Primary Care Reform Options

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The purpose of this paper is to outline issues relating to and possible directions for the reform of primary and community services.

Introduction

The nature of Australian primary and community services is changing. In the past, definitions and descriptions of primary care centred on its importance as a universal first point of contact within the health system. Fiscal pressure, technological innovation and social trends have, however, brought about the transfer of services from hospitals and residential care institutions to home and community settings. Demand will increase further as a result of demographic ageing—as the 'baby boomers' reach old age.

Increasingly, more complex health care is being provided by the formal care system at home and in community settings than was previously the case. In the past, such care would have been referred to as secondary and tertiary services.

Length of stay in hospitals has reduced, same-day procedures have increased, rehabilitation and treatment have transferred from hospital to community settings, institutions for people with disabilities and mental illness have been closed, and older people stay at home for longer while frail, ill and disabled. At the same time the availability of informal care and support provided by family, friends and neighbours has lessened. The boundaries are blurring.

Primary and community care is better thought of as a setting for providing care rather than a separate functional tier of the health care system (i.e. primary, secondary, tertiary). The main health and care functions provided in this setting can be described on a continuum that includes:

- Secondary prevention for those with behavioural, social and psychological risks.[1]
- Identification and treatment of straightforward acute conditions across a range of modalities (e.g. medical, dental, psychological).

[1] Primary and community services are part of primary prevention, but in reality these should be focused on 'upstream' interventions

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- Identification and referral of complex and acute conditions for specialist assessment and intervention (e.g. diagnostics, surgery, acute hospital admission).
- Identification and early intervention for chronic and potentially complex conditions.
- Community and home-based rehabilitation for post acute and subacute conditions (including post-acute care).
- Ongoing treatment and support of people with chronic and complex conditions in the community and at home (including palliative care).

A ‘system’ in need of reform

It would be a mistake to think the increasing availability of a more complex range of primary and community services across this continuum has occurred systematically. Unfortunately, Australia is fast becoming unique in its failure to embrace a national policy framework and strategy for developing primary and community health and community support services. The announcement by the Rudd Government that it intends to address this issue is not before time.

The organisation of primary and community services is a ‘renovator’s opportunity’. Incremental development has led to an inconsistent, fragmented and duplicated set of arrangements. Funding and payment systems, accountability and performance management, service models, organisational structures and roles and responsibilities vary significantly across jurisdictions. Worse, effectively, the Commonwealth runs one primary and community services system through Medicare and the Pharmaceutical Benefits Scheme and the states run a separate and varying set of arrangements through their ambulatory care and community health services.

None of this matters if clinical outcomes are excellent, consumer access and experience is good, and services are highly productive with the resources they use. This, however, is not the case.

Inadequate clinical outcomes

Sadly, studies of the quality of care in Australia are limited in number and size and no national data on quality of care in primary and community services exists. However, a range of studies conducted in the non-acute health care sectors of the United Kingdom, Australia and New Zealand have demonstrated that, in general, the quality of care provided does not meet recommended standards of practice.

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Generally, only about half the care recommended is provided. Preventable conditions are often missed in the primary and community care system. When they are identified, poor follow-up, gaps in service delivery, and failure to adhere to recommended care often results in suboptimal clinical outcomes.

This is particularly problematic for people with complex and chronic conditions. The current primary and community care service system is largely focused on the delivery of episodes of single modality (e.g. medical) care. Integrated and coordinated medical, psychological, behavioural and social programs to support complex and chronic care are relatively absent. Instead, consumers have to negotiate their way between a set of providers, where no one is responsible for the overall quality or efficiency of the care provided.

Physicians and other health care providers are generally aware of these limitations, but despite programs such as the GP collaboratives, they are unable to overcome the inherent systemic limitations to providing better quality care.

A range of studies indicate that the current inadequacies of the primary and community care system leads to significant avoidable disability, death and distress. It also results in a number of avoidable hospital admissions and increased system costs.

Fragmentation and duplication

The Commonwealth has the major responsibility for medical and pharmaceutical services including general practice. The Commonwealth Medical Benefits Schedule (CMBS) and the Pharmaceutical Benefits Schedule (PBS) provide fee-for-service rebates for general practice and pharmaceutical services. These programs provide universal access to medical and pharmaceutical services for the Australian population, although, more recently, concerns are emerging about reductions in the rate of direct or bulk billing.

Other primary health services, such as allied health, dental, counselling, drug and alcohol, community mental health and health promotion are largely funded and administered by the states. Funding, organisational and administrative arrangements and the models of program and service delivery that are in place vary considerably. These programs are generally budget capped and targeted on the basis of need and ability to pay. Compared with access to general practitioner and pharmaceutical services, there are significant levels of unmet need and inequities of access across geographic areas and population groups for primary dental, allied health and counselling services.

