Australian Health Care Reform Alliance (AHCRA)

Submission in response to the Australian Government Discussion Paper: *Towards a National Primary Health Care Strategy*

February 2009

1. Introduction

The Australian Health Care Reform Alliance (AHCRA) www.healthreform.org.au is a coalition of 50 organisations representing consumers and health care providers advocating for a fairer and more effective health care system.

AHCRA members agree that here are major problems with Australia's health care system.

These include:

- the yawning health gap between Indigenous and non-Indigenous Australians;
- many Australians being unable to access health care when and where they need it;
- an ongoing shortage of health professionals;
- too great a focus on acute care, reflected in a lack of prevention and comprehensive primary health care services;
- poor integration between services; and
- inefficient allocation of resources caused by the current State/Commonwealth division of health care responsibilities.

Addressing these problems cannot simply be fixed with a National Primary Health Care Strategy. Australian needs an integrated health system that nationally planned and coordinated to ensure that all elements of the system are connected and people are able to receive health care that is coordinated and reflects their immediate and ongoing health needs.

The Australian Health Care Reform Alliance recently outlined 15 principles that should underpin the health system, against which the performance of any aspect of the health system, policy or service could be measured.

These are:

1. Universality: Australia should have one universal health insurance system, with monies generated through the taxation system.
2. Equity: Refers to both equity of health outcomes and equity of access.
3. Partnerships: This principle acknowledges the importance of health care providers working in partnership with consumers.
4. Accountability: This principle refers to accountability in terms of expenditure as well the acceptance of responsibility by each and all of the parties involved in health care

5. Transparency: Australians are entitled to regular reports on the status, quality and performance of our whole health care system, both public and private, ranging across the spectrum from primary to tertiary to aged care and at local, state and national levels.

6. Appropriateness: The health system should deliver appropriate, timely and effective care in line with the best available evidence, aiming at the highest possible quality.

7. Person-centred: This principle acknowledges that the person (health consumer) is central in the development of policies related to and the delivery of services in the health system.

8. Community engagement: This principle reflects the importance of the engagement of consumers beyond having a voice in relation to their own health care to the true engagement of the community in the planning, development and delivery of health services.

9. Integrity: The system must have ethical values, based on honesty, objectivity and performance measurement; and high standards of propriety and probity underpinning stewardship of funds and resources.

10. Safety and quality: Effective systems of clinical governance are necessary at all levels of the health system to improve the safety and quality of services. This involves open, transparent reporting and effective organisational systems that promote safety and quality

11. Comprehensiveness: The health system should be able to meet the entire range of people's health needs over their life course.

12. Integration: This principle requires the integration of all types of health services; within and between institutions and individual providers; between government, non-government and private providers, as well as between all levels of government.

13. Effectiveness: Health care should be based on the best available evidence and delivered by the most appropriate health professional.

14. Efficiency: This principle refers to the need for health funding to be allocated and services to be delivered according to population health needs. It also demands that health care services and providers utilise resources efficiently.

15. Sustainability: This principle refers to fiscal sustainability as well to refer to the need to ensure health policy adapts to meet community needs. It also refers to the need to ensure that Australia trains not only the health professionals Australia needs but to also contribute to the health of our region.

These principles apply to every aspect of health care, including primary health care.

2. Response to Discussion Paper Questions

Q. Are there aspects of a future Australian primary health care system that are not included in these key elements?

The key elements are supported but there does not appear to be a requirement for care to be evidence based and for it to meet nationally agreed standards in terms of appropriateness, effectiveness, and cost effectiveness. AHCRA believes the principles of equity and universality should also be key elements of the primary health care system.

A focus on ensuring greater equity, accountability and transparency is promised in the Key Elements – however the only way to ensure there is a real commitment to them in primary health care is to make these elements explicit in the Primary Health Care Strategy .

Q. How can we ensure appropriate services for all geographical areas and population groups?

By allocating funding according to population health needs, not the availability of a particular provider, and by creating opportunities for communities to influence the allocation of health resources according to locally determined priorities, based on health needs data.

