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AUSTRALIAN HEALTH CARE REFORM ALLIANCE
RESPONSE TO PRIMARY HEALTH CARE ADVISORY GROUP
September 2015

AHCRA welcomes both the establishment of the PHCAG by the Federal Government, and the opportunity to participate in its consultation around the Discussion Paper. AHCRA congratulates the PHCAG on this paper, which represents a valuable shift forward in thinking about primary health care. AHCRA responses to the survey questions are as follows.

D1. Are you responding as an individual, or as a member of an organisation?

Organisation	2

D2. Are you…:

Male	1

D3. To which of the following categories does your organisation belong?

Other non-government	16

D4. What is the name of your organisation?

Australian Health Care Reform Alliance

D13. Do you…?

YES Consent to your comments being quoted in reports, as long as you are identified	2

D14. If quoted in reports, what is the name you would like any of your comments to be attributed to?

Tony McBride, Chair Australian Health Care Reform Alliance

SECTION 1 - OVERALL

Q1. What aspects of the current primary health care system work well for people with chronic and complex health conditions?

- Medicare funding for episodic care, and less successfully for ongoing care
- Increasing use of Care Plans
- Some (if very limited) access to allied health care
- Affordable medications in most (but not all) cases
- Highly trained workforce including many dedicated, committed professionals
- Range of services in many (but far from all) areas
- Some good resources to assist practitioners (eg RACGP Red and Green Books)
- Victorian community health services, especially where they have GPs as part of their multidisciplinary teams

Q2. What is the most serious gap in the primary health care system currently provided to people with chronic and complex health conditions?
b) Nationally?

There are a number of key challenges facing the primary health care system, including:

- Inequitable access to primary health care, via affordability and geography
- Workforce shortages and mal-distribution of workforce (especially affecting poorer urban and rural/remote communities)
- Poor coordination of service planning and delivery within the sector and with other health care, social and welfare sectors
- Addressing the needs of people from disadvantaged communities
- Out-of-date funding mechanisms (e.g. severely limited fee-for-service funding, lack of funding for multidisciplinary care with allied health practitioners especially, lack of facilitating much better links with social care)
- Building the capacity of Primary Health Care Networks to be effective system changers
- Bridging the divide between Commonwealth and state funded services
- Promoting and reporting on quality measures
- Poor access to oral health care for many people, in particular those on low incomes
- Conducting primary health care research and translating research findings into practice (a significant gap including in areas of significant costs (e.g over-prescription or pathology referral rates).

Research indicates that there are significant groups in the community who do not have adequate access to primary health care for reasons including geography, cost and cultural security. There are also a significant number of preventable hospital admissions every year for conditions that could

have been either prevented or treated in the community. This indicates that our primary health care sector is not functioning optimally.

Q3. What can be done to improve the primary health care system for people with chronic and complex health conditions:
b) Nationally?

Introduce funding systems and programs that facilitate:

- More equitable distribution of services
- A population health approach to prevention and management of chronic disease
- Multidisciplinary care and care coordination
- Close integration of primary health care, mental health care and social care (especially for people with mental illness)
- Stronger consumer, carer and community participation
- Investment in higher health literacy.

These imply the need to develop many more comprehensive primary health care services e.g on the Victorian community health model.

Q4. What are the barriers that may be preventing primary health care clinicians from working at the top of their scope of practice?

Lack of multidisciplinary services

Lack of funding for stronger multidisciplinary approaches, with clinicians sometimes not referring on clients because of their own financial considerations or the historical cultural of their profession

Lack of support for change management required to develop local approaches involving broader range of practitioners

Funding mechanisms that do not enable more appropriate and longer lasting involvement of allied health practitioners

SECTION 2 – THEME 1, EFFECTIVE AND APPROPRIATE PATIENT CARE

Q5a. Do you support patient enrolment with a health care home for people with chronic and complex health conditions?

Yes	1

Q5b. Why do you say that?

Yes although not compulsory with mechanisms to allow that.

