



**Australian
General Practice
Network**

*Delivering local health solutions
through general practice*

Submission to the National Health and Hospital Reform Commission

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AGPN is one of the largest representative voices for general practice in Australia. It is the peak national body of the divisions of general practice, comprising 119 divisions across Australia, as well as eight state-based organisations. Approximately 95 percent of GPs are members of local divisions of general practice.

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Executive summary

The National Health and Hospitals Reform Commission is tasked with advising the Government on a long term plan for health. Transforming the Australian health care system will not be easy but it is critical to change the system in ways that will make it more sustainable, efficient and equitable.

What's wrong with the current system?

The current health system is not best set up to deal with what we know will be issues in health over the longer term. There is evidence of the urgent need to change the way health care is funded and the way the health care system is organised and governed. Otherwise the pressure on health budgets will quickly become unsustainable and the capacity of the system to deliver equitable services with an acceptable level of quality and accessibility will wane.

The prevalence of chronic disease is on the rise and we have major health inequities in our population. Aboriginal and Torres Strait Islander people suffer much more ill health than other Australians and our regional and rural communities experience death rates that increase with remoteness and are more likely to exhibit risk factors such as alcohol use, overweight and obesity than those in major cities.

We face ongoing health workforce challenges and Medicare alone no longer offers universal access to care – its spend per capita decreases with increasing rurality. Existing payment systems reimburse inputs rather than outcomes and there are few incentives to avoid or slow the rate of hospitalisation, to invest in prevention and to allocate funding based on local needs. With responsibility for health spanning Commonwealth and state / territory governments, the patient's experience is often of disjointed and poorly connected services.

What are some of the solutions?

Australia already has some sound policy frameworks in the health arena. The *National Chronic Disease Strategy* provides national direction for improving chronic disease prevention and care. It is supported by National Service Improvement Frameworks which outline opportunities for improving prevention and care in relation to specific diseases. The *National Mental Health Plan 2008-2011* endorsed by COAG provides similar direction for mental health.

The question is not so much have we got the policy right, but have we got the implementation right? The most critical decision for health reform is how to best focus attention and resources on keeping our communities healthier and out of the acute care system. AGPN believes that key components of a long term plan for health must be:

A strong primary health care system

An integrated, well functioning health system which relies more on primary health care and general practice than on specialist and hospital care will deliver improved population health outcomes, equity, access and continuity of care while lowering costs in the long term^{1,2}. New funding should be directed into primary health care areas such as health promotion, patient self management, early intervention and team-based chronic disease management. It should also feature continued investment and expanded roles for the unique primary care organisation infrastructure represented by the current divisions of general practice network in recognition of the impact that PCO style organisations can have on population health improvement and health service access.

One health system: regionalised approaches through regional health entities

It is essential that we move to the concept of a 'single health system'. Only this will overcome the perennial problems associated with shared responsibility for health across jurisdictions and a patient experience of care that is disjointed. Regional health entities would comprise state / territory area health, divisions, hospitals and the community. They would monitor the health of their communities and jointly plan and allocate Commonwealth and state / territory funding for local health services targeting prevention and early interventions, chronic disease management and hospital avoidance.

Investment in prevention and early intervention

Less than two per cent of the health budget is spent on preventative care. This is despite the impact that preventable risk factors and chronic illnesses have on quality of life, medical costs and national productivity, and the subsequent burden on health services,

¹ Starfield B. *Balancing health needs, services and technology*. New York; Revised edition, Oxford University Press; 1998.

² Health Evidence Network. *What are the advantages and disadvantages of restructuring a health care system to be more focused on primary care services?* Europe; World Health Organization; 2004.

particularly hospitals and the acute sector. General practice and divisions, with their capacity to engage communities, are settings where health promotion and prevention action can be effective. Early investment in some key national prevention programs such as universal access to evidence based lifestyle modification programs for people at high risk of chronic disease, and a national parenting program addressing risk factors in children are recommended.

Hospital avoidance through primary care services

Better service coordination can deliver early and substantial gains in reducing unnecessary hospitalisations for people with chronic and complex illness³. In addition, active hospital avoidance programs that deliver good health outcomes for patients are possible through acute primary care services (for example, hospital in the home; hospital substitution services). These have been shown to have equivalent outcomes for patients as well as greater quality of life and satisfaction ratings reported by patients.

Outcomes based funding regimes

Our system reimburses inputs rather than outcomes, has few incentives to avoid hospitalisation and has few incentives to invest in preventative health care. A key principle for health financing overall must be a shift away from input based funding towards outcomes based funding approaches.

For general practice, comparison with international systems suggests blended payment systems produce better results, including improved health outcomes and reduced health inequity, than any individual payment systems in delivering primary health care services^{4,5,6,7}. In countries with a strong primary care focus, blended general practice

³ GPPartners . *GPPartners and Coordinated Care: Team Care Health II Perspectives*. 2008. Accessed 30 May 2008 at http://agpn.com.au/client_images/171080.pdf.

⁴ Robinson J. Theory and Practice in the Design of Physician Payment Incentives. *Milbank Quarterly*; 79; 149-177; 2001.

⁵ Van Weel C, & Del Mar, C. How should GPs be paid? *Medical Journal of Australia*; 181: 98-99; 2004.

⁶ Eggleston K. Multitasking and mixed systems for provider payment. *Journal of Health Economics*; 24(1), 1-223; 2005.

⁷ Mays N. Using financing and funding methods to improve access to primary health care. Presentation at the Australian National University, Australian Primary Health Care Research Institute; March 2004.

payments usually comprise some form of capitation system⁸. Capitation does not exclude fee for service (FFS) as part of a blended payment, but does require patient registration.

AGPN recommends the retention of FFS for episodic care combined with direct purchase of multidisciplinary primary care services by divisions of general practice, service coordinators and incentives for coordinated 'packages' of care involving voluntary patient registration.

A common performance framework

In line with the 'single health system' concept, a common set of goals should guide action for the health system overall. A common performance framework for both primary and acute care systems will assist to drive improvement in overall health performance. AGPN would recommend that national performance indicators for the divisions network derive directly from such a framework.

Workforce reform and development

To make the most of Australia's existing health workforce and to support emerging or new health practitioner roles, new workforce policies and programs as well as new ways of organising and configuring health care teams are required. It will also require closer integration between primary and secondary care, making use of intermediate care, focusing on chronic diseases and their effective management, and giving priority to self care is critical to a sustainable health system.

GPs will work more centrally at the primary health care / hospital interface and at the more complex end of care, delegating less complex and more routine matters to others in the team such as practice nurses. The concept of a GP consultant who would be paid to provide a leadership role to the next cohort of general practitioners, focusing on providing clinical consultation liaison support to more junior colleagues as well as teaching and mentoring younger doctors would be a central part of the scope of this role. Other measures that will improve the capacity of the primary health care sector include nurse practitioners, with limited prescribing rights, working collaboratively with the GP

⁸ Phillips R and Starfield B. 2004. Why does a U.S. Primary Care Physician Workforce Crisis Matter?

American Family Physician; Vol 70; No 3. 440-442.

and the general practice team to enhance patient care, and active programs to recruit and retain more nurses into general practice – presently a relatively untapped workforce.

A national e-health strategy

Health system reform must be enabled by e-health solutions that will enhance integration and information sharing between providers and settings within the system. The significance of e-health as leverage for driving integration throughout all parts of the health system should not be underestimated. E-health solutions should be the central component underpinning structural reforms.