Q. How could primary health care services/workforce be expanded to improve access to necessary services?

Utilisation of funding mechanisms that fund the services of a range of providers; that support the services of multidisciplinary teams; and provide an equitable distribution of resources.

Q. What more needs to be done for disadvantaged groups to support more equitable access?

Creating a funding system where resource distribution is based on health needs means that money would flow to where services are needed and disproportionate health needs would demand a disproportionate share of health resources.

Q. With limited public health dollars, how could priorities for accessing primary health care services be determined and targeting of public resources improved?

By ensuring that: services being delivered have a strong evidence base; that they are being delivered according to clinical protocols; that the outcomes are assessed; and the information about the performance of primary health care services is transparent, publicly available and made available in forms that the public can understand.

Q. What is needed to improve the patient and family-centred focus of primary health care in Australia for:

— individual patient encounters;

For people to receive information and advice regarding: what consumer engagement is, and how they might more fully participate in decision-making about their care; the extent to which each service provider places importance on patient empowerment; opportunities to participate in their care; and implementation of the ACSQHC Charter of Health Care Rights.

— health professionals;

The inclusion of information regarding consumer engagement, its benefits and impact on care, in the curricula for the education and training of all health professionals; and the provision of continuing professional education regarding partnership in care.

— health service organisations;

For the performance indicators of all health care services providers to include indicators to evaluate the effectiveness of consumer engagement.

— the broader primary health care system?

It is very important that the entire health care system become better integrated so that the health needs of individuals can be better monitored and illness prevention strategies put in place that are not only effective but are also reinforced across all health care providers.

Improving the “person-centeredness” of health care requires the education of health professionals to embed the importance of consumer empowerment into clinical practice (this includes demonstrating the evidence that exists in relation to positive patient outcomes that arise from consumer empowerment and partnerships in care); addressing Australia’s high rates of health illiteracy in the community (providing public education in the community, schools, in workplaces, and wherever people are accessing health care); but also for the primary health care system to be centred on locally determined priorities, developed through the involvement of community members in the planning and governance of health services.

Q. Are there specific strategies that are needed to better support consumer engagement and input?

National efforts to improve health literacy are vital; the implementation of a community engagement strategy; and the development of health service performance indicators to evaluate the effectiveness of consumer engagement (both in relation to patient satisfaction but also patient outcomes).

Q. How could primary health care be enhanced to better support prevention activities?

Regionalised or local planning for health services would allow services to be more responsive to community health needs. Incentives to provide prevention services need to be build into financing mechanisms as well as performance evaluation and accreditation procedures. Pooling of funds for primary health care would enable resources to be allocated to where they will be most effective.

Q. How could health professionals be better supported to provide lifestyle modification advice and support consumers in behavioural change?

By ensuring their reimbursement for services delivered uses financing mechanisms that reward improvement in health and healthcare outcomes and the delivery of effective services, not simply service volume. Education for all health professionals should include a greater emphasis on preventive health measures.

Q. How can consumers be linked with local primary health care services to support a stronger focus on population-based preventive health care with national reporting?

A system of patient enrolment or registration with a primary health care provider or local health service coordinator would allow a stronger population based focus. The allocation of funding according to population health needs would allow for a stronger focus on population based preventive health care. Improved accountability should also require nationally consistent reporting mechanisms. The current fee-for-service mechanism for primary care does not support population based approaches or the effective management of chronic disease. There is strong evidence that health systems which emphasise regionalised health service planning and delivery can deliver better health outcomes, better access to care, and improve population based approaches to care.[i]

Q. What measures have been, or could be, effective in addressing prevention for specific population groups (eg. Indigenous, rural and remote, low socio-economic status, CALD*)?*

If health service planning and delivery was based on health needs data, it would be possible to better address prevention in specific population groups. Comprehensive primary health care services delivered locally, with significant community input into the planning for and prioritisation of services would deliver better health outcomes for specific groups.

