



A NEW APPROACH TO PRIMARY CARE FOR AUSTRALIA

JENNIFER DOGGETT, JUNE 2007



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MAIN POINTS

An ageing population, increasing rates of chronic disease and health workforce shortages are straining our health system. Without change, we will spend more and more to achieve less and less.

Australia is preoccupied with hospitals, not health. Hospital should be a last resort not the first. Dignity, autonomy and good health are best served by delivering health services in the home or as locally as possible.

A wealth of international evidence shows that health systems oriented towards primary care achieve better health outcomes for a lower overall cost than systems focused on specialist or tertiary care. The international trend is moving away from hospital care.

Emphasising a universal approach oriented towards prevention and primary care, this proposal builds on the strengths of Australia's current system, while adapting the best (and avoiding the worst) of comparable systems internationally. As one element of comprehensive health reform, this approach will curtail chronic disease, reduce service fragmentation and cut inefficiencies.

How would this new primary care approach benefit consumers?

- » A greater focus on prevention, ensuring people stay healthier for longer;
- » Faster medical attention to conditions which could escalate, slowing their onset or reducing severity;
- » Consolidating service delivery, records and co-payments to be easier, safer and fairer for all;
- » More timely decisions, based on a best practice, seamless, one-stop approach;
- » Consolidated patient history and test results, enhancing continuity of care and population health monitoring, while reducing procedural duplication. Multiple services billed together; and
- » Universal care with better access, via fair and affordable consumer contributions.

Primary care reform is the single most important strategy for improving our health, and making the health system sustainable. Community-level prevention and primary care is essential to restoring universalism and efficiency in Australian health care.

SUMMARY OF RECOMMENDATIONS

Program

The author recommends the reorientation of Australia's health system towards primary care, to be achieved through the roll-out of around 200 integrated Primary Health Care Centres, each servicing a population of 100 000 on average. The Centres would:

- » Be the main focus of program delivery and consumer-focussed, integrated primary care and preventive health services;
- » Provide full/part-time GPs, dentists, nurses, pharmacists, physiotherapists, psychologists, other health services, plus specialist and day services where viable;
- » Be funded to manage the overall health of the local population, to provide pre- and post- hospital care, plus screening, education and other preventive health services;
- » Avoid a single business model. Staff should be able to work on either a fee-for-service or salaried basis, and the centres could be privately, publicly or community owned and operated;
- » Use standard systems for data collection. Keep patient records on a secure database, over which patients control the access and editing of details;
- » Be governed by boards comprising health care providers, government (including local council) representatives and consumers, and regulated by a joint federal-state body;
- » Be an integral part of a high-quality universal health system, benefiting Australians of all backgrounds and incomes, rather than a limited 'safety net' service designed to catch the fallout from a two-tier system

Implementation

- » A staged roll-out of around 20 health centres per year (depending on catchment size) over 10 years, could begin from as early as July 2008 under the next Australian Health Care Agreements;
- » Capital costs for primary care centres will vary with size and location. An indicative ground-up cost for an urban centre serving a population of 100 000 would be \$20 million. Capital investment of around \$4 billion would be required over 10 years to establish enough Centres to cover the entire population. Operating costs across the health system would be similar to those under present arrangements;
- » Services would be funded according to the type of care provided, e.g. fee-for-service funding may suit episodic, acute care but may not be suitable for preventative or chronic care;
- » Centres would be funded through a joint federal-state body, or under Australian health-care agreements. If agreement by all the states was not possible, the Commonwealth could negotiate state-by-state agreements to establish primary health care centres.

THE CPD - RETHINKING AUSTRALIAN HEALTH CARE

'A New Approach to Primary Care for Australia' builds on the arguments outlined in a previous Centre for Policy Development paper 'A Health Policy for Australia: reclaiming universal health care', which proposed fundamental reform of the whole health portfolio. 'A Health Policy for Australia: reclaiming universal health care' can be downloaded from http://cpd.org.au/policy_papers

ABOUT THE AUTHOR

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INTRODUCTION

...insufficient focus on prevention means that many people develop serious health problems... that could have been prevented or better managed in the community

Australia's health system faces a number of challenges, including an ageing population, rising rates of chronic disease and widespread health workforce shortages. Our current fragmented and uncoordinated health system is not well equipped to cope with these challenges, placing increased pressure on our limited health care resources. Our rigid health funding system has created health care silos, leading to both gaps in service provision and unnecessary duplication of services. An insufficient focus on prevention means that many people develop serious health problems and require hospitalisation for conditions that could have been prevented or better managed in the community. Consumers are forced to negotiate a maze of different administrative, funding and service delivery arrangements to receive treatment for common conditions, such as diabetes, arthritis and respiratory diseases. Unless we act now, these problems will only escalate in the future as demographic changes place increased pressure on the system.