Evidence shows that an integrated health network underpinned by information management and information technology reforms across the health sector will increase health quality and safety outcomes. AGPN supports the development of a National e-Health Strategy which includes investment in critical components such as infrastructure, standards, capability and governance. A Shared Electronic Health Record (SEHR) is an essential part of the mix. AGPN supports a common government mandated development path and provision of an SEHR with a strong framework for privacy, relevancy, connectivity and provider input, while still recognising the potential value adding contributions of private corporations.

1 Introduction

This submission is made to the National Health and Hospitals Reform Commission by the Australian General Practice Network (AGPN).

Divisions of general practice are a unique and valuable part of the Australian health care system and have substantially improved the health of their communities by delivering local health solutions through general practice. Since their commencement in 1992 with 10 demonstration sites, divisions have evolved into a vibrant network of organisations comprising 115 local divisions of general practice supported by 8 state-based organisations (SBOs) and AGPN, the national peak body.

Approximately 95% of general practitioners (GPs) are members of their division. Members increasingly include many GP registrars and non GP members especially practice nurses, practice staff and allied health professionals.

This submission has been formulated with input from a network working group which comprised general practitioners (GPs), divisional CEOs and senior network staff. The AGPN Board and CEO would welcome the opportunity to discuss the recommendations contained in the submission further with commissioners.

The submission draws on a range of existing position statements and policies developed by AGPN over the last 3-4 years, most notably the *Primary Health Care Position Statement*, the *Payment Systems for General Practice Teams Position Statement* and our *Submission to the National e-Health Strategy*, all available on our website. It also draws on the experience of many division-run hospital avoidance, service integration, care coordination and preventive initiatives.

The submission is in four parts:

- Why is Reform Needed? A short background discussion of current health system issues from a primary care perspective
- A long term health plan: AGPN's overall vision linked to the key themes in the Commission's terms of reference
- Principles for Reform – A comment on the Commission's draft principles
- Comments on other Commission terms of reference.

2 Why is Reform Needed?

By global standards, Australia's health system rates well and, compared to other OECD countries, Australians enjoy good health⁹. However, there is a large body of evidence suggesting that a major reform of our health system is long over due, and systemic change must occur if we are to have a sustainable future health system.

In August 2007 the Western Australian Chamber of Commerce released a report stating:

- as well as putting upward pressure on health expenditure, failure to invest adequately in preventive health care will retard future economic growth and restrict the productive capacity of the nation's workforce
- the link between chronic illness and absenteeism and poor work performance is well-documented; however, there is also a growing body of evidence linking general health and wellbeing to productivity
- the economic impact of ill-health on productivity can far outweigh the direct health system costs. Maintaining a healthy workforce will become an increasingly important strategy to bolster workforce participation and economic growth in the face of an ageing population¹⁰.

More significantly, the second Intergenerational Report states that over the next 40 years health expenditure is projected to nearly double as a proportion of gross domestic product – another factor that must be taken into account in long term health planning.

In the absence of strategic reform, pressure on health budgets will become unsustainable and the capacity of the system to deliver equitable and quality services will quickly wane. The prevalence of chronic disease is on the rise, we face ongoing workforce challenges and Medicare alone no longer offers universal access to care (with per capita spending significantly decreasing with increasing rurality). Existing payment systems reimburse inputs rather than outcomes and there are very few incentives to avoid or slow the rate

⁹ Australian Institute of Health and Welfare. *Australia's health 2006*. AIHW cat. no. AUS 73; Canberra; AIHW; 2006.

¹⁰ Chamber of Commerce and Industry of Western Australia. *Health: A Discussion Paper*. Western Australia: August 2007.

of hospitalisations and invest in prevention. With responsibility for health split between Commonwealth and state / territory governments, the patient's experience is often disjointed between poorly connected services.

Ageing population

Australia's ageing population will significantly increase over the next 40 years, with 25% of the population being aged 65 years and over by 2047 and the number of people aged 85 and over more than quadrupling. Our rapidly ageing population will result in substantial fiscal pressures due to projected increases in spending, particularly in the areas of health, age pensions and aged care¹¹.

An ageing population has significant implications for all sectors of our health system, particularly the hospital sector. In 2003-04 there were 2.38 million hospital admissions for people aged 65 or over, representing 35 per cent of all hospital admissions¹², with an estimated total cost of \$714.8m.

Reform of the primary care sector will deliver a number of benefits in providing accessible and quality care for our ageing population, including a reduction in avoidable hospital admissions, decreased health spending and higher levels of community participation, independence and quality of life for ageing Australians.

Growing rates of preventable chronic diseases

Chronic disease is set to become one of the greatest health challenges of the 21st century¹³, and already accounts for 80% of the total burden of disease, mental illness and injury in Australia¹⁴.

¹¹ Australian Government Attorney-General's Department. *Inter Generational Report 2007*. Canberra: Commonwealth of Australia; April 2007.

¹² Australian Institute of Health and Welfare 2006; op. cit.

¹³ National Health Priority Action Council (NHPAC). *National Chronic Disease Strategy*. Canberra; Australian Government Department of Health and Ageing; 2006.

¹⁴ Australian Institute of Health and Welfare. *Chronic Diseases and Associated Risk Factors in Australia 2001*. Canberra: AIHW; 2001. Accessed 30 May 2008 at www.aihw.gov.au/publications/phe/cdarfa01/cdarfa01-c00.pdf.

Currently seven out of ten general practice consultations are chronic disease related and require complex management¹⁵. With an ageing population, this figure is on the rise.

To prevent and lessen the impact of chronic disease, urgent reform is needed to refocus the primary health care system on wellness and prevention, provide patients with evidence-based packages of care and strengthen chronic disease self-management approaches.

Health inequities – rural and Aboriginal health

There are major health disparities between Indigenous and non-Indigenous Australians, including in the areas of life expectancy, infant mortality and child health, increased risk factors for chronic disease, higher rates of hospitalisation and higher prevalence of conditions such as Type II diabetes, cancer, kidney disease, circulatory system diseases and ear and hearing problems¹⁶.

Aboriginal and Torres Strait Islander people suffer much more ill health than other Australians. They die at much younger ages and are more likely to experience disability and reduced quality of life due to ill health. The Indigenous population is also disadvantaged across a range of socioeconomic factors that affect health such as low incomes, higher rates of unemployment, poorer education achievements and lower rates of home ownership. Higher levels of health risk behaviours such as smoking and alcohol misuse, and other risk factors such as poor housing and exposure to violence are also important determinants of Indigenous health¹⁷.

People living in rural and remote areas also face a number of health inequities, particularly in accessing primary care services. Rural and remote Australians often have limited access to preventative services, specialist services and medical care, emergency care (including ambulances), rehabilitation services and aged care services. Health inequities are also demonstrated by death rates which increase with remoteness (1.5

¹⁵ Veale, B. Meeting the challenge of chronic illness in general practice. *Medical Journal of Australia* 179 (5); 247-249; 2003.

¹⁶ Australian Institute of Health and Welfare 2006; op. cit.

¹⁷ Ibid.

times higher in very remote areas compared with metropolitan areas)¹⁸ and in the incidence of disease risk factors. People in regional and remote areas are more likely than those in major cities to report an acute or chronic injury, to drink alcohol in quantities risking harm in the short term, and to be overweight or obese¹⁹.

These health disparities are unacceptable for a first world country. Urgent systemic reform is needed to ensure all Australians have access to the same level and quality of care, by the “right health care provider or team of providers, at the right time and in the right place”.

The blame game: Commonwealth-state issues

The current governance structure of the health system where responsibility for the delivery of health services is split between Commonwealth and state / territory governments has resulted in the unnecessary duplication of services, inefficient health spending and a disjointed and fragmented approach to care.

