (Medicare and hospital-based funding) remains limited.

Strategic Outcome 2: Improve access and reduce inequity

2.1 Promote models that facilitate long term relationships between consumers and general practices to address service gaps.

This action and associated narrative is very GP-centric and, while the important role played by general practitioners is acknowledged, a broader view would be appropriate. As the consultation paper states on page 6, primary health care encompasses a large range of providers many of whom may be a consumer's point of entry to the health system and with whom an effective long-term relationship may be established. It can be argued that the GPs gate-keeper role can contribute to access issues, inefficiencies and poorer outcomes due to limited availability of GPs, inappropriate referral pathways, delays in accessing specialist care and at risk or inequality communities that do not access a GP service as their first point of care.

The consultation paper highlights elsewhere issues with GP numbers and the need to utilize their skills at "the top of their scope of practice" and yet chooses to perpetuate the gate-keeper role of the GP rather than support broadening of this role to encompass existing effective and efficient models including Nurse Practitioners, Pharmacists and Aboriginal Health Practitioners.

It is anticipated that this section will attract negative feedback from a range of non-GP providers.

The highlighting of patient centred care is laudable; however, many current models of patient centred care perpetuate barriers and silos. The NSW Clinical Excellence Commission model of patient-based care provides a suitable alternative approach.

2.2 Examine ways to improve access for people who experience difficulty accessing primary health care, including Aboriginal and Torres Strait Islander people, people living in rural and

remote areas, people with additional or specialised health care needs and people with lower socio-economic status.

Nil comment

2.3 Examine ways to work together with primary health care providers and professional organisations to promote the development of multidisciplinary teams in which all team members are supported to fully develop their clinical skills and potential

As previously noted, an action beyond 'examine' to encourage implementation would be appropriate.

This section of the consultation paper presents a number of contradictory positions. While increasing need will drive demand for a variety of health service providers, the existing shortages of providers other than GPs should be acknowledged, particularly in rural and remote areas. This is of particular relevance to the proposal that "the skills of health professionals are maximized to the top of their scope of practice or scope of license".

This is an unusual use of the term 'scope of practice' which is not defined. While it is assumed that the "top of their scope of practice" is intended to refer to complex interventions or processes that make maximal demand on a clinician's skills and knowledge, it could equally be interpreted as meaning the highest volume or most expensive interventions. The term 'scope of practice' is more routinely a part of the regulatory function for health professionals carried out by the respective National Boards.

The paper proposes that focusing GPs on the "top of their scope of practice" will enable other providers to work at the top of their scope of practice. This contradicts the next sentence in the paragraph which states that this approach will allow team members to fully develop their clinical skills and potential. It is difficult to see how focusing on one area within the full scope of practice will 'fully develop' a clinician.

It is further assumed that the intent is to minimize overlap in service provision by different providers as a means of ensuring that clinicians do not waste time and resources undertaking less skilled or menial tasks. The summation is at odds with the early arguments in the consultation paper calling for the maintenance of the GP as the gatekeeper to the primary care system. It also further contradicts the call for efficient team-based care. A system that shuffles clients between 'specialised' providers in the name of efficiency does not support a simple and seamless journey for the client.

The 'top of scope of practice' model also assumes that consumers have timely access to a broad range of providers, whereas the reality is primary health care providers must be skilled in a broad range of areas and have the capacity to become substitutes for scarce or non-existent services.

2.4 Translate both new and existing health system intelligence, such as research, economic modelling and needs assessments, into evidence based planning and service delivery.

Nil comment

2.5 Maximise the opportunities enabled by the transformations occurring through eHealth, including the Personally Controlled Electronic Health Record (PCEHR) and Secure Messaging initiatives.

Effective clinical hand-over is a key quality and safety issue and is included in the National Safety and Quality Health Service Standards. Specific mention of the use of eHealth advancements to support transfer of care between the primary and secondary/tertiary sectors would be warranted.

Strategic Outcome 3: Increase the focus on prevention, screening and early intervention

3.1 Examine opportunities to address the social determinants of health (such as social status, health literacy, housing and education) that are contributing to poor health outcomes.

On behalf of Catholic Health Australia, The National Centre for Social and Economic Modelling (NATSEM), University of Canberra, examined the cost of Government inaction in addressing the social determinants of health.

