

# A Primary Care Reform Agenda for Australia

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## Primary health care and primary care

The term 'primary health care' is commonly interchanged with 'primary care'. However primary health care is a strategy of public health, derived from the social model of health and sustained by the Declaration of Alma Alta, which was jointly sponsored by the World Health Organisation and UNICEF. Primary health care requires addressing the social, political, environmental and economic determinants of health. The task of primary health care and health promotion is to ensure that barriers to health creation are dismantled and that health disparities are addressed.

Primary care is the first point of entry into the health system if some sort of active assistance is sought. In Australia this is currently almost always the GP's office. It may simply involve a single service or intermittent management of a disease condition. But there is the potential, increasingly recognised, for primary care to provide preventative and early intervention services, continuity of care, and referral on for additional medical and non-medical services.

It is a particular problem for health care reform in Australia that these two approaches to health and wellbeing are run together, often with expectations that primary health care and health promotion will be undertaken by the same people who are charged with delivering primary care. This is especially the case when tackling issues such as Indigenous health, smoking, obesity, maternal health and immunisation.

An increased focus and a renewed investment in primary health care and health promotion must accompany reforms in primary care, and there is evidence from the New Zealand experience that this can be done.

For further discussion of the important and different roles of primary health care and primary care, see Keleher, 2001.

For the most part, both elements of the definition are used in this paper and thus primary health care includes general practice, community health services and community-based specialist services in areas such as mental health, alcohol and drugs. It also encompasses health promotion, illness prevention, treatment and care of the sick, and advocacy and community development<sup>1</sup>.

## Introduction

Primary health care services play an important role in the delivery of health care, prevention of disease and injury, and the promotion of health and wellbeing. A well-functioning and effective primary health care system makes an important contribution to the health of the population and the reduction of health inequalities (McDonald et al, 2007). Primary health care is seen as the

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<sup>1</sup> See, for example, the definition used by the Australian Primary Health Care Research Institute at <http://www.anu.edu.au/aphcri/>

linchpin of a well-designed health care system, and so becomes an important focus of health reforms.

However Australia's current system for the delivery of primary care is under strain due to workforce shortages, especially in rural and remote areas, the limitations of fee-for-service and increasing out-of-pocket costs for patients, and the need to better address prevention and to manage and integrate services for the chronically ill. Reform of primary health care services is made difficult by the fact that these services are currently funded by all levels of government, and as a consequence the focus has been too much on costs and blame shifting and too little on efficiency, outcomes and patients' needs.

The reform of primary health care has been clearly placed on the national policy agenda by the new Rudd Labor Government (Rudd & Roxon, 2007a & b). In tackling this important issue, there is little Australian experience and data to show what works, and considerable evidence from overseas to suggest that significant changes in the way such health services are funded and delivered will be needed.

Over the past decade we have seen a slow, evolutionary trend to more organised primary care through the Divisions of General Practice, which are now well embedded as geographically-based planning and development organisations (Smith & Sibthorpe, 2007). This has been accompanied by initiatives funded under Medicare such as GP After Hours Services, and the Chronic Disease Management program, community services funded by the States and Territories, and integrated services such as the Multi-Purpose Services Program in rural areas and the Aboriginal Community Controlled Health Organisations.

Internationally, countries such as New Zealand (Ashton, 2005) and the United Kingdom (Smith & Mays, 2005) have attempted a whole-of-system reform of primary health care services. The chief lessons to emerge from these efforts are that primary care reform needs new organisations and workforce structures, and that these need time and stability to build capability, trust, culture and systems in sustainable ways that will impact on quality and outcomes (McDonald et al, 2006).

Clear policy goals are necessary for defining a possible reform agenda. These policy goals need to address current concerns including: the disparities in health between different population groups; high levels of preventable illness; a growing burden of chronic illness; avoidable hospital admissions; and barriers in accessing primary health care services. Measures to ensure effectiveness and efficiency need to be included together with notions of fairness and equity.