There is a wealth of international evidence that a health system oriented towards primary care achieves better health outcomes, lower rates of all causes of mortality (including heart disease and cancer) for a lower overall cost than a health system focussed on tertiary or hospital care. Re-orienting Australia's health system towards primary care would deliver better health care for Australian consumers and would ensure that we get the best possible value from our health care resources. As 90% of the population sees a GP at least once a year, changes to primary care can also be a platform for reforms in other areas, such as chronic disease management, mental health and preventive health.

A new approach to primary care would give Australians a consumer-focussed health care system that delivers high quality and coordinated care, prevents the development and progression of chronic diseases and reduces the high levels of inefficiency within our current system. Primary care reform is the single most important strategy for improving the health of our population and ensuring that our health system remains sustainable into the future.

What is primary care?

There is no universally agreed definition of primary care. However, there is significant commonality between the various definitions used in the literature. These definitions usually focus on some of the specific characteristics of primary care (often in opposition to hospital/specialist care) in relation to the following areas: the type of care provided, the settings in which it is provided, the people providing the care and the specific activities or goals involved or its underlying values or ideology.

Most definitions or descriptions of primary care will include some or all of the following:

- » *The type of care provided:* usually emphasising coordinated and/or multi-disciplinary care from the same person/team over a period of time.
- » *The setting in which the care is provided:* usually community-based clinics or individual practitioners' rooms.
- » *The people providing the care:* including general practitioners/family physicians, nurses, nurse practitioners, community health workers physiotherapists, dentists, dental nurses, some medical specialists and indigenous health workers.
- » *The activities or goals involved in providing the care:* treating common illnesses, managing chronic conditions and providing preventive health services.
- » *The values underlying the provision of care:* these include equity of access, universalism, responsiveness to consumer concerns, accessibility and the appropriate use of resources.

One commonly used definition of primary care is contained within the [1983 World Health Organisation Alma-Ata Declaration](#). This definition focuses on the social justice and preventive focus of primary care, emphasising the need for equity, solidarity and intersectoral collaboration within the health system.

Without a new approach to primary care, we will continue to spend more and more on health care to achieve less and less.

Why does Australia need a new approach to primary care?

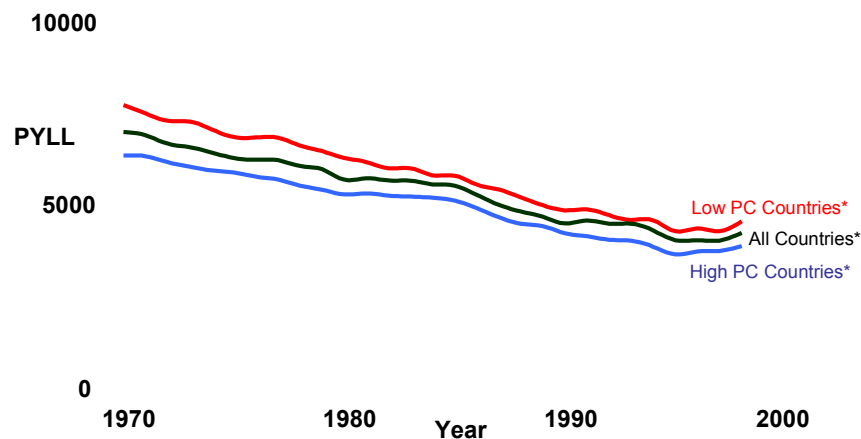
While there are many positive features of Australia's current primary care system, it also has some significant problems which mean that we are not obtaining the best possible outcomes for the use of our primary care resources. There are also a number of future challenges facing our health system that will place it under increasing pressure unless we change the way we approach primary care. These challenges include an ageing population, increasing rates of chronic disease and health workforce shortages. Expenditure on hospitals is growing while many hospital admissions are for conditions which could have been prevented or managed in the community for a lower cost. Without a new approach to primary care, we will continue to spend more and more on health care to achieve less and less.

A new approach to primary care will build on the strengths of Australia's current primary care system, while addressing its problems and ensuring we are able to successfully meet the health challenges of the future.

Why is it important to focus on primary care?

Research has demonstrated that a health system that is oriented towards primary care delivers better health outcomes for a lower cost than a health system that focuses on specialist or tertiary care. For example, cross-country analyses have found that mortality rates and total health care costs are lower in countries with a strong primary care system.^a Other studies have found that health systems which have more primary care doctors per head of population achieve better health outcomes, including lower rates of mortality from heart disease, cancer and stroke, independent of socio-demographic factors.^b

Primary Care Score and Premature Mortality in 18 OECD Countries



*Predicted PYLL (both genders) estimated by fixed effects, using pooled cross-sectional time series design. Analysis controlled for GDP, percent elderly, doctors/capita, average income (ppp), alcohol and tobacco use. $R^2(\text{within})=0.77$.