‘The blame game’ between the Federal and state / territory governments must end if the current gaps in the health system are to be addressed in the long-term. To ensure the future sustainability and performance of Australia’s health system, a single funding mechanism must be introduced to allow for the coordinated planning and delivery of health services at the local level.

The health workforce

Shortages across the national health workforce are of key concern, with shortages of up to 1300 GP graduates predicted by 2013 and 470 registered nursing graduates per year by 2010²⁰. Workforce shortages will particularly affect general practice, dentistry, nursing and some key allied health professions, which will have a considerable impact on the primary care sector.

These predictions become even more alarming given they have been made despite the fact that the health workforce is growing at nearly double the rate of growth of the

¹⁸ Australian Institute of Health and Welfare. *Rural, regional and remote health – indicators of health status and determinants of health*. Rural Health Series no. 9. Cat. no. PHE 97; Canberra; AIHW; 2008 www.aihw.gov.au.

¹⁹ Ibid

²⁰ Productivity Commission. *Australia's Health Workforce*. Research Report; Canberra; 2005.

Australian population, effectively meaning that the influence of various factors such as changing disease patterns, demography, technology have created a mismatch between workforce demand and support. The situation will get worse as both the population and workforce age.

A recent audit of health workforce in rural and regional Australia confirmed that supply is not sufficient to meet current needs. The same report also found that we are highly reliant on attracting overseas trained health professionals and that the supply of health professionals in many rural and regional areas is low to very poor²¹.

Clearly, increases in workforce numbers alone will not be enough to combat the issue. As a result, the health system must embrace new models of working and implementing care. These include increasing use of multidisciplinary teams, expanding roles within the primary care setting and making better use of practice nurses, and e-Health and technology solutions. These new models of working must be supported at the systems level to make any real inroads into creating accessible and sustainable health services.

Preventable hospital admissions: making the system affordable

Australia's hospital system is under great pressure and does not have the capacity to cope with future anticipated demand. Between 1996 and 2006, the number of hospital admissions has grown considerably by over 37% and with the annual 2005-06 hospital expenditure reaching almost \$24 billion, an increase of 5.6% from the previous year²².

There is evidence to suggest an over-reliance in Australia on public hospitals due to issues of patient affordability in access primary care and private health services, resulting in substantial higher costs for government in funding health care. A significant portion of hospital admissions (approx 9% in 2005-06) are preventable and more appropriately treated in the primary care setting²³. In addition, a further portion of hospital admissions are due to the health consequences of chronic disease and could be avoided through

²¹ Australian Government Department of Health and Ageing. *Report on the Audit of Health Workforce in Rural and Regional Australia*. Canberra; Commonwealth of Australia; 2008.

²² Australian Institute of Health and Welfare. *Australian hospital statistics 2005-06*. Health services series no. 30; Cat. no. HSE 50; Canberra; AIHW; 2007.

²³ Ibid.

effective prevention and management of chronic disease on an individual and population basis.

International comparisons between Australia, New Zealand, Kaiser Permanente (US) and the National Health System (UK) demonstrate the value of more integrated, primary health care oriented systems (see *Table 1*).

District Health Boards in New Zealand (NZ) and Kaiser Permanente, a non-profit health maintenance organisation in the United States (US), achieve lower utilisation of acute bed days through integration of care, active management of patients, the use of intermediate care, self care, medical leadership and greater investment in information technology^{24,25}.

Table 1 Comparison of bed utilisation rates per 1000 population in Australia (2005), NZ (2005/6), US Kaiser Permanente (2000), and UK NHS (2000)²⁶

Variables	Australia	NZ	Kaiser (US)	NHS (UK)
Average length of stay (days)	6.1	3.9	3.9	5.0
Discharge rates / 1000	341	157	69	200
Acute bed days / 1000	1108	441	270	1000
Hospital beds / 1000	4.0	2.0	0.9	3.4

²⁴ Ham C, York N, Sutch S & Shaw R. Hospital bed utilisation in the NHS, Kaiser Permanente, and the US Medicare program: analysis of routine data. *BMJ* 327;1257; 2003.

²⁵ Malcolm L. Trends in hospital bed utilisation in New Zealand 1989 to 2006: more or less beds in the future? *New Zealand Medical Journal*; Vol 120; No 1264; 2007.

²⁶ Ibid.

The integrated models of care explain their ability to keep patients out of hospital and to provide care in the community^{27,28}.

²⁷ Ham et al; op. cit.

²⁸ Malcolm; op. cit.

3 Towards a long term health plan : AGPN's vision

It will always be important for the community to have access to high quality, timely and affordable hospital care. Investing in primary health care infrastructure and service delivery capacity is the single most important strategy for improving population health, the performance of the health system and, importantly, for supporting a system that is sustainable.

AGPN's 2005 *Primary Health Position Statement* sets out our vision for Australia's primary health care system in more detail and contains a number of concepts and recommendations we would encourage the Commission to consider – see www.agpn.com.au/site/index.cfm?module=DOCUMENTS&page_id=6675&leca=16

In summary, AGPN believes that any plan for Australia's long term health system must include the following commitments. We indicate where our recommendations specifically relate to the Commission's terms of reference. Section 5 provides additional comments on the Commission's terms of reference where they haven't been addressed here.

Strengthening the primary health care sector

Health care funding and the health care debate are presently skewed towards hospital and tertiary care and to issues such as reduction of elective waiting lists. We must overcome this bias and the current underdevelopment of primary health care and community based services. This will occur by supporting a primary health care sector with system-wide capacity to provide accessible, affordable services, continuity of care, manage people in the community as much as possible and avoid unnecessary and costly hospital admissions.

Action in the primary health care setting is an issue that spans all the Commission's specific terms of reference. Primary health care matters because it is **first level care**. It is also comprehensive; that is, inclusive of health promotion, illness prevention, treatment and care of the sick, community development, advocacy and rehabilitation. There is solid international evidence that shows that health systems oriented towards primary care achieve better health outcomes for lower overall cost than systems focused on specialist or tertiary care.

Crucially, primary care acts as a gatekeeper to secondary care. If more people are passed from primary to secondary care, the multiplier effect on total health care costs

could potentially be huge²⁹. Primary health care merits special attention based on its cost, its impact on the cost of secondary care, and its potential to minimise unnecessary referrals to secondary care (provided it is appropriately resourced and supported).

There has also been an international trend towards **more organised primary care**. This is a move underpinned by evidence that suggests **well developed primary care is associated with improve health outcomes and greater cost effectiveness** within the health system. This has taken a number of forms including the emergence of primary care organisations (PCOs). In Australia, PCOs have emerged as divisions of general practice.

The core roles of PCOs vary but broadly they are to:

- improve health outcomes
- manage demand and control costs
- engage primary care physicians
- enable greater integration of health services
- develop more accessible services in community and primary care settings
- enable greater scrutiny and assurance of the quality of primary care services³⁰.

There is growing evidence that **PCO style organisations, with appropriate capacity, can have an impact on population health improvement** once initial attention to organisational development and practice based primary care services has been embedded. For example, where PCOs are able to contract with practices and other providers against specified performance and outcome frameworks, there is evidence that providers can achieve specified health outcomes³¹.

²⁹ Brennan J et al. *The Financing Of Primary Health Care*. A paper produced by the society of actuaries in Ireland; 2000.

³⁰ Smith J & Sibthorpe B. Divisions of General Practice in Australia: how do they measure up in the international context? *Australia and New Zealand Health Policy*; 4:15; 2007.

³¹ Ibid.

Similarly, there are many organisational interventions through PCO-type organisations that can increase access to primary health care. Deployment of doctors, nurses and specialist outreach teams in new ways can improve services to populations that are historically hard to reach. Various forms of fundholding can facilitate this³². Examples of fund held programs in the Australian context include More Allied Health Services (MAHS) and Access to Psychological Services (ATAPS). Both programs are administered by divisions of general practice and have capacity to apply to other areas of health such as the purchase of aged care services.