### **Key elements of the current primary health policy framework**

To date, efforts to strengthen the role of general practice in the provision of primary care in Australia have been predominantly through funding provided through the Divisions of General Practice, through GP funding incentives such as Practice Incentives Payments and Service Incentive Payments, and through new Medicare items to encourage health assessments, multidisciplinary care plans, access to allied health services and psychologists, and use of practice nurses.

The most recent review of the role of Divisions (DoHA, 2003) endorsed the general direction of the program and recommended that it be supported by the development of a national primary health care framework. The Howard Government agreed with most of the recommendations,

but stopped short of agreeing to the recommendations to develop a national primary care policy (Australian Government, 2004).

The current policy framework for general practice does go some way to adopting an integrated primary care model. This is, however, built around leadership by the medical profession and the Divisions of General Practice. The Divisions are seen in this model as the: "*the preferred provider for both the Australian Government and state and territory governments*". The detail of the policy framework is to be found in the GP Division Guidelines (DoHA, 2006) and Future Directions Toolkit for Implementation (DoHA, 2007). Key elements are:

- Working with State Government health agencies;
- Population-based funding;
- Incentives for increased use of nursing and allied health professionals; and
- Incentives for meeting disease prevention and management criteria.

### **How well does this primary health model work?**

In September 2006 the Australian Primary Health Care Research Institute at the ANU and the Research Centre for Primary Health Care and Equity at the UNSW undertook a systematic review of comprehensive primary health care models in Australia, the United Kingdom and New Zealand (McDonald et al, 2006).

No evidence was found on the attributable impact of Divisions in improving access to primary health care or improving the health and wellbeing of patients/ populations. However there was evidence of improved access to psychologists<sup>2</sup> and practice nurses who were contracted through the Divisions.

Overall this study concluded that, while there have been many primary care initiatives aimed at promoting access to more comprehensive primary care and multidisciplinary health care teams, these have generally been local initiatives that have not been generalised or sustained. Also there have been few innovations in workforce roles in primary care, with the exception of practice nurses.

Last year the Medical Journal of Australia devoted an issue (MJA 16 July 2007) to issues around primary care reform and the role of the Divisions of General Practice.

A number of salutary points emerge from the papers presented in this issue of the journal.

These include:

- No data is available to enable an assessment of whether the Australian Government (and the community) has obtained value for the considerable financial support provided to the Divisions of General Practice (Sprogis, 2007).
- Divisions have improved infrastructure and other support to GPs but apparently have little influence on primary care performance and it was not possible to examine integration with the rest of the health care system (Scott & Coote, 2007).
- The introduction of new MBS item numbers is a very crude and unpredictable approach to the goal of a strong, robust and integrated primary care system. There is a paucity of evidence that new MBS items have improved patient care (Beilby, 2007).

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<sup>2</sup> Ironically, recent policy changes may have had an adverse impact here. See Hickie & McGorry (2007)

- Only about 2% of patient consultations involve health assessments, care plans and chronic disease management items. Less than 14% of patients with chronic disease are placed on care plans and less than 1% are followed to see if patients adhere to these plans (Beilby, 2007).
- About half of general practice care for chronic illness does not meet optimal standards. Factors contributing to the gap between optimal and current practice include the method of financing, the availability of other disciplines to participate in team care, limited engagement with self-management education, and lack of information and decision support systems ( Harris & Zwar, 2007).
- A strengthened practice nurse workforce has the potential to drive change and improve the delivery of many aspects of primary care. Current initiatives to support the expansion of practice nursing are not based on strong evidence about effectiveness, outcomes or efficiencies (Keleher et al, 2007).

#### The need for better management of patients with chronic illness in primary care

Data from BEACH shows that one third of the problems encountered in general practice are chronic in nature. The Chronic Disease Management (CDM) program allows Medicare rebates for a limited number of allied health and dental services for patients with chronic and complex conditions whose care is managed by a GP under a management plan.