Source: Macinko, Starfield, & Shi (HSR 2003)

Starfield 06/02
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There is no single reason why health systems oriented towards primary care achieve better outcomes than those where more resources are put into secondary or tertiary care. However, the following factors are likely to contribute to this effect:

- » *Better management of chronic disease* – chronic disease is typically best managed in a primary care setting^c. As the burden of chronic disease increases (as is the case in most developed countries) the gains through better management of these conditions also increase.
- » *More continuity of care* – there is evidence that people receiving ongoing care from a trusted doctor or other health professional achieve better health

outcomes than those receiving care from a number of doctors over the same period of time^d. Primary care typically delivers more continuity of care than specialist or hospital care.

- » *A greater population health focus* – primary care typically has a broader population health focus than hospital and specialist care, which focuses more on individual patients. Many population health activities are better able to be delivered through primary care than in other health care settings, e.g. immunisation, health promotion and screening ‘at risk’ communities for specific diseases.
- » *Greater accessibility* – primary care is typically more accessible, in terms of price as well as geographical and cultural factors, than hospital or specialist care.
- » *More of a focus on indigenous health* – primary care typically has a greater focus on indigenous health and greater indigenous involvement through, for example, indigenous health workers (often working with nurses and GPs) and indigenous people on boards of primary care organizations.
- » *Greater consumer focus* – well managed and coordinated primary care focuses on consumer needs by providing the best possible mix of services for individual consumers’ in a convenient location, reducing transaction costs for consumers and resulting in better health outcomes.
- » *Earlier intervention* – primary care is the setting most suited to early interventions, such as lifestyle modifications, immunisations and screening tests, to prevent the development of chronic disease.
- » *Less risk of iatrogenic disease* – receiving treatment in a primary care setting avoids the potential risks of acquiring an iatrogenic disease through hospital care.

There is a range of evidence^e that the above factors both directly and indirectly contribute to the importance of primary care in influencing the overall health of a population. While increasing the focus on primary care within a health system can help reduce some inequities in the health status of the rich and poor in society, it does not achieve this through a redistribution of resources from the ‘affluent to the indigent’ but rather through a re-targeting of existing resources in a way which creates a more efficient and effective system of health care for all.

What are the good and bad things about Australia's primary care system?

Australia's primary care system has many positive attributes, when compared with that of other developed countries. These include the following:

- » universal medical and pharmaceutical insurance (Medicare and PBS);
- » a strong general practice sector (although many Australians experience access problems, and GPs are not always supported to provide comprehensive treatment for complex health problems);
- » some successes in preventive health (e.g. immunisation);
- » high medical, nursing and allied health education and training standards;

However, there are a number of areas in which Australia's primary care system can improve in order to meet the needs of the Australian community. The main areas of concern that have been identified with our current system are:

- » a fragmented and uncoordinated primary care system, with consumers forced to receive care at multiple locations with differing forms of payment and often little communication between care providers. This increases transaction costs for consumers, reduces overall efficiency and creates greater potential for errors and unnecessary duplication. It also increases the delays in providing treatment, which can result in the preventable progression of diseases. Often, valuable data can be lost when treatment is provided in multiple locations, which can also adversely impact upon the quality and efficiency of care provided.
- » an uneven imposition of health care costs on consumers (the poor pay proportionally more for their health care than the rich; people with chronic illnesses can struggle to afford the cost of health care, even when they have middle or high incomes; health care costs can also differ according to condition, with little fairness or rationality in how these costs are imposed, for example those conditions which require allied health care generally result in more out-of-pocket costs than conditions treated mainly by GPs)
- » GP shortages in some areas (in particular rural, remote and some outer-metropolitan areas)
- » poor access to general practitioner services for some groups in the community (i.e. some rural/remote, outer metro and indigenous communities, homeless people, some culturally and linguistically diverse and/or isolated communities)

Example

Jack is 55 years old and has recently been diagnosed with Type 2 Diabetes by his GP. The care that Jack requires for his condition over a twelve month period is as follows:

Service provider	Number of visits	Location	Funding source
GP	5	Private rooms	Medicare/consumer payment
Medical specialist	2	Private hospital	Medicare/consumer payment
Pharmacist	6	Shopping centre	PBS/consumer payment
Public hospital clinic	3	Public hospital	State government/hospital funding program
Podiatrist	2	Private rooms	Private health insurance/consumer payment
Dietician	3	Community health centre	State government/community health funding program

For a single condition, Jack is required to receive care in six different locations, from six health care providers, with little or no direct links to each other. This care is funded via six different funding mechanisms. This fragmentation obstructs the coordination of care, increases the potential for medical errors and creates inefficiencies for both health care providers and consumers.

- » high out-of-pocket expenses for many allied health services and some pharmaceuticals
- » a lack of consumer input into primary care policy, planning, resource allocation and service delivery
- » a lack of coordination between primary and secondary/tertiary care, and within the primary care sector itself (some efforts have been made to address this through Enhanced Primary Care item numbers, such as case conferencing and care planning)
- » an insufficient focus on prevention and population health (although some progress has been made on this through programs such as the Immunisation Incentives Scheme and other activities of organized primary care structures, such as Divisions)
- » an inflexible funding system (almost exclusively limited to services provided by doctors) that does not always allow consumers to gain access to the most suitable form of care for their condition or permit consumer choice of treatment modality (also addressed in a very limited way through recent Medicare funding for allied health)

How does Australia's primary care system rate compared with other countries?

