PRIMARY HEALTH CARE

Key Points

- Primary health care is a central part of Australia's health system
- A strong primary health care sector can increase the equity, efficiency and cost-effectiveness of our overall health care system and help meet the health care challenges of the future.
- Australia's primary health care sector has undergone significant change, including more larger practices, more funding for allied health practitioners and practice nurses and a slow shift to more multidisciplinary care, chronic disease programs, the introduction of community-controlled community health services, a range of quality improvement programs, more vocational training, and the use of information technology.
- Other reforms, such as moving away from a fee-for-service funding system and increasing the use of non-medical health care professionals, will further improve the responsiveness of the primary health care sector to the community's needs.

WHY IS PRIMARY HEALTH CARE IMPORTANT?

A strong primary health care sector is important to Australia for several reasons:

- Equity: ensuring universal timely and affordable access to primary health care increases overall equity of access to the health system more broadly
- Efficiency: the primary health care sector is a very efficient setting in which to deliver health care and contributes significantly to the overall efficiency of the health system.
- Cost-effectiveness: international evidence shows that health systems built on a strong primary health care sector achieve better health outcomes for a lower cost than those focussed on other sectors (such as hospitals)

Given Australia's ageing population, rising rate of complex and chronic conditions and the increased budgetary pressures facing health services, it will be vital for Australia to have a strong and well-functioning primary health care sector in the future.

BACKGROUND – WHERE HAVE WE BEEN?

In Australia, much primary care is delivered through privately-run general practices, funded largely on a fee-for-service basis by Medicare rebates. However, the primary health care sector importantly also includes a much broader and larger range of health practitioners and services, funded via a number of different mechanisms. Practitioners range from practice nurses, diverse allied health professionals to Aboriginal Health Workers. And apart from private practices, services also include diverse community health services, Aboriginal Community Controlled Health Organisations and allied health clinics.

The primary health care sector has undergone significant funding and policy changes over the past several decades including the introduction of:

- community-controlled Aboriginal health organisations

- community controlled community health services, especially in Victoria
- multiple ad hoc changes in state governments policies and funding arrangements for community health resulting in an inconsistent approach across the country
- more multidisciplinary care in private practice (although still relatively modest), especially involving psychologists (via the Better Mental Health and ATAPS programs) and other allied health practitioners (via GP Chronic Disease Management and Team Care arrangements)
- Super Clinics program, as well as incentive programs in the 1990s to increase size of GP practices to allow more diverse teams, and practice expansion grants
- specific rural and remote workforce incentives
- various programs and incentives for GPs to provide preventive services/improve quality (e.g. via PIP, EPC, vocational training, support for the use of IT, Primary Care Collaboratives, practice support visits)
- Divisions of General Practice evolving into Medicare Locals and now Primary Health Care Networks
- PHCRED strategy to support translational research
- specific mental health and chronic disease management Medicare item numbers.

CURRENT SITUATION – WHERE ARE WE NOW?

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

- Workforce shortages and mal-distribution of workforce (especially affecting poorer urban and rural/remote communities)
- Addressing the severe limitations of fee-for-service funding to create more effective care mechanisms
- Transitioning from Medicare Locals to Primary Health Care Networks
- Bridging the divide between Commonwealth and state funded services
- Rising rates of chronic disease and associated cost (that of the four most expensive chronic diseases currently equates to around 36% of all health expenditure[i])
- 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
- Promoting and reporting on quality measures
- Poor access to oral health care for many people, in particular those on low incomes
- Engaging the local community
- Conducting primary health care research and translating research findings into practice (a significant gap including in areas of significant costs (e.g over prescription 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.

FUTURE AGENDA - WHERE WE WANT TO GO?

AHCRA's vision is for a strong equitable and efficient primary health care sector which provides equal access to high quality care to all Australians. To achieve this we believe that we need the following to occur:

What can happen over the next 12 months

- Increase funding for the new PHNs to enable them to properly fulfil their roles
- Quarantine GPs from further involvement by private health insurance
- Monitor the impact of the current funding changes (including rebate freeze and the introduction of PHNs)

Over the next 2-3 years

- 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

Over the next 3-5 years

- Progressively implement funding mechanisms that promote prevention and care coordination
- Fund and support PHNs as regional health authorities to plan and deliver coordinated care within their regions
- Implement flexible and evidence-based health workforce reforms
- Establish a system-wide culture of research and implementation
- Resource a data warehouse that provides primary health care data to inform service improvement
- Implement ongoing consumer collaboration practices in all sectors of primary health care

CONTEXT AND CONTACT DETAILS

This paper is one in a series being developed by AHCRA focussing on the future of our health system. The other papers in the series include: Universal Health Care, Mental Health and Prevention and are available on the AHCRA website www.healthreform.org.au

For more information about this paper or AHCRA please contact:

Tony McBride
Chair and Media Spokesperson
Phone: 0407 531 468

Email: info@healthreform.org.au

[i] Australian Institute of Health and Welfare, *Australia's Health 2014*, Canberra, 2014, p. 98. The four are cardiovascular diseases, oral health, mental disorders, and musculoskeletal.