The aim of this program is to provide more coordinated quality care and better access to multidisciplinary team care. However there is no data to indicate that the program delivers effective and equitable care to the people who need it most. Data provided in 2006 by the DoHA showed substantial out-of-pocket costs for some services, especially dental. A recent paper found that the current funding and reimbursement arrangements do not encourage recommended clinical practice by allied health professionals and may be compromising clinical outcomes (Foster et al, 2008).

Analysis by the author shows that in 2006-06 the CDM program cost over \$200 million. But 50% of the cost went to GPs for GP management plans developed without the involvement of other health professionals and only \$43 million was spent on allied health services. The data suggests that the program is providing allied health services to no more than 930,000 people and could be serving as few as 186,000 people (each patient is entitled to 5 services in a calendar year). A comparison of data from 2005-06 and 2006-07 indicates that less than 50% of GP management plans and team care arrangements developed in 2005-06 were reviewed in the following year. This raises further questions about the overall success of the program.

#### The need for better management of patients with mental health problems in primary care

Less than 40 percent of people with a mental disorder report getting any treatment (and many of these did not get effective treatment) whereas 80 percent of people with comparable physical disorders get treatment.

A number of programs (Better Outcomes in Mental Health and the linked Access to Allied Psychological Services, More Allied Health Services) have helped GPs provide mental health services to their patients, but with the introduction in November 2006 of the Medicare Better Access to Psychiatrists, Psychologists and General Practitioners initiative, the focus (and the funding) was turned back from 'block-funded' schemes of collaborative care which provided

services at no cost to the patient to individual provider service systems and fee-for-service rebates. There are no provisions to target these services to those most in need and to ensure that services are delivered across all geographic areas. The evidence to date suggests that the main beneficiaries of this initiative are those who were already receiving mental health services – primarily people in metropolitan areas who can afford to pay the out-of-pocket costs (Hickie & McGorrie, 2007).

An analysis by the author of Medicare Australia data shows that in 2007 some 470,000 patients had a GP mental health care plan, which is a requirement for access to Medicare-funded psychological strategies provided by GPs, psychologists, occupational therapists and social workers.

In 2007 571,088 such services were provided. Over 80% of psychological strategies funded under this program are provided by psychologists. Although patients are entitled to 12 such services in any given year (and 18 in some circumstances) it seems clear that most patients are not getting anywhere near this many services.

In psychiatric services there has been a considerable increase in the number of management plans, although the total number of patients with these is still small, less than 10,000.

There has been no increase in the number of psychiatric consultations, in fact the number of annual services has fallen in recent years. One interpretation for this is that the small numbers of psychiatrists in Australia (around 1,800, nearly all of whom are in metropolitan areas) are so busy that they do not have time for new patients. Increased fees in 2007 may have encouraged them to do less for the same income levels.

### **Barriers to achieving stated goals**

Barriers to achieving these policy goals in the Australian health care system are many. They include:

- Separation of accountabilities between federal, state, territorial and local governments with often parallel policy development and service provision;
- Poorly developed population-based approaches to funding and provision of services and monitoring of population outcomes;
- A major focus on the central role of doctors in the delivery of all primary care services;
- Severe shortages in doctors, nurses, dentists, and allied health professionals;
- Payment systems that favour high utilisation of diagnostic and treatment services and low provision of education, prevention and support services;
- Limited development of group practices and multidisciplinary services on the same site;
- Slow development of nurse practitioner and practice nurse roles in general practice;
- Under investment in information technology and evidence-based decision support systems;
- Lack of incentives for controlling costs in other areas of the health system;
- Limited monitoring and audit of quality and effectiveness of services; and
- Almost no consumer and community involvement in the governance of provider organisations.

Currently only 2% of the health budget is spent on prevention and health promotion activities (AIHW 2002).