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A number of states have recently introduced strategies to improve the coordination and integration of their primary care and community support services. These have focused on the creation of local coordination structures (e.g. primary care partnerships, primary care councils) and the development of programs for the prevention and management of chronic and complex conditions.

However, there is little joint planning, funding and development of primary medical, allied health, dental, counselling and nursing services between the Commonwealth and the states. While a well-developed national strategy exists for general practice, this is not the case for other areas of service delivery. There is almost no population-based integration of primary care services and little by way of piloting or experimentation with capitation, enrolled populations or fund-holding. Significant opportunities exist for greater cooperation between the Commonwealth and the states, particularly around strategies for more integrated service planning and service coordination to improve continuity of care over time, between primary health and community care services, and between these services and the acute and subacute sectors.

The Commonwealth and the states are jointly responsible for home and community care services through the Home and Community Care (HACC) program, which is funded by both the Commonwealth and the states to provide support services to frail older people and younger people with disabilities. However, the objectives of the HACC program are closely tied to the Commonwealth's objective to reduce the inappropriate use of residential aged care services. There is inadequate recognition of the home and community care needs of younger people with disabilities, people with mental illness and people who require support services following discharge from hospital, people who are dying, and those with ongoing chronic and complex conditions.

The states have developed separate community support programs for younger people with disabilities, people with mental illness and those who have drug and alcohol problems. The range of community support programs that have developed overlap significantly. Often they involve similar agencies, practitioners, service models, funding mechanisms, performance monitoring, planning and reporting arrangements. This leads to substantial inefficiency, duplication and fragmentation across very similar programs and services and inequity in access, utilisation and outcomes for people with similar needs.

Primary medical, allied health, nursing and counselling services are often critical elements of the overall care and support required by people with ongoing and complex needs. However, these services are not generally well-integrated with community support programs. As a result, consumers often find it difficult to navigate through the service system to get the treatment, care and support they need. Improved planning, funding, communication, coordination and service

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delivery models are needed to provide better outcomes for consumers with continuing care needs.

Access problems

Differential access to primary care is of concern. By and large people who are socially disadvantaged have worse access to primary and community care services. Per capita general practitioner ratios are better in metropolitan and more affluent geographic areas. Interestingly, while consultation rates are similar, in lower socioeconomic status areas the burden of disease is higher and the length of consultations is significantly shorter—a clear example of the inverse care law. These problems are, of course, exacerbated for Indigenous people.

Access is also a problem for a range of allied health and dental services. Compared to medicine and pharmacy, access to these services is significantly curtailed in the Commonwealth's current social insurance arrangements. By and large, the states have stepped in to fill the gap, but with tightly targeted and relatively under-resourced programs that often do not connect well with general practice.

Similarly, with the increasing level of complexity and acuity in primary and community service, more access to social care is needed to support people at home and in the community. As with state community health and ambulatory care, home and community care services are tightly targeted and it is often difficult for people with complex needs to obtain integrated health and social support services.

Primary and community care make a difference

The competency of the primary and community care system matters. A number of reviews have now demonstrated that stronger primary care systems lead to better health outcomes. Numerous examples show that lower rates of hospitalisation for many ambulatory care sensitive conditions (ACSCs) are associated with receiving good primary health care.

Better interventions in the primary care system for frequent users of emergency departments—who have complex social and personal issues associated with their health needs—also provide an opportunity to reduce hospital utilisation.

In summary, the evidence suggests:

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- The current arrangements provide good access to primary medical and pharmaceutical care, but there are problems in rural and remote settings and for people who are socially disadvantaged (particularly Indigenous people).

- Access to treatment modalities other than primary medical and pharmaceutical services (e.g. dentists, psychologists, allied health professionals) for straightforward primary care is much more limited. Affordability and coverage are both barriers to access for a range of modalities.

- While data is limited, there is significant room for improving clinical outcomes in the primary and community care system, particularly for people with complex and chronic conditions. This includes both risk factor (e.g. obesity, smoking) prevention and reduction, and the treatment and management of established conditions.

- Current organisational arrangements for primary and community services are fragmented, duplicated and inefficient. As a result, people with complex and chronic conditions often have unsatisfactory experiences in negotiating the treatment and care system.

- Evidence exists that more effective primary and community care leads to better outcomes.