General benefits are :

Linking consumers with a single GP (or team of GPs) will enable practices / services have more certainty about the scale and scope of need and enable them to plan for their whole cohort of consumers with chronic disease (rather than see them as a stream of individual consumers). This should foster more innovation and higher quality service, e.g:

- Provide more coordinated ongoing care of higher quality
- Enable practice nurses or others to play more care coordination roles
- Facilitate a more multidisciplinary team approach to use the appropriate skills of range of allied health practitioners in conjunction with GPs and practice nurses
- Enable services to develop more relevant group programs (around self-management, exercise, health literacy, etc), more focus on prevention (primary and secondary) which will have benefits to consumers, the services themselves and the cost of care.

However this needs to be accompanied by more investment in allied health practice to enable such a multidisciplinary approach.

Q6a. Do you support team-based care for people with chronic and complex health conditions?

Yes	1

Q6b. Why do you say that?

People with chronic and complex care needs require:

- a variety of interventions and supports typically provided by diverse practitioners

- good links with agencies providing social care (welfare support, home care, counselling, housing, social interaction, etc)

These cannot normally be provided by one or two practitioners, however skilled.

The current system offers very limited access to such care, despite the evidence supporting it.

Q7. What are the key aspects of effective coordinated patient care?

Please number in order of importance.

Care coordinators	2
Patient pathways	3
Patient participation	1
other (SPECIFY)	96

Q8a. How can patient pathways be used to improve patient outcomes?

Ensuring a better informed journey for consumers with long-term conditions (via evidence and well-understood local contexts of health and social services)

Q9. Are there other evidence-based approaches that could be used to improve the outcomes and care experiences of people with chronic and complex health conditions?

The new profile of disease within our population, as described well in the paper, suggests to AHCRA that we need to develop much more of a population health approach to care. Funding and providing care as if each individual is a new case does not enable planners and service providers to provide optimal prevention and care. Population health approaches by the PHNs, facilitating broad community-wide approaches alongside the provision of individual care is required. This implies stronger investment in care coordination, in improving health literacy, in addressing some of the social determinants of health that affect many lower income and disadvantaged people with chronic disease, and broader community programs around exercise, self-management etc are required. Some of these are clearly beyond the scope of most current services.

SECTION 3 – THEME 2, INCREASED USE OF TECHNOLOGY

Q10. How might the technology described in Theme 2 of the Discussion Paper improve the way patients engage in and manage their own health care?

Q11a. What enablers are needed to support an increased use of the technology described in Theme 2 of the Discussion Paper to improve team based care for people with chronic and complex health conditions?

Investment in improving consumers' health literacy early after their diagnosis to enable them to play a stronger part in their ongoing care

Q12. How could technology better support connections between primary and hospital care?

Q13. How could technology be used to improve patient outcomes?

SECTION 4 – THEME 3, HOW DO WE KNOW WE ARE ACHIEVING OUTCOMES?

Q14a. Reflecting on Theme 3 of the Discussion Paper, is it important to measure and report patient health outcomes?

Yes	1

Q14b. Why do you say that?

How else do we know if our efforts as a health system are well-targetted and effective?
How will we know where to place our optimal effort?
How will we know where there is mal-distribution of services and how well action to redress is working?

Q14c. How could measurement and reporting of patient health outcomes be achieved?

Q15. To what extent should health care providers be accountable for their patients' health outcomes?

If a partnership approach between providers and consumers was developed, such mutual accountability would be inherent in such a relationship and this question would be self-evident.

Q15b. How could health care provider accountability for their patients' health outcomes be achieved?

Q16. To what extent should patients be responsible for their own health outcomes?

Consumers are already ultimately responsible for their own health, through their own ongoing actions (beneficial and otherwise). Service providers aim to enhance this but they should not assume overall responsibility. Many consumers can be encouraged and facilitated to take more responsibility but crucially will need the right supports and mechanisms to do so.

Q16b. How could patient responsibility for their own health outcomes be achieved?

A mutually respectful partnership approach to managing their health with providers will greatly assist such directions.

Consumer will need increased education in health literacy, decision tools, peer support networks etc.

