State forum background briefing paper
June 2008

Health system reform and primary care service delivery

This purpose of this paper is to:

- set the context for Victorian divisions to discuss health system reform and primary care service delivery at GPV's state forum on 25-26 July 2008
- summarise some of the main, relevant positions GPV has advocated, based on consultations with divisions.

Appendices draw together some of the documents that participants will already be familiar with, (links to some of the recent key documents, and brief overviews on some of the Commonwealth Government's main initiatives as part of its health reform plan), to assist participants to prepare for the discussion.

As part of the July state forum, sessions on health system reform and primary care service delivery will be held on Friday afternoon and Saturday morning with the following objectives:

- in the context of health system reform, discuss existing and potential arrangements for primary care health service delivery and divisions' roles in relation to them
- identify good practice examples of divisions' work to improve co-ordinated primary care
- help develop messages for advocacy to State or Commonwealth to inform and influence their deliberations about health system reform.

We know from international evidence that health systems with a strong primary health orientation are associated with improved population health and have improved equity, more appropriate use of services, user satisfaction and lower costs. But questions remain that do not have clear answers. These include: the configuration of primary care structures and teams, content and services and modes of delivery. [1]

In Australia, the Commonwealth is making some investments in primary care infrastructure through the GP Super Clinics funding, but this is not a systematic approach as it applies to only some areas, takes little account of workforce shortage and does not provide impetus for system redesign. State governments are also investing in primary care infrastructure in different ways.

The Victorian Department of Human Services (DHS) released a department-wide position last year that, for the first time, formally recognises the centrality of general practice as the first point of contact for primary medical care, and commits the Department to the attempt to bring together state and commonwealth directions for better patient care.

At the time of writing, DHS is finalising a new strategy which builds on the previous GPs in Community Health Services (CHS) Strategy. We anticipate that it will build on the directions in the GPs in CHS funding rounds – that is, to develop general practice systems within community health services, but also to focus increasingly on the links between the services and private general practice.

Divisions are likely to be interested in hearing about South Australia's *GP Plus Strategy* as it appears to link private general practices in an area with other state-funded services, building on general practice care rather than establishing an alternative point of service. David Panter, of the SA Health Department will give a presentation on the strategy to inform the forum.

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[1] Atun R (2004). *What are the advantages and disadvantages of restructuring a health care system to be more focused on primary care services?* Copenhagen, WHO Regional Office for Europe (Health Evidence Network report) www.euro.who.int/document/e82997.pdf

Over the 10-15 years since their inception, Victorian divisions of general practice have participated in discussions about the need for a stronger primary care system, a national policy on primary care,[2] and have debated what new systems, or system changes, are necessary to allow general practices to make the best contribution to improving the health and care of people in their local communities. As in any discussions about the Australian health system, a recurring theme has been the range of difficulties that arise from the complicated and inconsistent arrangements for funding and administering health care. Not only are responsibilities split between Commonwealth, State and local levels of government, and the models in each state somewhat different, but the combination of public and private arrangements that exist can make access as well as quality inconsistent.

Certainly the 'blame game' between levels of government is an impediment – and one general practices and their divisions are highly familiar with, as they commonly deal with parallel initiatives from State and Commonwealth with similar aims, and targeting similar high-need groups, which are separately planned, funded and then implemented in different ways. Ironically, greater attempts at intergovernmental co-ordination, through COAG and so on, have at times led to more of these parallel projects (on agreed health priority areas) rather than fewer, seeking the co-operation of general practices to use, for instance, two competing frameworks to assess patients at risk of developing diabetes, instead of one.

Divisions are placed at the intersection of Commonwealth and State initiatives and frequently provide a bridge between the two. For example, North East Victorian Division brings together State and Commonwealth funding to address mental health which is a crucial issue in primary care at both state and federal levels.

Divisions would welcome the Commonwealth Government's stated intention to 'eliminate the blame game' between different levels of government, but the question of what model to use to make the state-funded primary care system, as well as its hospital system, work together with (mostly private) general practices for better patient care is yet to be answered.

The discussion questions for this forum will revolve around the question of how services should be configured to improve accessible, co-ordinated primary care and what divisions' roles should be in relation to them.