Comparisons of the primary care systems of different countries can be controversial, as they differ according to the criteria used for the comparison and the person(s) making the comparison. However, there is some commonality between the conclusions reached by studies which compare Australia's primary care system to that of other developed countries, even though they use very different criteria and methodologies. These studies have found that, overall, Australia's primary care system ranks somewhere in the middle of those of other developed countries, although in some areas we rate higher than average and in others, lower than average^f. This indicates that while Australia's primary care system clearly has some positive aspects, there is still significant room for improvement and the potential to learn from other countries' experiences.

For example, primary care expert, Professor Barbara Starfield, has measured the primary care systems in a number of countries against the following criteria: access, longitudinality (consistency of care over time), utilization, comprehensiveness, coordination, community orientation and cultural competence^g.

Against these criteria, she scored Australia higher overall than countries such as the USA and Japan where there are more resources, proportionally, put into specialist and hospital care than in Australia. Australia's system where GPs provide the gateway to specialist care is one of the factors nominated as a positive attribute of our primary care system. However, Australia received a lower overall score than the UK, Canada and the Netherlands. This was due to factors such as the comparatively higher cost of seeing a GP in Australia and a lack of focus on continuity of care within our health system. Some countries scored well on some criteria, even though they received an overall low score. For example, the USA scored higher than Australia on the provision of preventive care, even though its overall score was lower.

A different type of comparative study was undertaken by the Commonwealth Fund using surveys of consumers in Commonwealth countries. In the 2004 report, Australia's primary care system was found to compare reasonably well with the other Commonwealth countries (perhaps unsurprising, as the majority of Commonwealth countries are significantly poorer than Australia). However, two significant areas in which Australia fell down were the affordability of primary care services and the lack of a preventive health focus in the primary care sector.

For example, 29% of Australians reported having “cost-related access problems” (e.g. skipped filling a prescription or put off seeing a doctor when sick due to cost) compared with 9% in UK and 40 % in USA. In relation to preventive health, 62% of Australians reported that they do not receive reminders for preventive care (compared with 55% in NZ and 40% in the USA).

Another important finding of this study was that 23% of Australians surveyed said that the health system should be “rebuilt completely” compared with 14% of Canadians and 13% of people in the United Kingdom. This indicates that Australians are less happy with their current health system than citizens of Canada and the UK.

These cross-country comparisons reveal that none of the countries studied has a perfect primary care system – all of them have some advantages and disadvantages. Developing a new primary care system for Australia should involve building on the strengths of our existing primary care system and adapting some of the best features (and avoiding some of the worst aspects) of the systems in other countries to the Australian context.

What are the major challenges currently facing Australia’s health system?

When looking at developing a new primary care policy, it is important to look not just at whether our primary care system is meeting our current needs but also whether it is well placed to meet our needs into the future. Health professionals take years to train and major changes to health systems do not happen overnight. This means that we need to start today to build the health system that we want for tomorrow.

Like most other developed countries, Australia faces some major challenges if it is to meet the future health care needs of our population. Some of the most significant challenges are outlined below.

- » *Health workforce shortages*: these cover most areas of the health workforce, and include doctors, nurses and allied health professionals. As this shortage is occurring worldwide it will be increasingly more difficult for Australia to recruit health professionals from other countries, even setting aside the ethical issues raised by recruiting doctors from developing countries.
- » *Ageing population*: an increase in the proportion of older Australians will result in more people requiring health care and fewer available to provide it.

Health professionals take years to train and major changes to health systems do not happen overnight. This means that we need to start today to build the health system that we want for tomorrow.

- » *Increase in chronic and complex conditions*: this is related to the ageing of the population and a decrease in infectious diseases. This will increase demand for coordinated and multi-disciplinary care.
- » *Lack of coordination*: across sectors, jurisdictions and levels of the health system. This is particularly a problem for people moving from one part of the health/aged care system to another.
- » *Lack of consumer/community input*: there is currently no formal process for obtaining community views on primary care to inform policy development. This means that we cannot be sure that current resource priorities of government primary care programs reflect community priorities.
- » *Discrepancy between indigenous and non-indigenous health*: reducing the high mortality and morbidity rates of Indigenous Australians compared with non-indigenous people will require a sustained effort within the health sector, as well as collaboration between health and other areas, such as community services and education.
- » *Allocation of scarce resources*: balancing the competing priorities for resources within the primary care sector and ensuring resource allocation is in line with community priorities will continue to pose a challenge for governments and funding bodies.

How should a new approach to primary care be developed?

Development of a new approach to primary care should involve all relevant stakeholders, including Federal and State/Territory governments (through the COAG process), health professionals, health service providers and, importantly, consumers. It should focus on improving the primary care system to meet the needs of all Australians, including helping those who are currently healthy to maintain their good health.