Australia's divisions of general practice network is a unique infrastructure that supports and links general practice with the wider health system and brings together Australian Government, state and territory programs for integrated service delivery. Each division provides service responses to local community needs and can hold funds independently. Effective use of the network, within a broader national primary health care framework, will address many of the problems in the current system. Australia's long term health plan should recognise the central role the divisions of general practice network in the health system and consider an expanded regional role for divisions.

One health system: regionalised approaches

To overcome the perennial problems associated with the shared responsibility for health across the federal and state governments it is essential that we move to the concept of a 'single health system'. Such a shift would also overcome the difficulties in delivering health care in an environment where a range of different boundaries exist for area health services, divisions of general practice and local government and to ensure we have a genuinely patient-centred system.

In practical terms this would involve the introduction of a single funding 'mechanism' where funding follows and supports patients to access the care, resources and information they need. It would be a health system development that would ideally be accompanied by synchronised boundaries across existing regional structures including

³² Glasgow NJ, Sibthorpe B & Gear A. *Primary Health Care Position Statement: A scoping of the evidence*. Canberra; Australian Primary Health Care Research Institute, Australian National University; 2005.

state health, divisions and other human service departments and programs, and regional liaison structures³³.

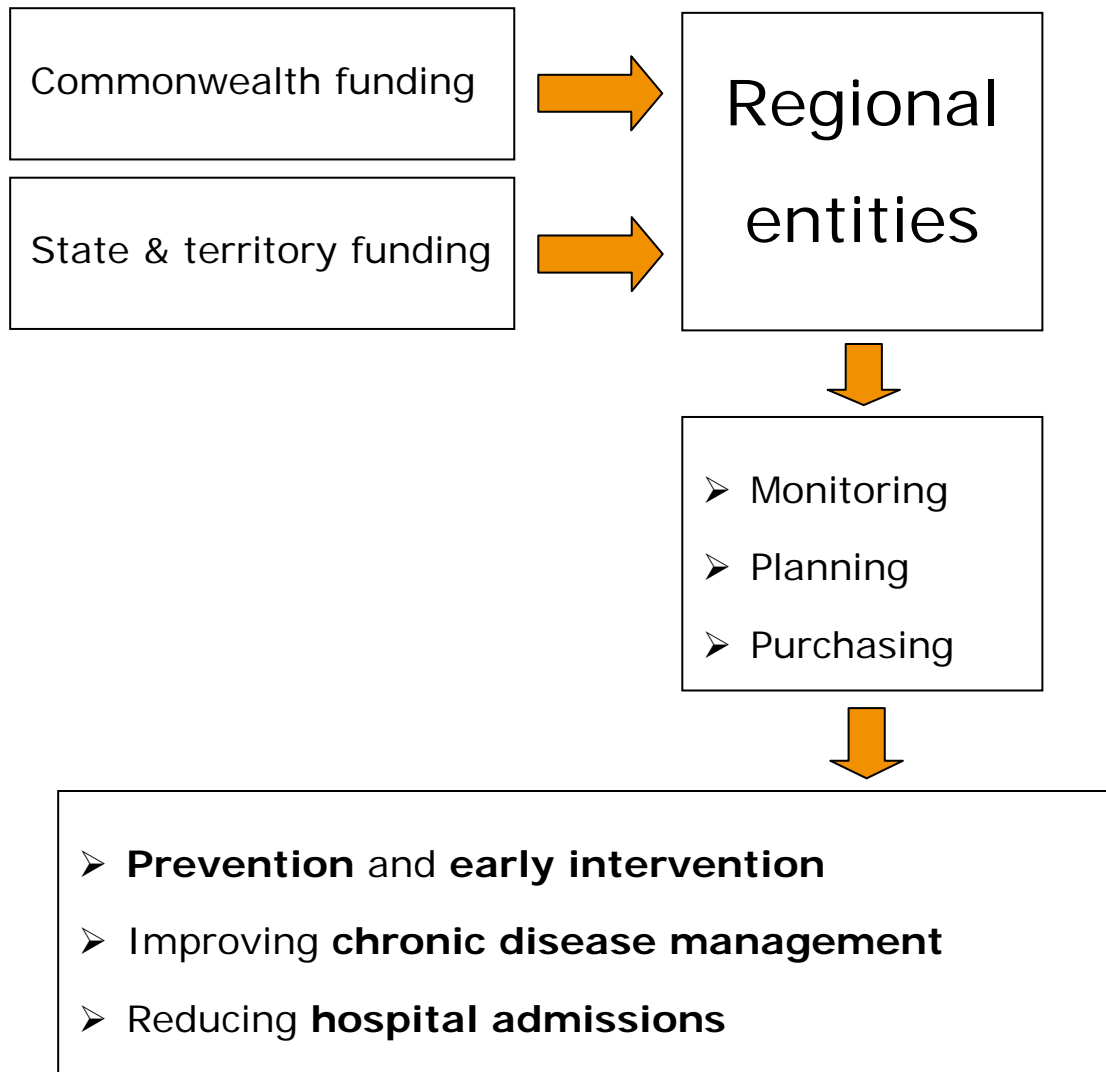
This would involve structural rather than constitutional reform in the form of regionalised approaches to health care planning and delivery through regional health entities. These entities would monitor the health of their communities and plan and allocate Commonwealth and state / territory funding for local health services. The goal would be to keep the community healthy and avoid preventable hospital admissions. In particular, this model of local health governance would allow for 'pooled' funding to create local partnerships to purchase and deliver local health services. Key outcomes would be an end to cost shifting and duplication, as well as better integration of private practice, community and hospital based services. A further outcome would be the requirement to purchase evidence based approaches to keeping communities well and out of hospital through locally tailored service solutions and monitoring of population health outcome.

The governance structure would include divisions of general practice, state / territory area or regional health services, hospitals and the community sector (see *Figure 1*). The boundaries of these organisations would be aligned to match in order to promote meaningful planning, local partnerships, ownership and accountability. Pooled funds would be used to deliver health services targeting 3 key areas:

- Prevention and early intervention strategies
- Improving chronic disease management
- Reducing hospital admissions.

³³ Australian Healthcare and Hospitals Association. *Service Integration Discussion Paper*. 2008.

Figure 1: Funding and function of regional entities



The role of divisions of general practice would be fundamental. Divisions would participate in the governance of the regional entity and continue to run health services along with other local deliverers such as NGOs and community health. These local arrangements would exist alongside existing MBS fee for service and hospital systems.

The concept of regional health entities is in line with international trends towards 'meso' level organisations in health systems. Meso-level organisations have strong primary health care orientations and sit between the micro levels of the system where clinical care for individual patients is delivered, and the macro levels where national policy, funding and public health infrastructure activity occurs. These are variously known as primary health care organisations, primary care trusts and, in some forms, health

maintenance organisations. The forms and functions of these organisations vary within and between countries but most will include functions³⁴ such as:

- local / regional decision making
- allocation of regional budgets
- after hours care
- brokering access to services
- clinical and practice support
- community engagement and intersectoral linkages; e.g. with aged care, housing
- contracting with providers
- data management
- funds pooling
- workforce recruitment and support
- monitoring quality
- triage
- population health activities and disease management
- education and training

Investment in prevention and early intervention

Wellness and prevention programs are essential as the burden of chronic disease and other illness in Australia is increasingly recognised. Risk factors such as smoking, poor nutrition, alcohol use and physical inactivity contribute to preventable chronic conditions and early mortality. Programs that assist people to reduce or eliminate these risk factors improve people's quality of life, cut medical costs, increase national productivity levels and reduce the burden on hospitals and the acute sector.