Key advocacy messages

GPV's ongoing consultative work with Victorian divisions has shaped our input to policy debates, [3] including AGPN's consultations on its position statements on primary care and on funding models for multidisciplinary team care. In summary Victorian divisions have tended to:

1. believe multidisciplinary teams are basic to good chronic disease management and therefore support changes to current funding system in order to fund teamwork effectively
2. hold that clinical leadership is the province of the GP while care co-ordination can be provided by a non-GP. Divisions would support funding mechanisms that increase emphasis on prevention and early intervention (while wishing to retain the fee-for-service MBS funding structure for episodic care)

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[2] See GPDV's policy issues paper 22, *The Need for a National Primary Health Care Policy*, which documents some of the current problems, and argues for a national policy to be developed against the criteria in the National Health Performance Framework. Visit http://www.gpv.org.au/, 'Policy and Consultation'→ Discussion/ Briefing Papers

[3] Mechanisms have included face-to-face forums for Division Chairs, where a particular topic is discussed; teleconferences with Chairs and representatives of GPV and AGPN boards; and circulated discussion and briefing papers and draft submissions, on which we invite divisions' input.

3. some divisions have expressed interest in regional (voluntary) registration for patients with a chronic disease, and as far as testing new funding models, they have supported the idea of starting with a clearly defined group, to test the models, with adequate guidance, clinical governance, evaluation, a quality framework, and data
4. support using the models of team-based care that have worked well through the Victorian HARP initiative, and with which GPs are familiar
5. hold that in the long run, the goal should not be to add an increasing range of options but to identify an approach and funding model that could develop that can be applied nationally to reduce complexity, enhance efficiency and ensure consistent and equitable primary care across Australia
6. suggest, in response to AGPN proposals, that they could not commit to being the only fundholder, given there is extensive infrastructure of services in Victoria, many of which would claim they are equally well-placed to hold funds. Victorian divisions and GPV have worked hard to develop effective working relationships with state-funded services and did not want to give the impression that divisions were subsequently proposing to enter into competition with them. A regional governance model could involve groups of divisions and state-funded services.[4]

Summary of GPV's submission to the National Health & Hospitals Reform Commission[5]

The submission made on 30 May 2008:

1. highlights some examples of the excellent work divisions do as they continually bridge the divide between state and commonwealth; and argues for wider application of some of the successful models
2. suggests that, however excellent the work of divisions, there are some system-wide problems in the way health services are structured and delivered which could only be overcome by the government making a serious attempt to re-design the way the whole system works, rather than to simply add on more initiatives, or make greater use of existing mechanisms[6]
3. makes some recommendations about ensuring adequate investment in general practice infrastructure to ensure achievement of the government's current strategies to address workforce shortage, on the grounds that an adequate and competent general practice workforce is crucial to achieving accessible health care in Australia.

GPV argued that some successful arrangements for accessing and co-ordinating primary care in Victoria share these important features:

- they cross the divide between what is funded by the Commonwealth and what is funded by the State
- general practice is strongly linked into the way the service is designed and provided
- the models are not set up in competition with other services but strengthen and complement existing general practice care.

Because they link with, and complement, existing general practice care, the models achieve strong support from practices (and therefore greater referral rates and potential for sustainability); and, because of the enormous 'reach' of general practice services (it is estimated that about 80%

[4] GPV, March 2007, Submission to AGPN on its paper, Funding general practice based multidisciplinary health care in Australia; GPV, September 2007, Submission on AGPN draft position statement – funding models for general practice based multidisciplinary team care. Visit http://www.gpv.org.au/; 'Policy and Consultation'→ Submissions.

[5] These 4 documents are on our website: 2-page summary; Submission; Policy paper on workforce infrastructure; Policy issues paper 22 on the need for a national primary care policy.

[6] For an account of the system-wide problems, see GPV Policy issues paper 22. Visit www.gpv.org.au; 'Policy and Consultation' → Discussion and Briefing Papers.

of the population see a GP each year[7]), they also have the potential for greater access and improved health than an additional, competing service that duplicates existing settings or reaches only a section of the population.

We recommended:

1) the Commonwealth and all states and territories use the National Health Performance Framework (or some other evidence-based, comprehensive framework supported by health system design experts), to overcome the systemic problems, by enabling policy makers to consider all dimensions of the system when they consider improvements.