Any new primary care proposals should be developed within an overall policy framework that articulates the underlying principles of Australia's primary care system, including its overall aims, priorities and principles for the provision of care. Despite recent policy initiatives and funding injections into primary care (e.g. MedicarePlus) there is no overall primary care policy in Australia. This has resulted in a fragmented funding and program delivery process that delivers piecemeal gains in some areas but leaves other problems unresolved. It means that consumers do not have a good understanding of what primary care services they are entitled to and/or how to have an input into the development of future primary care policies and programs.

What can Australia learn from other countries' experiences with primary care?

While there is no “perfect” primary care system in any country, in developing a new approach to primary care for Australia it is beneficial to look at the best aspects of primary care systems in other countries and consider whether these would be appropriate for adoption in Australia. We should consider the following international experience:

New Zealand: Primary care is delivered via locally-based Primary Healthcare Organisations (PHOs). PHOs are funded by District Health Boards, which are governed by elected representatives from the community (and Ministerial appointees), including dedicated places for minority representation (Maori and Islander). PHOs are required to show they are responsive to community needs and reflect the views of a broad range of stakeholders – not just one dominant professional group. They aim to focus on collaboration, community involvement and on developing local solutions for local problems. Specific features of PHOs that could provide lessons for Australia include their governance models, their capacity for data collection and analysis and their preventive health activities.

United Kingdom: Primary Care Trusts (PCTs) play a similar role in the UK as PHOs do in New Zealand. Some of the specific features of PCTs that may be of relevance in the development of a new primary care system for Australia include: patient registration, enabling practices to take on responsibility for managing the health of a population; the use of data from individual clinicians to provide them with feedback on their clinical practices and comparisons with colleagues and best practice standards; funding to identify and address the main public health problems in the community and to run preventive health programs; the integration of general practice with other primary care providers (and in some cases social support services) such as nurses, allied health, mental health services and social workers.

United States: The United States has an extremely diverse health system and it is difficult to make any generalisations about the health care provided in that country. While there are certainly many examples of the failure of the health system in the US to meet the health care needs of its population, there are also some positive examples of health care provision which are often overlooked. Two examples of this in the area of chronic disease management are the Evercare model (originally developed for the US Government) and a similar system developed by managed care organisation Kaiser Permanente. These systems

have successfully improved the health and quality of life of people with chronic conditions, in particular the frail aged, and reduced the frequency and length of hospital stays within this population. Key features of this approach include: a primary care-centred approach; a re-direction of resources into more appropriate areas – including community-based prevention; a greater focus on data collection and analysis to identify individuals at risk; and the strengthening of the nurse practitioner/practice nurse role.

What might a new primary care system for Australia look like?

The focus of a new primary care system would be the establishment of **Primary Care Health Centres**. These would be the prime points of program delivery and provide consumer-focussed, integrated primary care and preventive health services. They would build on the strengths of Australia's current general practice system and address current gaps in primary care service provision through supporting GPs to undertake more preventive and population health focussed care and by integrating general practice with other primary care providers.

The centres would be licensed by and overseen by a joint federal-state government body and governed by boards made up of health care providers, representatives of government (including local councils) and consumers. In most instances health centres would operate as private corporations, but in cases (such as remote communities) where such ownership would not be viable, public ownership would be required. Community equity, including equity of those working in the centres, is the preferred model, and in general no corporation would be permitted to own more than one health care centre. In urban areas the normal catchment population for a health centre would be around 60 000 - 100 000 people.

Centres would comprise GPs, dentists, nurses, pharmacists, physiotherapists, psychologists, other health services, some specialist services and day services where scale economies permit, and would be a focus for local community health initiatives. No one business model would be prescribed. Both fee-for-service and salaried services should be provided.

Besides these functions, some centres would be required to provide 24 hour outpatient/casualty services. Casualty services would be maintained at hospitals, but only for cases likely to require immediate hospitalisation.

All health centres and other service providers would use standard systems for data collection. Patients would be free to choose any health care centre, or to choose stand-alone facilities apart from the centres. Patient records would be kept on a

secure national database, with prime control in the hands of patients, who would be free to edit records, make sections confidential, and to give access and editing permission to health care providers.

Health care centres would be the prime recipients of government health funding, and would receive financial allocations for hospital and specialist services available from other providers, which can be purchased from private and public hospitals in their area. Responsibility for pre and post hospital care would fall to the health centres.

What services would these centres provide?