In 2006 the Australian Institute of Health and Welfare reported that less than two per cent of the health budget was spent on preventative care. A greater emphasis on health promotion and early intervention is required. The need for a shift of emphasis is

³⁴ Glasgow; op. cit.

increasingly recognised by the Commonwealth and state and territory levels of government. Joint government initiatives such as the Australian Better Health Initiative (ABHI) have started to make inroads, but a specific national prevention strategy is required to promote and maintain health and wellness in the community.

Prevention is not just about health promotion campaigns in isolation of other measures. Prevention policy must be guided by international evidence which suggests that multi-faceted strategies that include aspects such as social marketing campaigns, pricing signals, legislation and other regulatory interventions are most effective.

General practice is one setting where health promotion and prevention action can be effective; others include schools, workplaces and communities. Evidence has shown that brief clinical interventions by general practice can increase the chances of successful smoking cessation, as can counselling and behavioural change therapies³⁵.

From a primary health care perspective, a system that is prevention oriented would feature a number of widely accessible, evidence based preventive measures that will make a difference to population health outcomes. These measures include:

- universally accessible and affordable local lifestyle modification programs for people at high risk of chronic disease. These would be evidence based and provide structured support and access to group sessions in exercise, nutrition advice and motivation from accredited providers, building on those to be put in place under the COAG Type 2 Diabetes Prevention Program
- programs aimed at strengthening childhood development through positive parenting practices such as the national implementation of *Every Family*, a program which provides a range of targeted interventions for all Australian families, from raising awareness of positive parenting practices through to specific interventions for complex parenting and child behaviour problems. Local and overseas implementation of this program has demonstrated its capacity to reduce risk factors in children (particularly in relation to the development of mental illness, behavioural problems and poor social and vocational outcomes in later life), to improve workforce

³⁵ Fiore MC, Bailey WC, Cohen SJ, Dorfman SF, Goldstein MG, Gritz ER, et al. *Treating Tobacco Use and Dependence: Quick Reference Guide for Clinicians*. Rockville, MD; U.S. Department of Health and Human Services, Public Health Service; 2000. Accessed 30 May 2008 at www.surgeongeneral.gov/tobacco/default.htm.

participation and wellbeing of parents and reduce costs of downstream care both in the health and welfare sectors. For example, communities targeted during the trial of *Every Family* were found to have reduced levels of depression (by 22%) and happier and healthier children within 3 years of implementation

- changes to the Medicare Benefits Schedule to provide incentives for GPs and practice nurses to undertake preventative health care as a routine part of their work. The present time-based remuneration of the MBS does not encourage practitioners to take the time with patients in this area.

This recommendation addresses the terms of reference concerned with bringing a greater focus on prevention to the health system, and improving frontline care to better promote healthy lifestyles and prevent and intervene early in chronic illness.

Hospital avoidance through primary care services

While a great many of chronic disease cases end up being hospital admissions, at least one third of these are preventable and more are able to be managed cost effectively in the primary health care setting³⁶ through targeted hospital avoidance programs. For example, **through better service coordination, early and substantial gains can be achieved in reducing unnecessary hospitalisations for people with complex and chronic illness.** One Queensland Division - GP Partners in urban Brisbane – has already assessed the success of this type of approach.

The division's *Team Care Coordinated Care Trial* model involved service coordinators to coordinate general practice-based team care for patients with chronic and complex care needs. The coordinator purchased and brokered access to services in the community to prevent hospital admission or address a risk factor. This service coordination role was community-based and employment was overseen by the division, complementing the in-practice work of team members such as practice nurses.

The trial reported hospital utilisation for intervention participants was 11 to 36 per cent lower than control group participants, and participants' self rated general health and

³⁶ Australian Chronic Disease Prevention Alliance. *Chronic Illness; Australia's Health Challenge. The Economic Case for Physical Activity and Nutrition in the Prevention of Chronic Disease.* January 2004.

depression levels improved significantly, as did their knowledge of and satisfaction with the health system³⁷.

Active **hospital avoidance programs are possible through acute primary health care services**. A number of studies have proven the effectiveness of acute primary health care services in achieving good health outcomes. Studies have shown both perceived greater quality of life and patient satisfaction with community delivered acute care services than with hospital delivered care^{38,39,40}. Outcomes for patients using community acute care services versus in-hospital care have also been shown to be equivalent^{41,42,43,44}. For example:

- The ***Hospital Admission Risk Program (HARP)*** in Victoria targets alternative interventions at appropriate points in their journey through the health system for those at risk of repeated hospitalisation at the time of emergency presentation or hospital admission or at discharge from hospital. HARP has had a positive overall impact on the level of hospital utilisation in Victoria. In general, HARP patients

³⁷ GPPartners . *GPPartners and Coordinated Care: Team Care Health II Perspectives*. 2008. Accessed 30 May 2008 at http://agpn.com.au/client_images/171080.pdf.

³⁸ Caplan G, Ward J, Brennan N, Coconis J, Board, N and Brown, A. Hospital In The Home; A Randomised Controlled Trial. *Medical Journal of Australia*; 170:156-160; 1999.

³⁹ Maaravi Y, Cohen A, Hammerman-Rozenberg R. and Stessman J. Home Hospitalization, Long Term Care Around the Globe. *Journal of the American Medical Directors Association*; 3(2):114-118; 2002.

⁴⁰ Jones J, Wilson A, Parker H, Wynn A, Jagger C, Spiers N, and Parker G. Economic Evaluation of Hospital at Home Versus Hospital Care: Cost Minimisation Analysis of Data from Randomised Controlled Trial. *British Medical Journal*; 319:1547-1550; 1999.

⁴¹ Ackerman R, Kemle K. The Effect of a Physician Assistant on the Hospitalization of Nursing Home Residents. *Journal of the American Geriatric Society*; 46:610-614; 1998.

⁴² Corwin P, Toop L, McGeoch G, Than M, Wynn-Thomas S, Wells E, Dawson R, Abernethy P, Pithie A, Chambers S, Fletcher L and Richards D. Randomised Controlled Trial of Intravenous Antibiotic Treatment for Cellulitis at Home Compared with Hospital. *British Medical Journal*; doi:10.1136/bmj.38309.447975.EB; 2004.

⁴³ Richards D, Toop L, Epton M, McGeoch G, Town G, Wynn-Thomas S, Dawson R, Hlavac M, Werno A and Abernathy P. Home Management of Mild to Moderately Severe Community Acquired Pneumonia: A Randomised Controlled Trial. *Medical Journal of Australia*; Vol 183.5:235-238; 2005.

⁴⁴ Caplan G, Ward J, Brennan N, Coconis J, Board, N and Brown, A. Hospital in The Home; A Randomised Controlled Trial. *Medical Journal of Australia*; 170:156-160; 1999.

experienced 35 per cent fewer emergency department attendances, 52 per cent fewer emergency admissions and 41 per cent fewer days in hospital⁴⁵.