### **The Labor Government's approach to primary health care**

Health policy statements put forward by the Rudd Labor Government as part of its election platform give the following broad policy goals for primary health care:

- Improving health outcomes of all Australians;
- Reducing disparities among population groups, with an emphasis on indigenous health;
- Investing in prevention, early intervention and the health of future generations; and
- Controlling growth in health care expenditure, with an emphasis on the costs of chronic illness and hospital services.

More specific policy goals are to:

- Focus on promoting health, prevention and early intervention;
- Encourage better management of chronic disease;
- Support integration and multi-disciplinary care with an emphasis on provision of services in "one place";
- Have better coordination between privately provided general practice services, and community health services run by the states and territories;
- Take pressure off public hospitals; and
- Improve access to health services for working families.

Labor's \$2 billion Health and Hospitals Reform Plan includes funding of \$220 million to strengthen primary care services in local communities through the establishment of GP Super Clinics. These Super Clinics are described as providing infrastructure for GPs and other health professionals, including allied health workers, nurses and some specialists, to work together providing services in rural and regional areas and where Medicare has not been utilised to its fullest extent. Funds will be available for administrative and nursing support, the provision of teaching rooms and facilities and the renovation and building of needed infrastructure.

During the course of the election campaign announcements were made about the location of some 24 GP Super Clinics.

There is currently little information available about the approach and incentives the new Government will utilise to set up these Super Clinics and keep them effectively staffed and operational in the areas where they are most needed.

The National Health and Hospitals Reform Commission will be asked to identify strategies to better integrate primary care and other health services such as state and territory funded community health services and hospitals. Labor has also committed to establish a National Preventative Health Care Strategy which will be supported by a permanent expert taskforce. However there is no commitment to the development of a National Primary Care Strategy.

At this time Labor has made no commitments to the development of improved e-health systems which are essential for the integration of primary and acute care and the better management of chronic illness in the community.

## Lessons from New Zealand

In the United Kingdom and New Zealand, primary health care policy, funding and service delivery are the responsibility of a single level of government, which facilitates the development of shared priorities and goals across the system. In both cases the primary care organisations are required to ensure a broad range of stakeholder input into decision making, including local community representation in governance arrangements. This community orientation provides considerable leverage to influence the range and availability of services at the local level and ensures a greater focus on equitable access for all populations.

Significant health care reform has occurred in New Zealand over the last several decades. Most recently that has included significant population-based investment and restructuring of primary care services.

In 2002 the New Zealand Government introduced a set of primary care reforms aimed at improving health and reducing disparities by reducing co-payments, moving from fee-for-service to capitation, promoting population health care management and developing a not-for-profit infrastructure with community involvement to deliver primary care (Hefford et al, 2005). Increased funding is also provided for local health promotion.

Primary Health Organisations (PHOs) are the local structures for delivering and co-ordinating primary health care services, bringing together doctors, nurses and other health professionals (such as Maori health workers, health promotion workers, dieticians, pharmacists, physiotherapists, psychologists and midwives) to serve the needs of their enrolled populations. They are required to provide both personal care services and services to improve the population's health.

District Health Boards work with local communities and provider organisations to establish PHOs in their regions. There are currently 3.9 million people are enrolled in 81 PHOs, 72 of which have an enrolled population of fewer than 100,000 people (MoH 2007).

A striking feature of the Strategy is that while there are nationally established minimum requirements for PHOs, different approaches and innovations to suit different local populations are encouraged. It is considered that a strong PHC sector is a crucial factor in improving Maori health.

PHOs get a set amount of funding from the government to subsidise a range of health services. The funding is based on the numbers and characteristics (eg, age, sex, ethnicity) of people enrolled with them. That funding pays for:

- Providing care and treatment when people are ill;
- Helping people stay healthy; and
- Reaching out to those groups in their community who have poor health or who are missing out on primary health care.

