Submission

Australian Healthcare & Hospitals Association

National Primary Health Care Strategy

27 February 2009

About the AHHA

The Australian Healthcare and Hospitals Association (AHHA) has a strong commitment to primary and community healthcare. We represent the public healthcare sector which is increasingly working in the primary healthcare space, and has been working for decades in the community health sector. Our interest is primarily in the best-functioning *health system* possible, not the best functioning *sections* of the system that still may not interface well. To this end, our principle policy in primary healthcare is on *Service Integration* (copy attached) which explores practical options for better integration of care across a range of settings and contact points. This includes hospitals, general practice, community health centres, Aboriginal and Torres Strait Islander health services, private specialists, oral and dental services, residential and home-based aged care, rehabilitation and other allied health services.

Background

In early 2008 the AHHA undertook a major policy development exercise that resulted in three key policies, each relevant to a National Primary Health Strategy:

- Service Integration;
- Information Management; and
- Data and benchmarking.

In September 2008 the AHHA responded to our members' requests to hold a specific event to explore the principles on which primary healthcare should function (and arguably the system as a whole). Dr Hobbs was one of our keynote speakers for this event.

Earlier this month, the National Health and Hospitals Reform Commission (NHHRC) released its interim report which included a number of recommendations relating to primary and community health care. Our principles are broadly supported by the findings of the Commission. Several of the long-held policy positions of the AHHA have been picked up by the NHHRC in their report, as specified below. The AHHA also understands that the External Reference Group will consider the findings of the NHHRC.

Contact

Ms Prue Power
Executive Director
Australian Healthcare & Hospitals Association
P: 02 6162 0780
F: 02 6162 0779
E: ppower@aushealthcare.com.au

What is the *health system*?

The current health reform debate is a contested environment, and it is difficult to see a clear path through the expressions of vested interest from each sector or professional group. Indeed, the 'system' is often conceived as a sum of its parts – an approach we need to move away from.

How can we make it so that the *best* approach for integrated health care, which includes primary and community health as key tenets, is what we achieve through this reform process? If nothing else, the fragmentation that characterises our current system must be the starting point on which reform of the system is built.

While we talk about the *health system* and *healthcare*, what is fundamentally at stake is the increasing sense of *community* that the public has about its interactions with governments and service providers. The public has certain expectations of the health system, and the media tells us that they are not satisfied with the care they receive. This may be true for a likely minority of people, but the *ideal* system would work to ensure that minority is based only on the most difficult circumstances in which the professionals providing the care did everything they were meant to, and humanly could do with the best resources.

Increasingly the community want more input to their healthcare, through controlling their own health records and accessing them electronically, and fundamentally being empowered to contribute to service decisions at the local level.

The outcomes being sought from healthcare are of utmost importance in the reform process. If outcomes are measured on episodic care, this would probably reflect well on the system as it functions now. Yet we know that it often does not function to maximum efficiency OR community satisfaction – because the system we have is the product of historical circumstances that have generally not involved major planning and design with longer-term and more holistic outcomes in mind.

So for an improved system, the outcomes the community expects are critical: work on population-level design (for specific groups); ensure access is universally available; provide education for the public to know where to go for information; DO NOT base outcomes on diseases (positive results will show through if all care available to people is well coordinated and connected). To this end, the ultimate goal is to integrate medical, allied health, social and community services as much as possible. Expectations that professionals have of care they offer also need to be flexible depending on where people are at in their own life, health and wellbeing. What does the patient want?

Agreed principles

The principles agreed at the AHHA *Community & Primary Health Care Policy Think Tank* were:

1. Shared commitment to **partnerships**
2. **Independent governance** of community and primary healthcare
3. Population-based **health promotion** responding to local need
4. Services **planned** on a sustainable population basis (possibly for enrolled populations)
5. Using **data and evidence** for local planning, with cost and quality monitoring built-in
6. Promoting the **individual as responsible** for their health (including health literacy)
7. **Community ownership/buy-in** that allows for better response to local needs
8. **Communicating better** between professionals, settings and with the individual/family
9. Enabling **Medicare access** to a range of practitioners
10. Allowing for the broader **pooling of funds**, including support for the public/private mix
11. Celebrating and supporting the **role of the generalist** in primary and community health

Enablers to achieve reform

To ensure services are better integrated and offer clear pathways for patients throughout the system whatever their needs are, there are three key enabling foundations:

1. Good quality and timely data available at the local level for planning purposes, and to monitor the outcomes achieved by system reform;
2. Unique patient identifier with a nationally consistent electronic health record that is accessible by all health professionals in all settings, and by the patient themselves; and
3. The right workforce mix, planning, supply and ongoing education.

These factors are imperative for primary and community health, as well as the rest of the system. An improved approach to primary care will not happen until the best data are available, professionals can communicate across all borders, and the right mix of workforce is functioning to deliver the most efficient and effective care where and when it is required.