- The ***Advanced Community Care Association (ACCA)*** in South Australia established packages of care for patients following initial contact from a referring partner (primarily hospital emergency departments or GPs). Services included care for falls, fractures and wounds, minor infections, heart problems, mental illness, renal failure and bowel obstructions. ACCA brokered other necessary care from a range of community providers.
- The ***Healthy at Home*** (formerly the SAFTE Care Program pilot) model of care in NSW Health involves agencies working together in order to avoid duplicated assessments, deliver better coordination of services, improve communication and information management to better integrate primary and community health care for the older person. Patients receive care at home rather than in hospital resulting in less emergency department presentations and less hospital admissions.
- Under the ***Community Acute / Post Acute Care (CAPAC)*** model of care in NSW Health, selected types of acute / post acute care are delivered to patients at their home as an alternative to inpatient care. Services include the provision of comprehensive, holistic, multi-disciplinary, patient centred care, 24 hours a day by dedicated teams of hospital and community based staff. CAPAC teams usually include a variety of health professionals who coordinate and deliver a package of services that extend along the continuum of care.
- The ***Primary Options for Acute Care (POAC) Program*** in NZ utilised already established primary care resources to safely and appropriately manage 'avoidable admission' patients in the community, under the responsibility of their GP up to a pre-determined cost. GPs were given the opportunity to access a wide variety of services that were not normally funded, including rapid diagnostics, IV medication support, observation facilities and short term rest home care. A service coordinator was

⁴⁵ Victorian Government Department of Human Services. *Improving Care: Hospital Admission Risk Program. Public Report*. Melbourne, Victoria; Metropolitan Health and Aged Care Services Division, Victorian Government Department of Human Services; 2006.

employed to organise whatever the GP requested. During the program, 707 patients were enrolled by 100 GPs with 85 per cent of patients avoiding hospitalisation.

- The ***Pegasus Community Care Program*** in NZ allowed patients to continue to receive care from their own GP, with support from the community care team, in their own home or aged care facility. Services varied according to need, and included home or practice visits, household assistance, complex or chronic disease management plans, equipment loan and after hours support. Independent analysis demonstrated that Pegasus GP referrals to the emergency department reduced by 23 per cent since January 2000 compared to a 3 per cent reduction in non-Pegasus GP referrals⁴⁶.

AGPN would strongly urge the Commission to consider both national implementation of service coordinators for people with complex and chronic disease and acute primary care services similar to those described in this submission.

However, for acute primary care services to be effective in reducing and controlling expenditure on secondary care in Australia, there must be incentives for care to be provided at the most cost effective setting that delivers the appropriate clinical outcomes.

At a minimum, implementation of a more systemic national program of hospital avoidance initiatives in the primary care setting would need to include an infrastructure and incentive payment for GPs to stabilise and maintain patients in the general practice clinic. General practices would also require the appropriate physical space to house patients under observation as well as appropriate remuneration for time spent with such patients. The GP Super Clinics are likely to have appropriate infrastructure so it would be possible to introduce and evaluate acute primary care services in these settings in the first instance.

This recommendation addresses terms of reference concerned with reducing inefficiencies and better integration of primary care and hospital services around key measurable outputs for health.

⁴⁶ Independent Practitioner Associations Council of New Zealand. *Community Care Services – Keeping Patients Safely Out of Hospital*. IPAC Paper 10/5.

Outcomes based funding regimes

Higher health care spending is not necessarily associated with better quality – *more* care is not the same as *better* care. In the US, research has shown that regions with high Medicare spending do not have better quality, access to care, health outcomes or patient satisfaction⁴⁷. The same applies to Australia where our current health financing system is not best set up to deal with current issues facing the system. On the whole, our system reimburses inputs rather than outcomes, has few incentives to avoid hospitalisations and unnecessary or duplicative medical tests, and has few incentives to invest in preventative health care.

The following key principles should apply to health financing as well as the payment systems which are the basis for remunerating health care providers:

- incentives should be made available to providers who innovate on ways to improve quality and reduce cost
- payments should be linked to the utilisation of evidence based clinical guidelines
- there must be a shift away from input based funding and an adoption of outcomes based funding approaches.

For general practice, MBS based fee for service should remain as it works well for episodic care. However, fee for service has its limitations when it comes to chronic disease management, where more proactive and team based care is required. There is a need to strengthen payment systems for general practice teams with regard to the management of chronic conditions if we are to have a system that improves quality of care and access, promotes prevention, reduces the rate of hospital admissions, encourages team-based approaches and keeps red tape to a minimum.

Information about general practice funding suggests that blended payment systems produce better results (including improved health outcomes and reduced health inequity) than any individual payment systems in delivering primary health care services^{48,49,50,51}.

⁴⁷ Health Care Transformation Task Force. *Recommendations submitted to Governor Tim Pawlenty and the Minnesota State Legislature*. 2008. USA; January 2008. Accessed 30 May 2008 at www.health.state.mn.us/divs/hpsc/hep/transform/ttfreportfinal.pdf.

⁴⁸ Robinson J; op. cit.

In countries with a strong primary health care focus, blended general practice payments also usually comprise some form of capitation system⁵². Capitation does not exclude fee for service as part of a blended payment system, but does require patient registration.

AGPN supports:

- **a review of the current Medicare Benefits Schedule (MBS)** to ensure funding arrangements promote quality of care, chronic disease prevention and self management. The present focus of the MBS on time-based consultations, reimbursement of inputs and lack of incentives to avoid hospitalisation is inconsistent with the new directions for health set by the Government
- **direct purchase of multidisciplinary primary care services by divisions of general practice** using funds provided by governments. This approach offers patients greater access to multidisciplinary teams, improved access to care for patients who need it most, as well as offering GPs more referral options for chronic disease management. It also offers divisions flexibility to purchase a mix of services according to local need and to offer health professionals attractive recruitment and retention packages - a benefit in areas of workforce need. This approach could be extended beyond current examples of More Allied Health Services Program (MAHS) and Access to Psychological Services (ATAPS)
- **service coordinators** to assist patients with their multidisciplinary team care service coordination needs, whilst ensuring that GPs remain the clinical coordinators of care. In this approach, current general practice and allied health funding mechanisms remain in place but patient care is enhanced through:
 - better coordination and continuity of care
 - more proactive management of care appointments
 - better patient self management

⁴⁹ Van Weel C et al.; op. cit.

⁵⁰ Eggleston K et al.; op. cit.

⁵¹ Mays N et al.; op. cit.

⁵² Phillips & Starfield; op. cit.

- the avoidance of unnecessary hospital admissions.

Care coordinators would typically be clinically qualified (e.g. a nurse) and could be employed by a division in order to serve a critical mass of practices.

- **incentives for coordinated 'packages' of care for specific chronic diseases.**

Such packages are required where patients need multiple interventions, the involvement of several providers as well as the GP, and where patients can also benefit from lifestyle modification programs. To identify and support eligible patients, practices will need to have appropriate recall-reminders systems in place.

- AGPN supports payment for such packages to provide incentives to complete annual cycles of care. This does not mean 'cashing out' the MBS. Instead it provides additional incentives to ensure more effective use of existing MBS items and other referral pathways to achieve **optimum chronic disease care**.
- AGPN supports voluntary patient registration with practices for the delivery of chronic disease packages of care. This promotes a population based approach to primary health care and monitoring of population health outcomes. Voluntary registration arrangements should not prevent patient choice of provider for all or other aspects of their care.
- Provision of data indicating improvement in chronic disease outcomes would be required to trigger the payment. Decisions about how this payment could be administered would be flexibly determined in consultation with the local GP community. The payment could be provided direct to those practices that have the infrastructure and workforce to coordinate and deliver cycles of care. Alternatively, practices may elect for the payment (or a component of it) to go to their division who would then coordinate delivery of relevant aspects of the cycle of care, such as the purchase of services from other providers.