2) the commission develop strategies (funding, organisational, governance) that build on the strengths exemplified in the Victorian models described in our submission, as they illustrate ways to achieve integration or co-ordination of care.

   (The initiatives described and promoted in the submission were:
   - *Diabetes Cardiovascular Risk Management Program (DCRMP) – Dandenong Casey General Practice Association*
   - *Healthy At Home, involving Melbourne East General Practice Network, Knox Division of General Practice and Eastern Ranges General Practice Association*
   - *North East Integrated Primary Mental Health Service, involving North East Victorian Division of General Practice*
   - *Active Script in West Vic Division of General Practice*

   Speakers from divisions will give presentations on some of these projects at the state forum.)

3) the commission develop strategies which allow funds to be pooled at a regional level to reduce the inefficiencies created by different funding streams, from different levels of government, and increase the effectiveness of patient care at the local level.

4) the Commission ensure its recommendations to government to address the need:
   - to ensure that the space and equipment exist in general practice to expand its models of care, to serve as a training site and to attract future medical students to the profession
   - to support General Practice Education & Training's (GPET's) proposal to progressively increase GP training places by 2011
   - to document infrastructure costs and the present shortfall both for clinical placements and for the expansion of team-based models of care
   - to establish an infrastructure investment fund that ensures general practices are supported to make the transition to a substantially increased teaching commitment and a broader model of primary health care service delivery
   - to ensure that the Australian Health Care Agreements require state investment in infrastructure at a level that reflects the states' use of private general practice for the achievement of their public sector goals.

These workforce recommendations are necessary to ensure adequate infrastructure in order:
a) to meet the demand for general practice-based training of medical students and graduates seeking to become GPs
b) to further recruit practice nurses and other health professions as team members in the delivery of primary care.

[7] In 2004-05 financial year, 79.76% of the Victorian population saw one or more GPs. Medicare Australia: *Annual Report 2005-2006* - statistical tables – table 22, Medicare - Number and percentage of patients by number of General Practitioners consulted by State/Territory - for services rendered from 1 July 2004 to 30 June 2005. <http://www.medicareaustralia.gov.au/about/governance/reports/05-06/stats/index.shtml> accessed 21 February 2008.

Appendix 1: Links to key documents referred to in this paper

(To access the documents listed below, please click on each title)
GPV
Submission to National Health & Hospitals Reform Commission (May 2008)

Attachment to GPV submission to the NHHRC: Infrastructure for Workforce Development (May 2008)

Policy issues paper 22, *The Need for a National Primary Health Care Policy* March 2005)

Consultation paper for divisions to inform GPV's National Health & Hospitals Reform Commission submission (April 2008) – includes diagram of National Health Performance Framework, referred to in other papers and submissions.

AGPN
Submission to National Health & Hospitals Reform Commission (May 2008)
Position statement on Payment Systems for General Practice Teams (May 2008)

Early consultation draft on funding models for general practice-based team care (2007)
Federal Budget 2008-09: Budget Summary (May 2007)

DHS
Position Statement on Working with General Practice (2007)

Position statement 'at a glance'

Following on from the GPs in Community Health Strategy (2004) DHS will shortly be releasing a revised strategy, which is likely to include general practice system development within community health services, and also links between private general practice and community health services.
It will be available through the Primary Health Branch website.
See: http://www.health.vic.gov.au/communityhealth/gps/index.htm

Appendix 2: Overview of some of the current major commonwealth government directions

GP Super Clinics

The government has committed to providing 275.2 million over 5 years to fund 31 GP Super Clinics.[8] These are intended to "provide better coordination between privately provided GP and allied health services, as well as state and territory funded health services."[9] There will be five in Victoria (Ballan, Bendigo, Berwick, Wallan and Geelong). A departmental key performance indicator is to commission 20 GP Super Clinics by June 2009.[10] AGPN has developed a resource kit to assist divisions that are interested in submitting an application.[11] Organisations are being invited to tender. Some divisions are closely involved in development of local GP Super Clinics; others are less closely involved, and most divisions do not have a proposed clinic in their local area. The funding for GP Super Clinics includes initial capital funding for building/refurbishment/establishment; recurrent funding for employment of administrative support, practice managers and nurses; relocation incentives for GPs, nurses and allied health providers. GP Super Clinics may have a role in providing training placements.[12]