NATSEM reported that the adoption of the recommendations World Health Organisation Commission on Social Determinants of Health would result in:

- 500,000 Australians avoiding suffering a chronic illness
- 170,000 extra Australians could enter the workforce
- Annual savings of $4 billion in avoided welfare payments
- 60,000 fewer individuals admitted to hospital per year, over 500,000 fewer hospital separations and a reduction of 1.44 million hospital bed days, saving $2.3 billion in annual hospital expenditure
- 5.5 million fewer Medicare services per year, saving $273 million annually
- 5.3 million fewer PBS scripts per year, saving $184.5 million annually.

Given the significant benefits that can be achieved through addressing the social determinants of health, consideration should be given to making this strategic outcome goal the first in the strategy list.

Progress has been made in some jurisdictions to implementing a 'health in all policies' approach to addressing the social determinants of health (eg South Australia - Health in All Policies approach and Tasmania - Fair and Healthy Tasmania).

The inclusion of actions to promote the Health in All Policies model and the use of Health Impact Assessments is recommended.

3.2 Target known lifestyle-related health risk factors, such as excessive alcohol consumption, smoking, physical inactivity and poor diet and nutrition.

Australia has established an international benchmark with the introduction of plain-packaging for tobacco products. The inclusion of actions supporting similar landmark policies (including limitations on alcohol and junk-food advertising) is recommended.

Undertake research and evaluation to identify the best use of new technologies and enable increasing use of home based monitoring, treatment and support.

The inclusion of actions supporting translation of research and evidence to practice is recommended.

Strategic Outcome 4: Improve quality, safety, performance and accountability

4.1 Ensure performance indicators are in place to determine whether primary health care services are being used as, when and how they should be.

Consumer involvement in the development of performance indicators will support relevant and responsive measurement and reporting.

4.2 Support the Australian Commission on Safety and Quality in Health Care to develop safety and quality standards for primary health care, with the expectation that these standards will support integration through consistency with the standards developed for the acute sector, where appropriate.

Nil comment

4.3 Promote the role of consumers as key members of the health care team and empower them to make decisions about their own health and social needs

This action would be better placed under the current Strategic Outcome 1: Build a consumer-focused integrated primary health care system

5. Related Activities

5.1 Innovative issue analysis

In June 2011 the AHHA conducted a ground-breaking National Health Reform (NHR) Simulation and Master Class which brought together senior clinicians and managers with current or recent experience in the health care system to participate in a 'road-test' of the new environment to be created by the NHR Agreement and its enabling legislation. Their task was to identify some of the challenges around its implementation. While not being deterred by the emphasis on increasing productivity, participants agreed that:

- the NHR 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
- traditional funding mechanisms are unlikely to provide adequate incentives for multi-professional team care involving a range of services
- the Independent Hospital Pricing Authority must ensure innovative use of Activity Based Funding including the development of a comprehensive understanding of how ABF systems for non-admitted patients are constructed in order to fund care delivery in the setting most appropriate to the patient needs
- innovative models of care created by the need to integrate services (eg across LHN-ML boundaries), need to be priced; this is particularly so for patients with complex needs, such as the chronically ill and the aged

- without this approach, there is the potential for skewing of incentives resulting in some patients being treated inappropriately as inpatients.

These outcomes echo the issues raised earlier and emphasise the need for funding models to support seamless provision of care across traditional boundaries. The simulation process was also an effective mechanism to examine the impact of proposed structures and models.

5.2 Networks

The AHHA coordinates a number of policy networks. These networks bring together clinicians, managers, policy makers and academics to examine concerns, identify possible solutions and develop policy position in relation to key issues confronting the health sector. Networks can be focused on particular clinical issues, service streams or policy matters. The networks provide a mechanism to rapidly review issues and proposed policies and draw on the knowledge and skills of many of the nation's most senior and experienced clinicians and managers from across the public, non-government and academic sectors in all States and Territories.

5.3 Research

The AHHA has recently launched the Deeble Institute. The Deeble Institute brings researchers, policymakers and clinicians together in a new research institute.

The Institute will focus its work in four main areas:

- publishing accessible and objective briefs on evidence-based health policy
- undertaking rigorous, independent research on important national health policy problems
- organising conferences, seminars, think-tanks and workshops
- assist policymakers, researchers and practitioners to build relationships in areas of mutual interest

The AHHA believes that the best health policies are made when policymakers, practitioners and researchers work together and the Institute that will bridge the traditional gaps that have existed between these groups.

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