



AGPN response: National Health and Hospitals Reform Commission Interim Report

AGPN supports the overall thrust of the report, particularly the focus on developing a strong primary health care (PHC)-led system. The following comments highlight areas for further consideration in framing the final report.

Role of GPs and general practice

- AGPN strongly recommends that the NHHRC recognise the vital role of GPs and general practice in developing a stronger PHC system: It is essential GPs are not disenfranchised by the final report, that GPs and general practice are supported as central to any change, and that the benefits of change for GPs, general practice and their patients are identified and promoted.
- The report should recognise the increasingly multidisciplinary approach to general practice in Australia: since divisions were established, significant changes in practice have occurred, more than 8,000 practice nurses now work in general practice, along with practice managers and allied health professionals. Multidisciplinary teams provide comprehensive care to patients.
- AGPN supports comprehensive PHC but cautions whether this needs to be delivered through new Comprehensive Primary Health Care Centres (CPHCs). While this is one model of multidisciplinary service delivery, collocation will not automatically deliver integrated comprehensive care. Other factors, such as interdisciplinary team work education, infrastructure (eg. eHealth), support for health service design and development, and clinical governance support are needed.
- Rather than investing in new Centres, the focus should be to build on what already exists through the 7300 general practices throughout the country. Many practices are constrained in their ability to deliver integrated multidisciplinary PHC by lack of infrastructure. Access to capital should be identified more broadly to both encourage more comprehensive integrated care and enable the infrastructure required to assist in teaching the next generation of the PHC workforce.

Service design and delivery

- Any reform agenda must include models of care and service re-design to reduce avoidable hospital admissions and readmissions. AGPN supports recommendations for increased investment in self management, sub-acute services and 'step up, step down' services delivered in the community. AGPN suggests the Commission further explore divisions of general practices' potential to take a greater role in providing sub-acute services.
- Voluntary enrolment as proposed is supported provided patients still have access to providers of choice.
- AGPN commends the commitment to embed quality and health outcomes across PHC services. General practices have embraced the Collaborative methodology to improve health outcomes through data management, benchmarking, practice improvement and information sharing facilitated by the Divisions Network. AGPN recommends the Commission support an enhanced Collaboratives approach, to systematically embed a Collaboratives-type methodology across general practice. Collaboratives are funded as a 'project', an unsustainable model.

Tackling health inequities

- The focus on Aboriginal and Torres Strait Islander health and supporting people with mental illness is welcome. AGPN recommends the final report consider strategies to improve mainstream health's capacity to better service these vulnerable groups. Divisions and general practice are major service providers to these populations. In some Indigenous communities, divisions are the only health providers. Likewise there has been considerable investment in primary mental health care under COAG mental health and this momentum should be extended, not lost.

Financing

- AGPN agrees there must be a mix of funding for PHC (page 88). A blended payment system including fee-for-service (FFS), pay-for-performance and capitation payments will best support the delivery of optimum care and flexible PHC solutions suited to practice populations. Capitation payments must not replace GP FFS arrangements – FFS will remain the basis for remunerating GP services. The Commission’s suggestion that over time payments will be developed that bundle the total cost of care of enrolled individuals over a course of care or period of time in preference to existing fee-based payments (page 80) is not supported by AGPN.

Divisions of Primary Health Care:

- AGPN supports a regionalised approach to health care planning and delivery. Over time, regional health authorities with responsibility for all health care planning and purchasing would provide a mechanism to drive coordination, integration and efficiencies across and between the primary, secondary and acute sectors. AGPN acknowledges the Commission’s recognition of the value of ‘meso’ level organisations – in this case divisions of general practice.
- The evolution of divisions into Divisions of Primary Health Care is identified in the report, however, AGPN believes further consideration of the role and function of these organisations is needed. Divisions are already increasingly going beyond the ‘health stewardship’ role the report suggests. Divisions are often service providers and their role in direct service delivery is continuing to expand. In some communities, divisions are the only providers of primary health care: they recruit, deploy and manage all primary health care staff. To remove this direct service delivery role would be a regressive step: the move to Divisions of Primary Health Care should improve integrated primary health care delivery to the community.
- The final report should recognise the role of divisions and their evolution from general practice support into broader primary health care organisations. They are well placed to step up to the role of Divisions of Primary Health Care.
- In the debate regarding region size AGPN believes form should follow function ie. establish what functions a region needs, and then determine its form. This will be influenced by population, communities of interest, and geography. Whatever regional sizes, it is essential existing support for general practice is at least maintained at current levels or preferably improved.
- AGPN also supports population needs-based funding on a regional/local basis, including cashing out of benefits in relatively “underfunded” areas. Divisions are well placed to hold these funds and deliver or commission services.

Governance options:

- AGPN agrees the Commonwealth should take responsibility for all PHC policy, planning and funding to overcome fragmentation and duplication – to deliver a cohesive ‘joined up’ system.
- The development of Regional Primary Care Enterprises (RPCE) evolving from existing divisions, should be the first step in health care governance reform. Other changes to governance can be progressively added to this fundamental building block. AGPN supports regional entities to ensure local responsiveness and flexibility. Option A does not provide a mechanism for planning, funding and delivering services at a local level. Rather, it appears to involve direct funding from the Commonwealth level, potentially through the States and Territories. Under this scenario fragmentation concerns will not be addressed.
- An option between Option A and Option B (Option A+ or B-) is required, involving creation of RPCOs. This will mean primary health care funding is quarantined at the early stage of change and will focus on strengthening primary health care, without the competing demands of planning and funding acute care. Development of RPCOs could be a step on the road to development of Regional Health Authorities with broader funding and planning responsibilities (ie. including acute care).
- Divisions could take on this RPCE role – developing from divisions of general practice to Divisions of Primary Health Care with regional planning, funding and service delivery responsibilities.