Reform

Internationally, the reform of the primary care to address emerging pressures on health systems in industrialised nations is of major interest. Primary care is seen as being central to managing access, quality and cost. In this respect, reforms have been introduced in New Zealand and the UK, and Canada is experimenting with a number of initiatives. There has been significant interest in giving greater control over the management of health resources—including those for acute and subacute services—to primary care providers and organisations through pooling, capitation, funding and managed care arrangements on behalf of enrolled or registered populations. This has driven a greater emphasis on prevention, care coordination, service substitution and closer organisational integration across service sectors (through the development of disease pathways).

The Commonwealth has implemented a range of initiatives to promote the integration of general practice with acute, subacute and continuing care services and with other primary care providers. For general practice, these include the introduction of divisions of general practice to

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improve planning, communication, innovation and coordination of general practice. Research and development funding has been introduced. Workforce strategies, including vocational registration and incentives for rural practice, have been implemented. As well, a range of blended payment arrangements and modifications to the CMBS has been designed to improve continuity of care, care planning and coordination and involvement in disease prevention programs and the introduction of new service modalities (e.g. psychology, allied health).

States and territories have also implemented a range of initiatives to promote integration of primary and community care services. Geographically based bodies to improve planning, communication, innovation and coordination across primary and community services (e.g. primary care partnerships) have been established. Hospital demand management programs to coordinate care between hospitals and the primary and community care system have been put in place. Programs to prevent and better manage complex and chronic care in community settings have been established.

In Australia, it is not that we are unaware of the problems in primary and community care, or that we are ignoring them. It is more that everywhere you look everyone is simultaneously piloting or rolling out innovations in their own area of responsibility to fix the problems. We are awash with innovation and piloting.

Although many of these innovations are laudable in their own right, everyone knows the combination of competing approaches is leading to duplication, discontinuity and complexity. But, in the absence of national leadership across different program areas, jurisdictions and local actors press on regardless.

The key findings from international and Australian experience suggest that better outcomes are achieved when:

- The health care organisation ensures governance and management of health care providers around the needs of consumers for enrolled or catchment populations.

- Partnerships exist between consumers and providers to ensure consumers are able to effectively self-manage risks and chronic disease.

- Consistent application of practice guidelines and decision-making support for the prevention and management of specific conditions such as diabetes, chronic obstructive pulmonary disease and renal disease are in place.

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- There are care pathways for prevention and management of chronic disease where consumers access programs and services on the basis of systematic assessment and care planning.

- Coordinated, team-based, multidisciplinary care, across a service continuum ranging from risk prevention to complex care, is provided.

- Integrated information systems for the transfer of client/patient information across providers, the provision of practice guidance and the coordination of care have been established.

- Payment models that promote best practice and effective outcomes for consumers have been established.

A national strategy

The first step in reforming primary and community care services has to be the Commonwealth and states/territories reaching agreement on a national approach to primary and community care. Logically, the Commonwealth has a major role in setting a national framework for access, outcomes and efficiency of primary and community care services through national policy, funding, regulation and monitoring mechanisms. The states/territories are much better placed to plan, govern and manage the service delivery system.

It seems likely that both levels of government will continue to have an interest in primary and community care. The Commonwealth and the states/territories should therefore agree on complementary roles for the development of this sector with an agreed national approach to funding, regulation and monitoring to achieve consistency in access, outcomes and performance.

These arrangements should be negotiated through Commonwealth–state health care agreements.

The states/territories should have responsibility for planning, governing, monitoring and managing the primary and community care system within the overall national framework that is established.

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Scope and goals

It is important that a contemporary and broadly based definition of primary and community services is adopted in the development of a national strategy. A narrow focus on primary medical care will not resolve the issues identified above.

Primary and community care services should be broadly defined across a continuum of health and community care functions that include:

- Secondary prevention for those with behavioural, social and psychological risks.
- Identification and treatment of straightforward acute conditions across a range of modalities (i.e. medical, dental, allied health, nursing, pharmacy and optometry services).
- Identification and referral of complex and acute conditions for specialist assessment and intervention (e.g. diagnostics, surgery, acute hospital admission).
- Identification and early intervention for chronic and potentially complex conditions.
- Community and home-based rehabilitation for post-acute and subacute conditions (including post-acute care).
- Ongoing treatment and support (i.e. personal, home and community care) of people with chronic and complex conditions in the community and at home (including palliative care).

There should be a national approach to overall policy objectives, including access, outcomes and performance criteria for the primary and community care system for these functions. A national performance framework that creates appropriate benchmarks for access, outcomes and performance should be established. The benchmarks should be used to evaluate and drive improvement in overall system outcomes.