These recommendation addresses the terms of reference concerned with reducing inefficiencies in the system, as well as other key themes of improved integration and coordination. For access to a further background paper see

www.agpn.com.au/site/index.cfm?PageMode=indiv&module=NEWS&page_id=34380&leca=16

A common performance framework

AGPN supports the proposed performance benchmarks contained in the Commission's first report *Beyond the Blame Game: accountability and performance benchmarks for the next Australian Health Care Agreements* released in April 2008. We would urge that, over time, the national performance indicators for the divisions of general practice network also derive from these indicators. If we desire an improvement in overall health performance, a clear and direct way to drive this is needed to ensure a **common performance framework** for primary and acute care systems. Where governments are funding and requiring data, performance benchmarks need to be linked across systems.

AGPN would also draw the Commission's attention to the performance measures suggested in the National Health Performance Framework for all levels of the health system, a body of work undertaken in 2001 under the auspice of the Australian Institute of Health and Welfare⁵³.

Workforce reform and development

Australia has a health workforce problem that needs more than just 'more doctors' to remedy the situation. New policy and programs for workforce reform and development are required. New ways of organising and configuring health care teams are also required. This is necessary to make best use of Australia's existing health workforce as well as to promote and support emerging or new health practitioner roles.

A key principle for funding and organising the health workforce is to ensure that the right health practitioner provides the right care at an appropriate time in the right setting. It is essential that the health system is increasingly organised so that primary health and hospital settings are brought much closer together. This means a changing role for GPs in the future and will inevitably see the emergence of new or expanded roles for existing health practitioners in the primary health care environment, with GPs remaining as essential members of the team.

For a more effective system, GPs will increasingly be located in health care centres or multidisciplinary primary health care services where a range of health care will be available such as physiotherapy and community pharmacy – there will be fewer solo

⁵³ See reports of the National Health Performance Framework Committee at www.aihw.gov.au.

practices. These transitions will require support in the form of infrastructure payments and other capacity building strategies. Inter-professional learning at pre and postgraduate level will help to establish truly multidisciplinary teams.

Infrastructure funding is also required to support general practices meet the costs of training new GPs and other primary health care providers. Expenses include supervision, practicing rooms, IMIT equipment, medical equipment, accommodation, travel and access to medical journals.

GPs will work more centrally at the primary health care / hospital interface. They will have a strong role in hospital avoidance, spending their clinical hours dealing with diagnosis, managing comorbidity and treating those patients more complex problems. GPs will routinely delegate less complex and more routine matters to others in the team such as:

- practice nurses who will function in increasingly expanded roles, outreach and / or specific roles (such as dedicated child health and aged care nurses)
- various appropriate allied health professionals
- nurse practitioners with limited prescribing rights who will complement and support the role of the GP and assist to enhance existing service provision and improve access; e.g. through the provision of outreach services to the frail aged and people with disabilities
- new technical roles such as medical or physician assistants.

The notion of a GP consultant is a concept that should be given particular consideration by the Commission. The GP consultant would be a leadership role to support the next cohort of general practitioners. A focus on providing clinical consultation liaison and advice to more junior colleagues as well as teaching and mentoring younger doctors would be a central part of the scope of this paid role.

A workforce strategy of this nature addresses the key theme of the Commission's terms of reference concerned with a well qualified and sustainable health workforce into the future. It will require extra training to develop new roles as well as attract and retain existing workforce to the primary health care setting. It will also require boosts to, and smarter use of, primary health care infrastructure and changed payment models to appropriately remunerate new and emerging roles. For example, newly graduated

nurses are the potential future workforce for general practice nursing. A new graduate nurse program to support nurses who wish to take up an appointment in general practice could be funded and implemented through General Practice Education and Training (GPET) in partnership with the divisions network, both of whom have an existing infrastructure to support training for general practice registrars and other general practice staff.

A national e-health strategy

Health system reform must be enabled by e-health solutions that will enhance integration and information sharing across the primary health care sector, between the primary care and secondary and tertiary care sectors, and lead to an increase in health outcomes.

Evidence shows that an integrated health network underpinned by information management and information technology reforms across the health sector will increase health quality and safety outcomes^{54,55,56}. The use of information technology tools and systems to support the delivery of health care services also has the potential to increase cost-effectiveness⁵⁷.

Appropriate use of e-health solutions, such as secure electronic messaging in the short term and Shared Electronic Health Records (SEHR), will facilitate and support multidisciplinary team care. This can improve patient care outcomes by increasing the coordination of care, through:

- timely access to accurate and reliable patient health information records

⁵⁴ May C, Rapley T, Moreira T, Finch T, Heaven B. Technogovernance: evidence, subjectivity, and the clinical encounter in primary care medicine. *Social Science and Medicine*; 62(4):1022-1030; 2006.

⁵⁵ Kawamoto K, Houlihan CA, Balas EA, Lobach DF. Improving clinical practice using clinical decision support systems: a systematic review of trials to identify features critical to success. *British Medical Journal*; 330(7494):765; 2005.

⁵⁶ Dorr D, Bonner LM, Cohen AN, Shoai RS, Perrin R, Chaney E, Young AS. Informatics systems to promote improved care for chronic illness: a literature review. *Journal of the American Medical Informatics Association*; 14(2):156-163; 2007.

⁵⁷ Hillestad R, Bigelow J, Bower A, Girosi F, Meili R, Scoville R, Taylor R. Can electronic medical record systems transform health care? Potential health benefits, savings, and costs. The adoption of interoperable EMR systems could produce efficiency and safety savings of \$142-\$371 billion. *Health Affairs*; 24(5):1103-1117; 2005.

- secure sharing of information between members of multidisciplinary teams, and across all levels of the health sector (including between the primary, secondary and tertiary sectors)
- consistent messages to patients with seamless transition across the continuum of patient care.

E-health solutions also offer the benefit of increased efficiency of care, through reduced duplication of collecting patient information and ordering of clinical tests and procedures and a number of business innovation and cost and time efficiencies.

General practice is the most computerised and most connected part of the health system. Indeed, the largest database of health information resides on the computers of general practitioners (GPs). This places general practice at the centre of e-health development in this country. At the same time, information management (IM) is becoming a focus of both state and federal health jurisdictions, as modern health care requires modern IM systems to deliver effective health services.

AGPN supports the development of a National e-Health Strategy and the principle of a national integrated health network, which will allow different information technology systems and software applications to communicate across all levels of the health system through shared electronic health records. AGPN also recognises the dynamic nature of the evolution of new technologies and a growing focus on using business and clinical data to inform and guide policy and operational activities.

AGPN recommends the following priorities for national action in e-health over the next 5-10 years:

- *Infrastructure investment* – including fundamental measures such as:
 - a Unique Patient Identifier Registry and Unique Provider Identifier Directory
 - interoperable and low cost secure messaging including open source alternatives
 - improved and affordable broadband cover for rural health initiatives
 - a grants program for specialist, allied health professionals, and residential aged care facilities to improve IM capacity

- targeted financial incentives including through Medical Benefits schedule payments
- *Standards* for content and connectivity including:
 - a national data dictionary of aligned terminology for primary healthcare
 - discharge plan and referrals content and data elements at a nationally consistent levels
 - standards for operation and embedding of Electronic Decision Support (EDS) and Clinical Decision Intelligence (CDI) products
 - alignment of national privacy and data management standards and legislation
 - common minimum standards for patient consent across all jurisdictions and healthcare settings.
- *Capability development* – including capability to transmit and receive core data sets from hospital discharge plans and electronic referrals to and from general practice ideally in a format that can be incorporated into emerging SEHRs, and into desktop clinical information systems
- *Governance reform* – including the requirement for full stakeholder participation in the governance of major data repositories.

A Shared Electronic Health Record (SEHR) is a particularly important part of the mix. AGPN supports a common government mandated development path and provision of an SEHR with a strong framework for privacy, relevancy, connectivity and provider input, while still recognising the potential value adding contributions of private corporations.