Primary Care Health Centres would provide a range of services to meet the needs of the broad community, as well as identified groups with specific needs. These services may differ from centre to centre, according to the needs and priorities of the local community. These services could include:

- » General practice, including GP Specialists (where GPs can refer to other GPs to reduce waiting times for specialist advice)
- » Visiting specialists on an outreach basis from the local tertiary or general hospital
- » Minor procedural facilities for general practitioners or visiting specialists
- » Minor injuries services to reduce the need for attendance at an emergency department for non life threatening events (most centres would have extended opening hours and some centres would be open 24 hours)
- » Community Nursing and Nurse Practitioner services for early risk assessment clinics, patient education and advice
- » Diagnostic Services such as:
 - » Pathology including 'point of care testing'
 - » Radiology – upper/lower limb and chest x-ray
 - » Ultrasound – general and cardiac
 - » Respiratory function tests
 - » Electrocardiograms
- » Care Coordinators for patients with complex health needs, providing consistent support at home to maintain health and independence
- » Special services for children, such as developmental clinics and parenting

workshops, and linkages to children's departments at local hospitals

- » Cancer support services
- » Ante/post natal care and maternal health
- » Physiotherapy
- » Speech therapy
- » Mental health services
- » Counselling
- » Diabetes and asthma education programs
- » Family planning
- » Health promotion
- » Indigenous health
- » Alcohol and other drug services (i.e. Methadone programs)
- » Weight management programs
- » Personal health plans/programs
- » Dentistry
- » Podiatry
- » Chronic condition management
- » Local health education – schools etc
- » Pharmacy

Typically, all centres would provide a core of general health care services plus additional services that reflect the priorities of the local community. This would benefit consumers, as it would result in more efficient provision of care at the one location and support greater collaboration between health care providers. Centres would also be funded to manage the overall health of the local population and to provide screening, education and other preventive health services. The centres would be designed to provide mainstream primary care services to all community members, rather than a "safety-net" service to those unable to access other forms of care.

Voluntary enrolment of patients at centres could be considered in order to facilitate the promotion of population health outcomes and assist in chronic disease management. International experience in the UK and in New Zealand has demonstrated that there are benefits associated with patient enrolment. Enrolment would be voluntary to ensure the rights of consumers are protected and enrolment

would not restrict patients to receiving care just at one centre. Patients who choose to receive care at more than one centre (for example if they are travelling) could nominate a "home" centre where they register and agree to have their relevant health information made available by that centre when receiving care elsewhere. Consumers should be able to nominate their preferred health centre for enrolment purposes, as many may prefer to receive care at a centre close to their place of work or study, rather than their homes. Particular consideration should be given to people who are homeless or itinerant to ensure that their need for continuous and coordinated care can be met through flexible enrolment options.

Who would run the new primary care health centres?

These centres could be managed by a range of different private operators, including existing organisations operating in the health sector, such as Divisions of General Practice, community health services, Aboriginal health services, groups of primary care practitioners, consortia of a number of organisations, or new organisations formed for the purpose of managing primary care health centres. In some areas where private ownership is not viable, they would be owned by governments.

Governance of the centres would involve boards of directors, including community representation to ensure that priorities and policies of the centres reflects the priorities of the local community. Community representatives would be nominated by local councils and thus be accountable to their communities. Provision would also be made for representation of minority groups with specific health care needs, such as Indigenous Australians, on the boards.

How would the new primary health care centres be funded?

Funding for the centres would come from both Federal and State/Territory governments, through the Australian Health Care Agreements. In some cases this may require the pooling of existing funding sources, for example, Federal and State/Territory funding for mental health services. Funding would come through existing state-based health services funding administration.

Consideration should be given to alternative funding arrangements in areas where the current funding system does not result in optimum care. The funding mechanism used should not be driven by ideology or by sectional professional interests but should be the one which best fits the type of care being provided. For example, while a fee-for-service funding system may suit episodic, acute care it is not as suitable for providing comprehensive care for chronic conditions or

for many types of preventive care. Funding arrangements also need to take into consideration the specific needs of vulnerable or marginalised population groups who may have difficulties with a fee-for-service system. These groups may include young people, people on low incomes, indigenous people and homeless people.

How would this new approach to primary care benefit consumers?

There would be a number of benefits to consumers of this new approach to primary care including:

- » receiving more appropriate care, as decisions about the care provided would be based on best practice rather than on cost or location of service;
- » receiving care in a more convenient location, either close to home or work;
- » a seamless approach to the delivery of care – care would be received in the one location thus reducing the need to travel to multiple locations for different services;
- » no cost barriers to access – a more rational approach to consumer contributions, ensuring they are fair and affordable to all;
- » simplified billing practices – no more separate bills and billing practices for each service received for the one condition or episode of care;
- » better coordination of care – reducing the current high level of duplication of tests and other services when consumers move from one care provider or service to another;
- » a greater focus on prevention, ensuring people stay healthier for longer;
- » improved data capture – eliminating the need for duplication of tests and consultations; and
- » faster attention to conditions which could escalate – preventing or delaying the development of more serious conditions.

How would this new approach to primary care benefit health care providers?

This new approach to primary care would provide a number of benefits to health care providers. In particular it would improve clinical care by supporting a greater focus on multi-disciplinary care with other health care providers, such as nurses and allied health workers, working collaboratively with doctors to manage patient care. This reduces the burden on individual clinicians and allows them to focus on

providing the more specialised medical care that they are trained for. It also reduces work pressures on the medical profession by sharing their existing workload with other health care providers. Many clinicians who have experienced working in multi-disciplinary teams also report greater work satisfaction as they learn from the knowledge and experience of other professionals in their health care teams. Supporting clinicians to focus more on preventive and population health can also provide greater professional satisfaction, and reduce the frustration that many doctors feel in being unable to address the underlying cause of many of the health problems they encounter among their patients.