National Preventive Health Strategy

A National Preventative Health Taskforce will develop a national preventative health strategy by June 2009. The taskforce is chaired by Rob Moodie (former CEO of VicHealth and now Professor for Global Health at the University of Melbourne's Nossal Institute for Global Health). AGPN's CEO, Kate Carnell, was appointed to the taskforce and will remain on it. By July 2008, the taskforce is to provide advice to government on the framework for the Preventative Health Partnerships to be included in the Australian Health Care Agreements (funding agreements) between the commonwealth and the states and territories.[13] The taskforce will have an initial focus on reducing the burden of chronic disease currently caused by obesity, tobacco and alcohol.[14]

National Primary Care Strategy

On 11 June, Nicola Roxon announced the membership of an external reference group, which will help the government develop the new Primary Care Strategy. The states, territories and other health stakeholders are also to be consulted. Tony Hobbs, Chair of AGPN will chair the reference group.

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[8] Department of Health and Ageing: *Budget at a Glance 2008-09*. www.health.gov.au/internet/budget/publishing.nsf/Content/budget2008-glance.htm.

[9] Department of Health & Ageing Budget Portfolio Statement, Section 2 Outcome 5: Primary Care, www.health.gov.au/internet/budget/publishing.nsf/Content/2008-2009_Health_PBS/$File/Outcome%205.pdf> p.109.

[10] Budget paper

[11] AGPN's GP Super Clinic Toolkit can be downloaded from AGPN's National Resource Library by members (divisions). NRL is accessed through www.agpn.com.au. Members need to enter their username and password to enter the secure areas of the site.

[12] Further information, including answers to Frequently Asked Questions is at DoHA's site www.health.gov.au/internet/main/publishing.nsf/Content/pacd-gpsuperclinics

[13] New health taskforce on prevention - tobacco, alcohol and obesity priorities, Media statement, 9 April 2008 <www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr08-nr-nr046.htm>. The taskforce is due to release a discussion paper in September 2008 and a draft strategy in March 2009; and will seek comment on both. Information about the taskforce, including member profiles is available at: <www.preventativehealth.org.au/internet/preventativehealth/publishing.nsf/Content/home-1>

[14] Nicola Roxon's speech at AGPN Primary Mental Health Care Forum, Sydney, 11 June 2008.

A review of the MBS will occur at the same time. The Health Minister says this will focus on 'simplifying the primary care item structure, reducing red tape and giving more support to prevention.' [13]

New MBS items

New items including the Healthy Kids check and items to address the health of people at risk of developing type 2 diabetes are being introduced in 2008-09. These are presented as part of the government's commitment to supporting people with chronic disease, and orienting primary care towards prevention and early intervention.

National Quality and Performance Measures for Divisions

As part of their funding agreement for 2008-09 divisions are contracted to provide, for the first time, information on a new set of indicators, which draws on information about some practice systems (like recall/reminder registers) and aggregated patient health measures (e.g. for diabetes and coronary heart disease). Initially, this will be for only a relatively small proportion of practices, but it is likely that the number of practices that need to be included for these indicators will increase over time.

National Health & Hospitals Reform Plan

The plan announced by the ALP prior to the election has three stages:

1) $2.5 billion National Health and Hospitals Reform Plan.
   - Additional funding to be given to State and Territory Governments if they reach agreed reform milestones.
   - Investing upfront in health and hospital systems.
   - Ensure funding is available for projects to strengthen our primary care system.
2) Establishment of the National Health and Hospitals Reform Commission (NHHRC), whose terms of reference include:
   - Provision of advice on the framework for the next Australian Health Care Agreements (AHCAs), including robust performance benchmarks in areas such as (but not restricted to) elective surgery, aged and transition care, and quality of health care.
   - Report (by June 2009) on a long-term health reform plan to provide sustainable improvements in the performance of the health system[15].
3) If by mid 2009 States and Territories have not begun implementing a national reform plan, the ALP will seek a mandate from Australians at the following election 'for the Commonwealth to assume all funding responsibility for the nation's public hospitals.'[16]

[15] For more information, including membership of the commission, draft principles, and a report on framework for the AHCAs, *Beyond the blame game*, see www.nhhrc.org.au.
[16] ALP (2007): *New Directions for Australian Health: Taking responsibility: Labor's plan for ending the blame game on health and hospital care*; p. 6.