This recommendation addresses key themes in the Commission's terms of reference concerned with better integration and coordination.

For more information see AGPN's submission to the National e-health strategy at www.agpn.com.au/site/index.cfm?display=13307.

4 Principles

AGPN supports the design and governance principles proposed by the Commission. It is important that the design of any long term Australian health reform is founded on a suite of principles that are widely subscribed to across public and private sectors in order to guide policy, intergovernmental agreements and new programs that will endure.

With regard to specific principles, we would suggest the 'value for money' principle emphasise that clinical interventions at the individual patient level as well as health programs delivered at the population level should be evidence based and well evaluated. A commitment to evidence base gives public funders an assurance that they are paying for positive health outcomes.

In a similar vein, AGPN also suggests that an explicit commitment to outcomes based funding be reflected in the 'value for money' and 'responsible spending' principles respectively.

5 Other comments

The Commission's second term of reference is to report on a long-term health reform plan to provide sustainable improvements in the performance of the health system. This section includes other AGPN's comments against the key themes taken from the Commission's terms of reference:

Better integrate acute services and aged care services, and improve the transition between hospital and aged care

The Australian Government's Intergenerational Report indicates that over the next 40 years the proportion of the population aged over 65 years will almost double to around 25 per cent. For Australians aged 85 and over, the growth is expected to be more rapid⁵⁸. This will place additional burdens on the health and aged care systems. Good health among older Australians will help reduce the demand for acute health and aged care services, which is important as Australia's population ages over coming decades⁵⁹.

In 2003-04, there were 2.38 million separations from Australian hospitals for people aged 65 years or over, representing 35% of all separations. Heart diseases, stroke, diabetes and vision problems were among the most common reasons for hospital separations among older Australians. Treatment and management of these conditions tends to include both acute and long term care, however, options exist for community and residential aged care facility (RACF) based services designed to prevent hospital admission – an outcome preferred by the older person and their families.

There is a strong relationship between the provision of timely primary care based medical, nursing and allied health assistance and reducing the admission or risk of readmission of older people into the acute health care setting. However, effective team-based primary care requires coordination and the right incentives.

AGPN proposes a model of service that will maintain a focus on quality service delivery in residential aged care facilities that results in positive health outcomes for residents. It is a model of care that provides:

⁵⁸ Australian Government Attorney-General's Department, op. cit.

⁵⁹ Australian Institute of Health and Welfare 2006; op. cit.

- a more structured and coordinated cycle of multidisciplinary care for older Australians
- strengthened integration between general practice, acute and community health, home care and aged care and continuity of care for the RACF patient
- more effective team based arrangements
- one contracting entity responsible for service delivery
- reduced hospital admissions through the provision of enhanced RACF based primary care services and savings in ambulance transfers
- links with existing programs such as palliative care, mental health and various nursing initiatives.

The model would comprise:

- an incentive payment for GPs to encourage them to take on new patients within RACFs, continue to provide services in RACFs, provide cycles of care, carry out currently non-remunerated activities such as family case conferencing and advance care planning and participate in quality activities deemed appropriate for quality service provision such as participation in medication advisory committees
- MBS rebates for the provision of nursing outreach services to RACFs
- incentives to encourage allied health providers to provide services to aged care facilities. The services could include both direct patient care and whole of facility programs which benefit all patients as well as specific patient groups; e.g.. dementia patients, those with mobility issues
- a key role for divisions in supporting the implementation and operation of the initiative. Functions of local divisions would include establishing contracts with providers of care (practices, GPs and allied health) as well as other local liaison and administrative support for the initiative such as holding and allocating funds to service providers and the collection and collation of relevant data.

Improve the provision of health services in rural areas

Improvements to the provision of health services in rural areas will follow from the range of broader improvements described in this submission; i.e. a focus on wellness and

prevention, multidisciplinary team based care, smooth transition between levels of care, interoperable IMIT systems, practice systems that promote a proactive approach to care, chronic disease management and care coordination.

Likewise, regional entities as described above will improve the capacity for local responsiveness. The ability to pool Commonwealth and state funding, with flexible guidelines governing spending, is crucial to delivering localised health solutions. Funding formulas for regional entities would need to take account of factors such as remoteness, population demographics, number of Aboriginal or Torres Strait Islanders, socio-economic status and disease profile. AGPN therefore welcomes the Australian Government's May 2008 announcement that the Rural, Remote, Metropolitan Area (RRMA) classification system is to be updated. This is step long overdue.

A focus on attracting and retaining the health workforce to rural and remote Australia must remain a priority. AGPN supports the range of programs funding training placements in rural and remote areas. Steps to streamline these are again overdue; the current system is complex and difficult to navigate.

The 'easy access, gracious exit' model of service, in which health providers are able to front up to an established business and work as a salaried officer are proving an attractive option for many professionals who do not wish to take on the risks and challenges of starting a business.

Expansion of successful programs will also improve access to otherwise unavailable health services for people living in rural and remote areas. These include:

- the More Allied Health Services (MAHS) and the Access to Allied Psychological Services programs, which should be extended to allow employment of more and more varied allied health professionals, and delivery of more services
- the More Specialists Outreach Assistance Program, which should be extended to cover allied health services
- introduction of a National Orientation Program for Overseas Trained Doctors, which would increase support to improve integration and retention of OTDs in rural and regional areas. This program should include education and training resources for practice nurses to help orient OTDs

- the Rural Outreach Vocational Education (ROVE) initiative, which should be extended for a further 3 years and expanded to all regional and rural divisions, plus to divisions with high levels of OTDs.

Improve Indigenous health outcomes

A whole of life approach is necessary to achieve improvements in Indigenous health outcomes. The social determinants of health such as housing, employment, education and safety must be addressed if long term gains are to be made.

Within the boundaries of health, strategies are needed that build both the capacity of Aboriginal health services and the responsiveness of mainstream health services to the needs of Aboriginal and Torres Strait Islander peoples.

Aboriginal and Torres Strait Islander Australians should be supported to access services provided:

- in their community
- in major centres
- provided by visiting medical specialists, general practitioners or allied health professionals as determined by medical need.

Access could be improved through a national initiative aimed at building links between the Aboriginal Community Controlled Health Sector and mainstream health services, so that each ACCHS is partnered with a division of general practice and relevant community and hospital based services to provide assistance identified by the ACCHS. Assistance could include:

- organisational support, in the form of:
 - assistance to recruit staff
 - support in preparing for accreditation review
 - finance, administration and management support
 - advice and assistance in accessing funding opportunities
- clinical support, in the form of:

- locum support
- access to visiting medical practitioners, GPs and allied health professionals
- referral pathways
- training and education, including access to clinical supervisors.

Under the same initiative, mainstream services would address:

- cultural sensitivity training
- systems to improve identification of Aboriginal and Torres Strait Islander patients and consequently the delivery of culturally appropriate care.

Improvements to Indigenous health outcomes will be supported by working collaboratively with the Aboriginal community controlled health sector. It will be necessary for consultation to occur with the Aboriginal community controlled health sector regarding such a national initiative to ensure it is both supported and structured to best meet the needs of this sector. Any initiative imposed from the outside will fail.

In addition to the measures discussed above, AGPN supports the recommendations of the Close the Gap campaign, including the calls for:

- an additional \$460 million per annum for the first 5 years for Indigenous health for culturally appropriate primary health care to help bridge the gap in health standards
- monitoring of Indigenous access to health services
- a strategic maternal and child health plan
- greater support for Indigenous-specific population programs for chronic and communicable disease
- increased funding and support for health promotion regarding nutrition, physical activity, fresh food, and healthy lifestyles
- increased funding and support for adequate housing and environmental health.