Providing a diversity of employment options can also benefit clinicians, particularly those who do not want to work full-time and/or do not have an interest in owning their own practice. It would also benefit those who don't want to work "fee for service", even if the centre charges fees for its services. The establishment of primary health care centres can also provide professional supervision for new entrants to the health workforce (in some cases replacing elements of hospital-based training), greater physical security for health care providers and staff and ensure the more efficient use of administrative support staff. Larger centres also allow for the full use of minor items of capital equipment resulting in an overall more efficient use of health resources. Primary care centres would also be able to take on responsibility for managing indemnity insurance for clinicians and be able to do this much more efficiently as they could negotiate on behalf of all health professionals employed by the centre.

How would these centres help address the current problems in Australia's primary care system?

These centres would address a number of the current problems in our health system as follows:

- » *Workforce shortages:* by offering flexible employment options (including part-time hours and "walk in walk out" arrangements) these clinics would be likely to attract health professionals not currently in the health workforce, such as women with young children and nurses who have left the hospital system. Providing options such as salary-based employment on a "walk in, walk out" basis should also help attract the younger generation of medical professionals who are more reluctant to own practices than their predecessors and who are willing to work for periods of time in a variety of settings to gain experience. A more flexible approach to the provision of care, with greater scope for service substitution can also assist in dealing with shortages in one professional group. A greater emphasis on multi-disciplinary care, a

Supporting clinicians to focus more on preventive and population health can reduce the frustration that many doctors feel in being unable to address the underlying cause of many of the health problems they encounter among their patients.

team-based approach and more potential for service substitution increases the flexibility of the existing workforce, which assists in addressing workforce shortages in specific areas.

» *Coordination of care:* bringing together different healthcare disciplines in the one place would facilitate the coordination of care and assist consumers requiring inter-disciplinary care. A more flexible funding system that is designed for the provision of chronic care services should also facilitate integrated and coordinated care.

» *Population health focus:* centres would be responsible for managing the overall health of a population, rather than just that of individuals, and would be funded to achieve population health outcomes. In general, increased investment in primary care has been demonstrated to increase population health outcomes, such as the early diagnosis of cancer.

» *Maldistribution of health professionals:* increased flexibility in the provision of care would help address the maldistribution of health professionals by enabling some service substitution, where clinically appropriate. For example, routine immunisations could be provided by nurses instead of GPs. By offering more flexible employment options (such as sessional work on a walk-in, walk-out basis) health professionals may be more likely to be prepared to work for some time in less popular areas that have problems attracting health professionals on a full-time, long-term basis.

» *Uneven imposition of costs/ high out-of-pocket costs for some consumers:* bringing different primary care professionals together in the one place would facilitate coordination and consumer-centred care and the rationalisation of costs. Flexible funding systems would enable the high out-of-pocket costs currently faced by some consumers to be ameliorated.

» *Poor access for some groups:* centres would be established in areas of need and have the flexibility to target specific groups, i.e. centres in areas with a high indigenous population would be able to ensure that the culture and service provision of the centre met the needs of indigenous people. Board representation from groups with identified access problems would assist in ensuring the centres catered for their needs.

» *Inflexible funding:* by providing a range of funding and remuneration options, including salaries, fee-for-service and capitation funding, centres would have greater flexibility in their use of resources. This would enable them to develop funding systems that best meet the needs of both health care providers and consumers. Different funding options may suit different groups of patients, i.e. a fee-for-service system may suit episodic acute care and a capitation-based system may be more suitable for people with chronic

conditions.

» *Poor indigenous health outcomes:* addressing the serious problems with indigenous health requires a primary care-centred approach. Research on the factors contributing to indigenous health disadvantage stress the importance of cultural sensitivity in the provision of indigenous health services. This includes the need for health care to be provided in a physical environment that is appropriate, as well as a recognition of the different cultural norms of indigenous communities in the way that care is provided. Primary care is much more able than tertiary and hospital-based care to work with indigenous communities and indigenous people to develop culturally appropriate models of health care. These can learn from existing successful models, for example, indigenous health services where community members are involved at all levels, including on the Board, the management staff and the clinical staff, and non-indigenous care providers work in association with indigenous nurses and health workers to provide culturally sensitive health care to their communities. In some cases this may require the establishment of separate indigenous health facilities although this may not necessarily be the case and other options, such as integrated indigenous and non-indigenous health care centres should also be considered.