Comments on the NHHRC Interim Report

The AHHA fully supports the development of **Comprehensive Primary Health Care Centres** based in some part on GP Super Clinics but with a broader remit and mix of services. The model of Community Health Centres in Victoria should also be considered in the development of such Centres. The AHHA believes that while GPs are critical in the primary and community care mix, there must be a considerable range of professionals in such centres who can provide timely and high-quality care when it is required. This should not be limited to rural and remote areas as suggested by the NHHRC; for example enabling practice nurses to undertake a broader range of tasks within their skillset to take the workload off GPs across the board. It is recognised that the general practice workforce is changing, and with more GPs choosing to work part-time the role that practice nurses and allied health professionals can play in coordinated patient care must be reconsidered, clearly defined and funded appropriately. A practical approach for funding Comprehensive Primary Health Care Centres is included in the next section.

The AHHA reiterates the imperative for significantly improved, nationally coordinated and publicly reported **data on primary health care**. Data would be collected primarily with consideration for safety, quality and cost-effectiveness. At present there is very limited data available on primary healthcare at any level, and though Medicare contains a large amount of information it is not optimised to enable analysis, and is certainly not available to researchers on a confidentialised basis. Data is one of the first steps towards understanding the current system and planning for improvements.

With the proposal for the Commonwealth Government to **take over all primary** and community health responsibility (funding, policy and planning), data collection and reporting should be easier. However the AHHA does caution against two possible outcomes of full Commonwealth responsibility:

- **Duplication**: the Commonwealth must invest upfront resources to fully scope the current delivery of primary and community health care in Australia, in all areas. There is a significant risk that if this kind of scoping exercise is not undertaken, and tenders proceed for the delivery of services in particular areas, there may be duplication of existing services and severe wastage of funds – not to mention confusion for consumers;
- **'Cheap medicine'**: in the pursuit of 'best value for money', services must not be funded that will 'churn' patients through in a way that promotes poor quality healthcare, such as simplistic Enhanced Primary Care plans. This kind of practice is a large risk in the current fee-for-service model of many primary health services, and clearer incentives must be built into the funding system to achieve the right outcomes for patients based on their specific needs.

The AHHA believes that, under Option A proposed by the NHHRC, there will still be **'border issues'** around the interface between primary/ambulatory and other forms of healthcare (ie. between the Commonwealth

and state/territory service expectations). There is a concern that there still may be cost- and blame-shifting occuring in this system, particularly when one sector stands to benefit or save money by unnecessarily shifting patients into the other sector. Other areas of complication may arise, for example for people seeking mental health care that often have to cross service boundaries on a regular basis.

Another area briefly commented on by the NHHRC is the **multi-purpose service (MPS)** model. The AHHA is currently working in partnership with the Australian College of Health Service Executives (ACHSE) on exploring and revitalising the MPS model for rural and remote areas. Some of the issues already raised during this policy development exercise include:

- The MPS model has brought complexity (reporting, acquittals) as well as flexibility;
- There are major inconsistencies within states let alone across jurisdictions;
- Individual corporate governance is a concern for consistency while maintaining local flexibility;
- The variation in accountability, accreditation and standards across MPS's in operation;
- The critical relationships between the service delivery and customer base – containing services within the catchment area;
- The need for a clearly defined national policy document and regulatory framework;
- The need for evaluation of the model and the setting of national benchmarks to demonstrate the successes and evidence of the model's cost-effectiveness;
- Concern over the equitable distribution of Commonwealth funds for aged care services where they have been specifically earmarked; and
- Ongoing concern at the hospital-centric focus of many MPS.

The AHHA and ACHSE are working towards a clear direction forward for the MPS model in Australia, which will feed into the broader development of Divisions of Primary Health Care and Comprehensive Primary Health Care Centres.

Practical options

Option A – Divisions of Primary Health Care

The AHHA fully supports the evolution of *Divisions of General Practice* to *Divisions of Primary Health Care* as a first step in the reform of healthcare.

There is no question that the Divisions of General Practice are in need of review, with some operating well and others less so. In order to better reflect the range of primary care options and professionals across the country, the Divisions should be broadened to incorporate all forms of ambulatory care. The review should also include redefinition of Division boundaries based on population needs, and consideration of the roles and responsibilities of the new Divisions (for example, in local planning).

The AHHA envisions that the revised Divisions would be an integral part of regional governance arrangements in the longer term, with the devolution of planning and funding decisions to the same level (as outlined in both the *Service Integration* policy and *Mental Health Funding and Governance*, AHHA pubications attached).

On request, the AHHA is prepared to assist in developing a more detailed business case ('road map') for the transition to Divisons of Primary Health Care, particularly as they will relate to acute services.