The system of comprehensive primary health care delivered by Aboriginal Community Controlled Health Services (ACCHS) is a locally developed model that provides effective culturally appropriate comprehensive primary health care services that are both responsive to and reflective of local community

needs. Greater support should be provided for the Aboriginal community controlled model and the model considered for wider application.

Q. With limited public health dollars, how could preventive care priorities be determined and public resources subsequently targeted?

If health funding is allocated according to health needs, resources will be available where they are most needed. The allocation of resources should occur where the evidence suggests they will be most effective.

Q. What target groups would most benefit from active clinical care and/or service coordination?

Everybody, but in particular those with special needs; people requiring management of chronic diseases; those with poor health literacy; those of low socio-economic status; those who are culturally or linguistically diverse.

Q. Who is best placed to coordinate the clinical and/or service aspects of care?

No particular discipline - the coordination of care is best managed by a provider (ideally within a local primary health care service) who is geographically close to the consumer and able to liaise with all other providers.

Q. How could information and accountability for patient handover between settings (eg. hospital and general practice) be improved?

The implementation of a nationally consistent electronic health record; through the establishment of funding mechanisms that create incentives for information sharing.

Q. What changes are needed to improve integration between different primary health care organisations?

The establishment of a local health care planning and coordination body which could provide integration between all health care service providers.

Q. Would there be advantages in patients having the opportunity to 'enrol' with a key provider?

Yes. There is evidence to suggest that this would provide better continuity of care (and carer), [ii] better coordination of care,[iii] less duplication, more streamlined processing for patients/consumers, and linkages with other areas of the health system e.g. aged care, and the acute hospital sector.

Q. What aspects of performance of the primary health care sector could be monitored and reported against (eg. for each Element in this Discussion Paper, what are key areas of performance that could be monitored and how)?

Access; timeliness; out-of-pocket costs; appropriateness; affordability; patient centred; health literacy; opportunities for self-management; preventive care; integration with other services; coordination of care; safety; quality; use of health information technologies; flexibility; sustainability (e.g. staff turnover, patient/consumer satisfaction); effectiveness; cost-effectiveness; evidence of collaboration; extent to which partnerships in care are being developed; equity; universality.

Q. Who should be responsible for developing and maintaining a performance framework?

Health professional and consumers should be involved in the development of a performance framework; its implementation, evaluation and monitoring should occur through an independent body, like a permanent Health Commission, or the Safety and Quality Commission should be resourced to undertake this role.

Q. Would there be advantages in linking patient health outcomes and quality of care provided to incentives for health care professionals?

There is some evidence that this can be effective, but incentives should be carefully chosen, fiscally responsible, simple to administer and evaluate, and sufficiently flexible to support continuous improvement, individualised care and improved equity.[iv]

Q. How can we improve the current research culture and evidence-base in primary health care?

By increasing investment in primary health care research; supporting implementation of research and use of clinical protocols; better evaluation of primary healthcare through the use of performance monitoring.

Q. How can we translate evidence or innovation into practice more systematically?

By making the implementation of research part of the process for assessing quality and monitoring performance.

Q. What options could be used to support health care professionals' involvement in research and innovation?

More funded positions to support research in clinical practice in primary health care.

Q. What is the role for eHealth in supporting the provision of quality primary health care?

Very important – improvements in quality and effectiveness will not be realised unless there are improvements in the availability and interoperability of data and health information in primary health care.

Q. Where should the Government prioritise its actions in relation to implementing eHealth reform?

By linking the entire health system electronically – creating a national e-health system.

Q. How can the various information systems be integrated (e.g. state health services and general practice)?

By linking incentives for performance to the provision of robust information from the information system operated by health services.

Q. How could planning for primary health care services at the local level be improved?

If resource allocation were driven by health needs, there would be a strong obligation to collect data about community health needs and for this data to be used for service planning and delivery. The creation of regional health organisations to undertake this role would provide an opportunity for population based health planning that is not available in the current system.