SECTION 5 – THEME 4, HOW DO WE ESTABLISH SUITABLE PAYMENT MECHANISMS TO SUPPORT A BETTER PRIMARY HEALTH CARE SYSTEM?

Q17a. Theme 4 of the Discussion Paper discusses different payment mechanisms. How should primary health care payment models support a connected care system?

If you prefer a blended model, as described in Theme 4, select all the components that should apply.

Capitated payments	1
Salaried professionals	2
Pay for performance	3
Fee for service	4
Other (SPECIFY)	96
Prefer not to answer	98

17b. Why do you say that?

Mechanisms may well have to be context-specific, and hence none of these is likely to work in all situations. Salaried staff, eg care coordinators, allied health staff, practice nurses, and GPs too may be the most sensible approach in many cases, especially as the system moves away from fee-for-service. Such arrangements, esp for clinical staff, but may not work so well in all contexts.

Capitation is a highly favoured option by AHCRA for care of people with chronic disease, although it may need to be piloted and phased in.

Q18a. Should primary health care payments be linked to achievement of specific goals associated with the provision of care?

Yes	1

18b. Why do you say that?

This will need to be designed carefully in consultation with consumers and professionals, but such an approach would focus all parties on better outcomes.

Q19. What role could Private Health Insurance have in managing or assisting in managing people with chronic and complex health conditions in primary health care?

AHCRA sees no role for private health insurance companies to play a role in managing care. That is the role for practitioners and services broadly. Neither does it see an increased role for PHI in the primary health care field more broadly. AHCRA is highly concerned that greater involvement will lead to a two tier system which would widen the disparities in health in Australia.

Greater private care, where the financial incentives for providers were greater than through Medicare, would inevitably lead to a steady drift of practitioners and/or their time towards such private care for the insured. Given the profile of PHI members, this would lead to greater inequities in access for non-insured citizens.

Q20. Do you have anything you would like to add on any of the themes raised in the Discussion Paper?

Given both the social gradient in health and the inequities in access and outcomes for many low-income, disadvantaged, rural and remote Australians, the paper is very reticent about this issue. There are wide disparities in the complexities of people's social situations, education, income, culture and health literacy that cannot be addressed by assuming a 'one size fits all' approach to care and funding.

AHCRA believes that addressing such inequities should be a very high priority in designing new systems and funding mechanisms.

AHCRA considers that the $5.5 billion currently expended on the private health insurance rebate is an inefficient allocation of resources and that sum would produce much greater outcomes if redirected to investment in public hospitals ($2b) and primary health care and prevention ($3.5b).

AHCRA agrees with the Discussion paper on the range of challenges facing the system and population and also its recognition that:

- a stronger primary health care system is the best way to improve health outcomes
- Medicare is not currently structured to meet our new challenges
- GPs are core to primary health care but we need to be thinking in terms of primary health care services more broadly, reflecting a more desirable multidisciplinary approach
- Greater consumer participation and health literacy are crucial to future sustainability and quality

The principles articulated are supported but AHCRA would add importantly an increased focus on prevention, and equitable distribution of services / affordable access. This should be reflected in the Vision too.

Oral health is a vital part of primary health care, and is mentioned at the beginning of the paper. However no further reference is made to it. There are major gaps in services and this should be addressed.

Key future strategies should include to:

- Identify relevant 'best practice' models of care in different geographical locations
- Develop a mechanism for translating models of care across relevant areas of the health system (such as an information exchange portal)
- Develop and trial funding models which promote high quality primary health care, e.g. capitation, patient enrolment (e.g. in a 'medical home' practice/service for multidisciplinary ongoing care), and block funding
- Increase the scope of practice for non-medical primary health care workers and team-based care, where supported by evidence
- Develop and trial more effective consumer and community consultation practices
- Engage consumers in the development and implementation of models of person-centred care, as well as primary health care policies and programs
- Gradually remove the PHI rebate and redirect towards public hospital, prevention and primary health care funding
- Progressively implement funding mechanisms that promote prevention and care coordination