Funding and payment

A national approach to funding and payment is critical. Funding and payment drive the overall system. Funding levels determine overall capacity. Payment systems create the incentives for innovation, efficiency and high quality outcomes.

The overall funding levels, relative shares and growth for the primary and community care system should be negotiated through COAG and the health care agreements. The payment model should include the following elements.

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Maintain and extend item-based payments

The Commonwealth Medical Benefits and Pharmaceutical Benefits schemes are well-established and should form the basis for the ongoing development of a national primary and community care payments scheme.

The CMBS and PBS arrangements focus on activity-based payments. These are effective for the treatment and management of straightforward primary care functions. The current scheme of item-based payments should be left largely as it is for:

- Identification and treatment of straightforward conditions across a range of modalities.
- Identification and referral of complex and acute conditions for specialist assessment and intervention (e.g. diagnostics, surgery, acute hospital admission).

However, there should be a discussion about extending the scheme to other primary care treatment modalities—notably dental and allied health—where there is clear evidence of effective primary care treatment for agreed conditions and inequitable access. It is, for example, likely that a strong case could be made for dentistry.

Additionally, consideration should be given to the efficiency of service substitution (particularly in areas of workforce shortage) for particular assessment and treatment modalities and for particular conditions.

Relevant state and territory primary and community care services (including community health) would be provided on the same basis through the item schedule. Access to some service modalities such as dental and allied health could continue to be determined on the basis of eligibility criteria such as income and age.

Payments could be made to private, not-for-profit, state-run or Commonwealth agencies on the same basis. Medicare Australia should be the basis of a national payments agency for all primary care payments, including those currently made by state governments.

Payments for complex and chronic conditions

A new system of payments is needed for complex and chronic conditions. The CMBS and PBS need to be further developed to address:

- Identification and early intervention for chronic and potentially complex conditions.

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- Community and home-based rehabilitation for post-acute and subacute conditions (including post-acute care).
- Ongoing treatment and support (i.e. personal, home and community care) of people with chronic and complex conditions in the community and at home (including palliative care).

These functions require much greater focus on continuity, coordination and team-based care over extended time periods, care providers and settings. The transaction costs of payment, monitoring and cost control associated with the current system of simple item-based payments for these functions are high and lead to fragmented and discontinuous care. The introduction of the current CMBS chronic disease management items has only been partially successful.

Payments need to ensure that services are coordinated and consistent with good practice. There needs to be a stronger focus on clinical outcomes and more seamless care for consumers.

Case payments such as those designed for Ambulatory Care Groups (ACGs) could be developed for Australia, but their capacity to predict costs and adjust for risk to providers is limited. Their introduction could lead to gaming, adverse selection of consumers and over- or under-payment and servicing.

Instead, at this point in time, a coordinated payment model for complex and chronic primary and community care should be introduced. The main elements of a coordinated payment approach should be to:

- Pay for services through the item-based schedule on the authority of appropriate care coordinators.
- Make coordination payments for planning, monitoring, review and coordination of services.

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People with specified chronic and complex conditions such as diabetes, chronic obstructive pulmonary disease, schizophrenia, cardiovascular disease and so forth should voluntarily enrol in a chronic and complex condition management program. Agreed conditions and criteria for access should be developed as part of the program design.

Those who agree to participate in the chronic and complex condition management program would enrol with a primary and community services care coordinator such as a GP practice, a community health service, a mental health service, or a hospital outpatients department. Periodic care coordination payments would be made to the agency with which the person is

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enrolled. The agency would be able to purchase services for consumers by authorising item-based payments for a comprehensive range of services to treat and manage the person's condition. Services would need to be planned and purchased in accordance with recommended care.

Consumers enrolled in the chronic and complex condition management program would have access to general Medicare and Pharmaceutical Benefits Services and to an enhanced range of service items appropriate for the treatment and management of their condition. This would include risk factor prevention services, home and community care and palliative care where appropriate.

All payments for those enrolled in the complex and chronic condition program would be tied back to the care plan. Coordinators would have flexibility to arrange services from the chronic and complex care schedule and the social care schedule within overall cost limits for particular conditions and levels of complexity and chronicity. Services could be sourced from within the home agency or from other providers as appropriate. The coordinator would be responsible for ensuring that appropriate clinical guidelines and outcomes for individual consumers were met.

Incentive payments for agreed performance on adherence with clinical guidelines, achievement of clinical outcomes and consumer satisfaction for particular conditions could be introduced. These would build on the current GP practice and service incentives arrangements.

It would be a requirement of the chronic and complex condition program to provide data on adherence to guidelines, clinical outcomes and consumer satisfaction. Coordinators would be accountable for the effectiveness of their service planning and implementation against these indicators.