Option B – Comprehensive Primary Health Care Centres

In conjunction with revised Divisions of Primary Health Care, the AHHA recommends the development of Comprehensive Primary Health Care Centres (CPHCC), modelled in part on UK Primary Care Trusts. For this to be coordinated and put into operation, there are some clear up-front requirements such as evaluation of all existing Australian models of primary care (corporate, Community Health Services, GP clinics, Aboriginal

and Islander Health Services) and a realistic appraisal of the financial and staffing resources required to ensure the Centres are successful in servicing the needs of their local communities.

A public-private partnership approach would enable the government to cost-share with private companies and businesses to leverage the funds as appropriate. For example, in a CPHCC, space may be rented out to specialist, pathology and imaging services, the buildings may be renovated or built from new in partnership with development companies, and a range of private allied health professionals would be co-located. Initially the developers may own the building space for 50 year terms, for example, at which point they would vest to the government.

Any plan for implementing CPHCCs would need to invest considerably more funds into capital, staffing and design than allowed for the current GP Super Clinics, and would need to be planned on the basis of population needs. Where facilities and services are already established, these should be assisted to evolve into CPHCCs to ensure there is no duplication of existing services across regions. For example, Community Health Services and GP Super Clinics (including GP Plus Centres in SA, HealthOne in NSW, etc.) should be considered as existing CPHCCs with reporting requirements streamlined and developed to reflect national performance benchmarks and accreditation standards.

Any transition process must be managed well, particularly if the establishment of CPHCCs leads to the closure of small GP surgeries and allied health practices. Public awareness is imperative to ensure there is limited backlash over any service relocations or closures. In the context of regional planning and contracting, there would still be the need for stand-alone practices as long as they are involved in local planning processes through the Divisions described above.

As above, the AHHA is prepared to assist in developing a more detailed business case ('road map').

The historical reactive approach to healthcare – waiting for patients to show up and treating their problems – will not facilitate reform. Health services and delivery must be shaped around a new approach to responding to community needs. Associate Professor Lynn Robinson [University of Queensland] suggests an innovative way to begin changing the behaviour of GPs and as a result the care of their patients – the appointment book. Using the GP's appointment calendar, time can be planned out in advance – their skills can be devoted to complex care for increasing numbers of people with chronic diseases or their particular area of interest; while an expanded workforce on-site can provide the bulk of routine care even to people with complex needs. At the local practice/clinic level, this will make a big difference to the job satisfaction for GPs and other health professionals, and increase the capacity of clinics to see more people on demand.

More detail on The Principles

1. Shared commitment to **partnerships**

   Allowing for local solutions/representation and using flexible funding models
   Examples:
   - Hospital Admission Risk Program (HARP) – Victoria
   - Primary Care Partnerships – Victoria
   - Community Health Centres – Victoria

2. **Independent governance** of community and primary healthcare

   Allowing for community accountability, self-determination ethos within national standards, financial security for viability and fostering partnerships
   Examples:
   - Community Health Centres – Victoria
   - 'Active Service Model' – ability assessment and enhancement

3. Population-based **health promotion** responding to local need

   Supporting self-responsibility and management, requiring a community development framework that is respectful and inclusive of culture, location and socio-economic background
   Examples:
   - Colac Childhood Obesity program – Victoria
   - Community Health Centres - Victoria

4. Services **planned** on a sustainable population basis (possibly for enrolled populations)

   Patient centred assessment and care planning funded by packages that follow the patient to provide both individual and group interventions as well as social determinants (eg. transport costs); possibility of enrolled populations based on community-level rather than individual enrolment with one provider – with clear responsibilities for who does what
   Examples:
   - Alpine Health (contact: Lyndon Seys) - Victoria

5. Using **data and evidence** for local planning

   Evaluation of programs to assess short- and long-term outcomes, with services to be funded accordingly; access to services monitored and measured to plan for future funding

6. Promoting the **individual as responsible** for their health (including health literacy)

7. **Community ownership/buy-in** that allows for better response to local needs

   Allowing for community to contribute to and engage in planning and direction-setting, using performance indicators on policy development, implementation and outcomes
   Examples:
   - Darebin Community Health Centre (contact: Vicki Mason) – Victoria
   - Gateways 4 Sustainable Communities – Victoria
   - GP Plus centres – South Australia

8. **Communicating better** between professionals, settings and with the individual/family

   Providing access to a broader range of health and social disciplines, allowing for continuity of care and effective evidence-based referral pathways; ensuring communication is electronic and based on unique identifiers
   Examples:
   - Silver Chain Home Improvement Program – Western Australia
   - Health-E-Link – New South Wales
   - Hatrix medication management – Northern Territory

9. Enabling **Medicare access** to a range of practitioners

   Possibly nurse-led but including other practitioners, less pathologised and integrated to GP's software

10. Allowing for the broader **pooling of funds**, including support for the public/private mix

    Organise health sectors into one system by coordinating funding and resources to reduce duplication and fragmentation; allow flexibility of funding for local responsiveness

11. Celebrating the **role of the generalist** in primary and community health

    A new kind of training for professionals who account for the biological, psychological and social contexts of their patients, backed up by a multidisciplinary team of specialists