## **New Zealand's success in the delivery of primary health care services**

The performance management program for PHOs began its staged implementation in January 2006. Enrolment data shows that virtually all high need groups, and a majority of the remainder of the population, are enrolled in PHOs and receiving low-cost access to care.

To date there is little data on which to base an analysis of the success or otherwise of the New Zealand reforms in terms of improving health outcomes. However there is emerging evidence of improvements in access to an enhanced range of primary care services at a local level, including a stronger focus on prevention and early intervention (McDonald et al 2007).

In a recent comparative report of adults' health care experiences in seven countries, New Zealand patients gave their system the highest rating for quality of care. (Commonwealth Fund 2007)

## New Zealand's advantages

Following a recent visit to New Zealand, a group of NSW doctors analysed the advantages that New Zealand primary care services bring to the management of chronic illness and related hospitalisations:

- The New Zealand system favours patient / practice registration;
- There are very few small GP practices, especially in urban areas (and therefore a better platform for structured multidisciplinary chronic disease management);
- Allied health and community health services are closely integrated with, or within, GP practices;
- GPs take a strong interest in reducing hospitalisation and are financially rewarded for doing this;
- There is a greater use of practice nurses; and
- There is a greater use of IT services and consequently better communication about patients' management. (Ruscoe & Stewart 2007)

## **The evidence about what works in primary care reform**

Adapted from the Primary Health Care Position Statement: a scoping of the evidence, commissioned by the Australian Divisions of General practice from the Australian Primary Health Care Research Institute in xxx

### 1. Access

There are a variety of organisational interventions that can increase access to primary health care.

Evidence shows that practice nurses and clinicians' assistants are just as effective as doctors for the outcomes measured, can improve public access, are cost effective and associated with a high degree of patient satisfaction.

Deployment of doctors, practice nurses and specialist outreach teams in new ways can improve services to populations that are historically hard to reach, as can identifying and dealing with specific factors relating to specific populations.

Various forms of fundholding can service as tools to increase access but more research needs to be completed to establish this.

## 2. Chronic disease prevention and management

The main ingredients for success in the organisational delivery of chronic care include:

- Central registry of patients of particular disease types;
- Clinical guidelines and doctor education;
- Collaboration, better communication and delegation of tasks to other team members (particularly nurses and pharmacists);
- Decision support for primary care workers;
- Patient self-management education and support;
- Patient-centres organisation;
- Regular assessments and follow-up; and
- System delivery design and stakeholder involvement in this.

In general, the greater the experience a health system has with particular diseases, the better the patient outcomes and multi-faceted approaches are more successful.

## 3. Population health and health promotion

There is some limited evidence that organised primary care can be effective in health promotion and prevention. Effectiveness is variable across populations and health issues.

## 4. Community /consumer participation

There are clear benefits that result from including consumer input into health policy formulation at governmental and regional levels. It cannot be assumed that altruism will win over self-interest, and the community needs to be educated about health needs outside their own experience.

Patient involvement in their health care decisions is associated with better patient satisfaction, confidence and understanding of their needs.

Effective engagement and Aboriginal and Torres Strait Islander communities and patients has the potential to make a significant contribution to access and health outcomes.

## **Incentives and policy drivers needed**

### 1. Collaboration with State Health Systems

Need policy drivers that will align Federal and State planning and delivery of primary and community health services.

### 2. Population-based Approaches

Need incentives that will result in the development of population-based approaches such as:

- Disease registers.
- Health promotion programs.
- Community consultation and provision of information.

#### Changes in general practice

Need incentives strong enough to:

- Increase the use of practice registers.
- Encourage GPs to reduce hospital admissions and readmissions.
- Encourage GPs to reduce inappropriate expenditure on diagnostic tests and pharmaceuticals.
- Encourage GPs into group practices and working relationships with allied health professionals.
- Increase the use of chronic disease management initiatives.
- Increase the investment in information technology and evidence-based decision support systems.

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