Prevention

Similarly, uncoordinated item-based payments for those with significant behavioural (e.g. smoking) or biological (e.g. hypertension, obesity) risks are ineffective. The chronic and complex condition management program could be extended to allow enrolment of people who meet agreed risk factor profiles. Coordinated access to a range of risk factor reduction services could be managed through these arrangements.

Incentive payments could also apply for those enrolled in risk factor reduction programs. Additionally, practice-based payments for agreed risk factor reduction activities, such as immunisation for all relevant patients, could be made for performance across the whole practice population.

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People focused service delivery

People should have straightforward access to local primary health and community support services – a local 'one stop shop'. They should be able to get a comprehensive range of primary care services through these services. These include general practice, optometry, pharmacy, dentistry, psychology and allied health.

Ideally these services should be collocated. But at the very least they should be close by and functionally integrated. A range of service delivery, organisational and ownership models are possible.

For more complex and chronic care, local care teams should be brought together locally to provide health, psychological and social services. As proposed above, for these people there should be an integrated national funding scheme for chronic and complex conditions.

Consumers with chronic and complex needs should be able to enrol with appropriate local primary and community care services for all their primary and community care needs. The local services should be able to provide rapid response after-hours services at home when necessary to prevent the need for emergency department visits for people with complex and chronic care who are enrolled with the service. The 'super clinic' model is a step in that direction.

Clear access and performance criteria for local primary and community care services should be established. In particular, people with complex and chronic needs should be able to enrol with services which can provide a comprehensive, integrated set of services which can meet all their primary and community care needs. These services could be integrated agencies such as super clinics, community health services or private community health services which provide a comprehensive set of services. But they could also be provided by networked providers who can demonstrate that they can meet the service delivery model and criteria required.

However, only those local primary and community care services which can demonstrate they can provide appropriate comprehensive and integrated services for people with chronic and complex needs should have access to the Medicare chronic and complex care payment scheme. Services and providers should be accredited for access to Medicare chronic and complex condition payments by a local primary and community care governance organisation.

Governance and development

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National goals, objectives and a funding and payment system will not be sufficient to produce an integrated primary and community care system. Organisational structures to facilitate the planning, monitoring and development of integrated local primary and community care services are needed.

A diverse set of private, not for profit and government agencies now provide primary and community care. These providers have little capacity to develop the service system independently.

Despite significant and growing levels of funding for primary and community care, organisational capacity for specific catchment populations remains weak. Divisions of general practice were established to provide a local organisational structure for general practitioners. States also have a variety of mechanisms for organising primary and community care services, but there is little overall governance and accountability for the primary and community care.

As a result, the elements required to develop integrated service systems across agencies for catchment populations are poorly supported. These include capital planning, information technology, training and service system design.

Similarly, little real performance management and quality assurance exists for primary and community services, notwithstanding the development of some agency accreditation models. While national benchmarks and performance monitoring are an important component of reform, they need to be supported by more local performance management.

Given the current mix of public and private funding and provision, it is unlikely that a market solution will be effective. A new set of governance and management arrangements need to be put in place to address these issues. These could build on the existing divisions of general practice and state-based organisational structures.

It is not possible or desirable to develop one national approach to solve these issues. Different solutions will be required for different circumstances.

While a national payment agency and agreed performance framework should be managed by the Commonwealth, it is appropriate that the states/territories have primary responsibility for putting in place new governance and organisational arrangements for primary and community care.

The new governance and organisational structures should be based around geographically defined catchments. Their purpose should be to:

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- Plan primary and community service systems and provision for the catchment population including appropriate service utilisation and funding levels
- Develop service system capacity including clinical information systems, practice guidelines, workforce, physical infrastructure and innovation
- Register and accredit providers for access to national primary and community care funding
- Monitor and manage provider performance and population primary and community care outcomes, including the determination of provider incentive payments
- Report to government, consumers and the community on primary and community care performance for the catchment

International experience suggests that the size and configuration of geographic areas and population catchments will vary depending on circumstance. However, they need to be of a sufficient scale to complement and integrate with hospital and specialist services and to have the organisational capacity to effectively develop and manage the service system.

Given the mix of private, public and non-government providers in the primary and community care system, it is important that new organisational arrangements are at arms' length from providers. New organisational arrangements should be primarily focused on governance, development, management and accountability rather than service provision.

Over time, these new governance organisations could also assume responsibility for purchasing and commissioning health and community support services more broadly, as they develop expertise and experience in service planning and development for their populations.

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