Q. What advantages/disadvantages would there be in having a regional organisational structure with responsibilities (ranging from local planning through to service delivery) for primary health care services?

Lots of advantages – there is good evidence that having a regional organisational structure can: improve integration and outcomes, improve coordination of care, allow population based approaches, and improve access;[v] services that more responsive;[vi] potential for improvements in access and reductions in out of pocket costs for consumers;[vii] address integration and coordination of care, improve the quality of care and the responsiveness of services to population health needs;[viii] and improve the responsiveness and accountability of services, as well as promote community participation in, and understanding of, decisions about health system planning and service delivery.[ix]

Q. Who could undertake this role? – What changes would be need to existing organisations (eg. Divisions of General Practice, Area Health Services) to undertake this?

To avoid the continuation of existing structures in a new framework, it would be more appropriate to create new regional health organisations in which there was participation from the community and all the existing stakeholders.

Q. What advantages/disadvantages would there be if regional organisations were responsible for purchasing some primary health care services for their communities - that is, should they 'hold funding' for health services?

Fund holding would be appropriate but only once the organisation has proved itself to be accountable and effective, in terms of its advocacy and

responsiveness to community health needs. Once the organisation had proved its effectiveness in appraising health needs, and collecting necessary data, funds could be transferred to the regional organisation for distribution according to locally determined priorities. This would allow the development of locally relevant programs, improving the responsiveness and effectiveness of services and (over time) improve health outcomes.

Q. What mechanisms could be used to improve the accountability of primary health care services being delivered in a locality (in respect to quality of care, reach and equity)?

Local governance is the key to improved accountability and responsiveness of services, therefore involving the community in the governance of local services is important. Improved performance monitoring, the development of independent benchmarks, and incentives to improve accountability and transparency are vital.

Q. How can greater community engagement be supported in primary health care?

Consultation with the local community should be part of the planning for primary health care services – this should be an integral part of the performance monitoring of those services; and the involvement of community members in the governance of local health authorities can help prevent the domination of those with vested interests.

Q. What other approaches could improve planning and service integration at the local level?

Publishing comprehensive information regarding the health needs and health outcomes of the local community would allow the development of services and programs to address (and prioritise) health needs.

Q. What changes in working arrangements and conditions will better support primary health care professionals?

Changing the way primary health care services are funded and delivered is necessary in order to support the delivery of care by multidisciplinary teams. There is good evidence that the current fee-for-service funding systems fragment care and prevent population based approaches and that multidisciplinary teams provide safe, effective care, and improve access to primary health care.[x] Therefore the development of an alternative funding mechanism is important to facilitate collaborative practice within multidisciplinary teams.

Q. How is teamwork facilitated in primary health care services and between them?

Through the equitable remuneration of all health professionals; interdisciplinary education; multidisciplinary continuing professional

development; and alternate funding mechanisms to promote equity and collaborative practice.[xi]

Q. How could the general practice nurse role be developed and enhanced?

By utilising people working in these roles to work to the full scope of their practice and skills, whatever they may be, not limiting them to a number of prescribed tasks.

Q. How can newer models of care or newer workforce roles (such as nurse practitioners and physician assistants) better support health professionals to meet demands created by a changing primary health care environment?

There is strong evidence for the safety, quality and effectiveness of care provided by nurse practitioners[xii] and the role of nurse practitioner is well established both internationally and in Australia in terms of education, regulation and professional practice. The role of physician assistant is less well established however and there needs to be further work to develop the nature and scope of the profession, its educational base, professional competencies, regulatory framework, and relationship with other existing health disciplines.

Q. Are there specific changes needed in those regions or populations where there is difficulty attracting and retaining staff?

The creation of new funding models to support the delivery of primary health care by a range of health professionals would improve opportunities for collaborative practice, so often cited as an incentive to practice in rural and remote settings. Comprehensive approaches to attract health professionals to practice in regions where there is difficulty in attracting and retaining staff are required – financial incentives alone do not work.