» *Increasing rates of chronic illnesses:* as the burden of chronic illness grows, along with the ageing of the population, it becomes more important that our health system is geared towards the successful primary and secondary prevention and management of chronic disease. This requires a focus on primary care and a re-orientation of our existing primary care system to promote the prevention and better management of chronic illness. This would involve radically changing the way in which primary care is funded and adjusting current remuneration systems to reward prevention and chronic disease management. The main change needed is to fund primary care centres for the overall management of chronic conditions, rather than the current approach of funding individual health care providers for isolated episodes of care. Funding centres for the management of chronic conditions allows for service substitution – enabling the most appropriate and cost effective mix of services to be provided – and creates an incentive to minimise the progression of the illness and to support strategies for the self-management of chronic conditions.

» *An insufficient focus on prevention:* our current primary care system has only a minimal focus on prevention. Given that funding invested in preventive health saves more resources than health funding spent elsewhere, this approach does not make economic sense. Re-orienting primary care to focus on prevention requires funding to be directed to preventive health activities,

Our current primary care system has only a minimal focus on prevention. Given that preventive health saves more resources than funding spent elsewhere, this approach does not make economic sense.

such as immunisation, screening, early diagnosis services and health promotion. Our current funding system generally rewards health professionals only for treating an established condition, e.g. writing a prescription for a drug to treat obesity. There are few resources available for GPs and other primary care providers to work proactively to prevent the development of obesity in their community in the first place.

A better system would be one which provided more support and incentives for primary care providers to work with consumers to prevent the development of chronic conditions. In order to re-focus primary care on preventive health, funding needs to be provided for preventive health activities and for the measurement and monitoring of communities' health status. This could be achieved by providing financial incentives for the management of health outcomes in the catchment population of the centre and for evidenced-based outreach and health promotion activities that will promote population health outcomes within that community.

What would the establishment and operation of the new primary care centres cost?

The main costs and savings that would need to be factored in when assessing the overall cost of establishing new primary care centres are outlined below.

The cost of establishing and operating primary care centres will vary according to their size and location. An indicative capital cost for an urban centre serving a population of about 100 000 needing to be built from scratch would be \$20 million^h. Around \$4 billion would be needed over a period of ten years to roll out enough centres to service the entire population of Australia. This amount can be compared to the cost of federal government support for the Private Health Insurance (PHI) industry: the combined cost of PHI rebates and incentives is currently around \$4 billion *per year*ⁱ.

Capital costs include building new facilities and equipment. Many centres could potentially use existing facilities with minimal modification. For example, existing larger general practices or clinics close to hospitals could be adapted for use as a primary care centres (with agreement from the current owners), as could smaller rural hospitals and community health centres. However, in some cases new infrastructure and/or a purpose-built facility would be required. As a general rule, between 4000 square metres and 5000 square metres would be required for a Primary Care Centre and about 1000 to 1500 square metres for a satellite centre.

Recurrent costs include labour costs, equipment and consumables. These would largely be met from existing allocations to Medicare, PBS and other programs, so only the incremental costs of currently non-funded services, such as podiatry, need to be factored into the overall cost.

Savings

Establishing a new primary care system would also result in savings to both the health budget and to consumers in the following areas:

- » *Taking pressure off public hospitals* due to the prevention of unnecessary hospitalisation^l
- » *Reduced travel costs* due to the co-location of services
- » *Less duplication of services* due to better coordination and sharing of data
- » *Service substitution*, enabling the most cost-effective service mix to be provided

Where would the centres be located?

As a general rule, one primary care centre would be required per 100 000 head of population, with a total of 200 required to service the entire population of Australia. However, there would not be a rigid “one size fits all” approach to the size of the centres and in some areas, such as rural communities, smaller satellite centres would be established linked to a larger centre in an urban centre. Each centre would require approximately 15-20 GPs, as well as allied health and administrative and support staff.

The precise location and size of the centres would need to be based on the following local factors:

- » Population distribution
- » Specific burden of disease characteristics
- » Socio-economic and ethnic characteristics
- » Current level of service utilisation
- » Accessibility, including transport

Additional community consultation and research may be required to determine local needs and priorities and to inform decisions on the location of the centres.

When could implementation of the new primary care system begin?

A staged approach to the implementation of the new primary care system should be taken. Funding arrangements could be established through the next Australian Health Care Agreements, due to commence in July 2008. Work could commence on establishing the first centres almost immediately with the aim of opening approximately 20 per year. Over a period of ten years the entire population would be served by the new primary care centres.

Endnotes

- a Starfield, Shi and Mackinko 2005
 - b Starfield, Shi 2001
 - c Zwar et al
 - d Saultz and Lochner 2005
 - e Starfield 2003, Engström 2004, Starfield and Makino 2005
 - f Macinko J, Starfield B, Shi L. 2003
 - g Starfield B, Shi L 2002
 - h Based on the cost of the proposed 'Health One' services in NSW, and South Australian experience with the 'GP Plus' centres. Calculations available on request.
 - i McAuley I, 2007
 - j There is a range of research demonstrating that better chronic disease management in the community can reduce hospitalisation rates, for example the asthma management program undertaken by South Eastern Sydney Illawarra Area Health Service
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