Q. What funding arrangement could best support team-based care?

Consideration needs to be given to capitation based funding for primary health care which can be used to deliver services that are based on population health needs and permit the delivery of services by a range of providers. Current funding arrangements do not support team based care or multidisciplinary practice.

Q. How is it determined who is best placed to lead in multi-disciplinary team arrangements?

This is most appropriately determined at a local level, using professional practice guidelines and regulatory frameworks to support decisions.

Q. Are other changes needed to current roles and responsibilities (e.g. for prescribing and referral rights to be extended to non-GPs and specialists)?

Providing flexibility in terms of prescribing and referral rights has the potential to improve access to care.

Q. What improvements are needed to primary health care education and training? e.g.:

— How can innovative vertically and horizontally integrated teaching models in primary health care be encouraged?

Through the equitable funding of each of the health disciplines; improving support for the provision of inter-disciplinary education; by encouraging multidisciplinary practice and research.

— How can the role of teaching be better supported in a sustainable way?

Increased funding for all teaching, including clinical teaching and clinical placement support; more scholarships for nursing, midwifery and allied health in primary health care; revision of the relative funding clusters in the health disciplines to increase funding for universities; to have funding follow each student, so it will not be subsumed into general revenue for universities or used to cross subsidise less profitable courses.

— How could inter-disciplinary learning be better supported and provided in a more sustainable way?

Through the development of nationally consistent inter-disciplinary curriculum units for undergraduate and post graduate education, and the development of incentives to encourage their implementation.

— Is there a greater role for competency-based education?

AHCRA supports any clinical education and training which leads to graduates who are able to demonstrate levels of competence that enable them to meet regulatory requirements for the standards of practice for health professionals. To the extent that competency-based education achieves this, AHCRA supports this.

— What incentives could be offered to trainees to make settling in high needs/ workforce shortage communities more attractive?

The availability of mentoring programs, and for financial support for the role of mentors; the availability of broad social support and professional development programs; availability of relief (locums) for holidays/professional development leave.

Q. Are there other funding models for primary health care that need to be considered?

There is lots of evidence to support the assertion that other funding models should be considered. As already stated, there is strong evidence that fee-for-service funding systems fragment care and prevent population based approaches, therefore other mechanisms for funding primary health care need to be considered. The provision of funds to regional health organisations to commission services to address identified health needs, including inequities and inefficiencies, should be considered. Comprehensive information regarding the health needs and health outcomes of the local community would need to be made available to these entities.

Q. How can we ensure that primary health care expenditure is sustainable?

By directing funding to the most significant health needs in the community, and targeting priorities as determined by communities themselves.

Q. Should a new mechanism(s) be implemented to consider whether proposed new primary health care interventions should be subsidised?

Funding for all health care interventions should be assessed on the basis on evidence of effectiveness, appropriateness and cost effectiveness. Funding to be directed at services/treatments that are proven to be effective. This should include incentives for institutions and/or providers to deliver cost effective evidence-based health care.

Other performance measures for primary health care services should include:

- access to services, including according to geography (to demonstrate variability between metropolitan, regional and remote);
- delays in referrals;
- health outcomes;
- specific indicators for evaluating health outcomes of Indigenous people;
- the provision of culturally appropriate care;
- workforce factors (staffing, workload, skill mix, turnover, staff satisfaction, workplace injuries);
- safety and quality indicators;
- compliance with clinical guidelines;
- specific indicators for access to mental health services;
- specific indicators for access to dental and oral health services;
- patient satisfaction/consumer experiences of care;

- utilisation of electronic health records; and
- waste and energy audits to assess greenhouse gas emissions.

Q. What should be an appropriate mix of public and private funding for primary health care?

Funding should be equitable and efficient. To answer this question, we first need to undertake a national audit of current health expenditure and health need – including barriers to equity – to determine what the current mix is before we can identify what an "appropriate" mix is. Ultimately the Australian people should be able to decide on this, possibly through mechanisms like citizens juries.

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[xii] Laurent et al. (2004) Substitution of doctors by nurses in primary care, The Cochrane Collaboration.