



**An overview of the policy environment for the
divisions of general practice network**

A Background Paper

***Promoting community health and wellbeing through
General Practice Networks and primary health care teams***

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About this paper

It is important that members of the divisions of general practice network have an understanding of the broader environment in which the Divisions of General Practice Program presently operates. As we consider how we want to position ourselves, it is also important that we appreciate the current policy agendas, prevailing stakeholder views and their possible impacts on the network which can manifest as either threats or opportunities.

This is a *Background Paper* not a discussion paper. It provides a summary of the current and evolving national policy environment. In particular, it provides an overview of key policies and reviews announced by the Australian Government, an overview of the stances taken by key stakeholders and a brief analysis of the potential implications for the network. It is the first in a series of three papers that will promote network discussion about current issues of relevance. The subsequent two papers will be discussion papers on network funding models and models of regionalisation. These will be made available in mid October prior to the 2008 AGPN Forum.

How can members use this paper?

The paper is a reference guide. Members are encouraged to:

- disseminate it to Board members and staff
- use some of the material in divisional newsletters and opinion pieces
- use as a basis for discussion at local and state forums.

Overview

The medico-political environment for the divisions of general practice network continues to be dynamic, contestable and ever changing. The community traditionally rates health highly as an election issue, making it a perennial priority for governments. The Australian Government has set a reform agenda for health so there is no doubt that we are likely to see significant changes in how health care is funded and organised over the next 3-5 years.

In a recent speech, Minister Roxon gave clear commitments to building the capacity of the primary health care sector, to targeted approaches that better serve communities, and to overcoming the 'blame game' in health between the Commonwealth and States.

She said that reform will be delivered through “recognition of the ways in which primary care and acute care interact, the introduction of activity-based funding and performance measures”¹. In a more recent speech she described “shifting our health system to focus on prevention and workforce changes as a the next generation of health reforms crucial in delivering better equity in health, as well as alleviating the threats to the sustainability of our system.”²

In the longer term, the government may well also consider major structural changes such as a move to establish primary health organisations (PHOs) in Australia, following the trends in the UK and New Zealand. The indications are also that the next Federal Budget will also be a ‘savings’ budget, with the government looking for a second round of savings to finance broader reform. In the shorter term then, our environment will most certainly see the government looking for increased efficiencies and economies of scale in program delivery and being more discerning in the programs its funds by opting for more targeted, evidence-based programs.

Key government policies and reviews

Prior to its election, the current Australian Government made a number of pledges for health. These included commitments to eliminate cost and blame shifting between the Commonwealth and states, to invest more in prevention including through the Australian Health Care Agreements, a focus on child health development and wellbeing, improvements in Aboriginal and Torres Strait Islander health and to the development of a primary health care policy. More broadly, pledges were made to a social inclusion agenda with a focus on ensuring that policy and programs across portfolios and levels of government can work more effectively together to combat economic and social disadvantage.

Since the election the Government has commenced a number of reviews into the health system. There are three major ones that involve the oversight and input of independent experts with planned public and / or stakeholder consultation phases – the work of the National Health and Hospital Reform Commission (NHHRC), the Primary Health Care

¹ The Case for Change. Minister Roxon’s address to the National Press Club, 13 August 2008

² The Light on the Hill: History Repeating. Minister Roxon’s address to the Annual Ben Chifley Memorial “Light on the Hill” Dinner, 20 September 2008

Strategy Expert Reference Group (the ERG) and the National Preventative Health Taskforce (the Taskforce). A number of other programs or schemes are also under review internally. These include a review of the Medicare Benefits Schedule, the RRMA classification and rural health programs and a review of maternity services.

More broadly, the Government has a strong social inclusion agenda. A review of the National Drought Policy is examining the social and health impacts of drought on farm families and rural communities, a Homelessness White Paper will deliver strategies to arrest the rates of homelessness and a Social Inclusion Board with membership from leaders with the not-for-profit and business sectors has been appointed and will consult widely and provide views and advice on various aspects of social inclusion.

National Health and Hospital Reform Commission

The NHHRC has been established to provide advice on performance benchmarks and practical reforms to the Australian health system that could be implemented in both the short and long term to address challenges such as access to services, the growing burden of chronic disease and inefficiencies in health care delivery.

The NHHRC's long-term health plan will maintain the principles of universality of the Medicare and Pharmaceutical Benefits Scheme and public hospital care. The NHHRC has two specific terms of reference:

1. By April 2008 the Commission will provide 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.
2. By June 2009, the Commission will report on a long-term health reform plan to provide sustainable improvements in the performance of the health system addressing the need to:
 - reduce inefficiencies generated by cost shifting, blame shifting and buck passing
 - better integrate and coordinate care across all aspects of the health sector, particularly between primary care and hospital services around key measurable inputs for health
 - bring a greater focus on prevention in the health system

- better integrate acute services and aged care services, and improve the transition between hospital and aged care
- improve frontline care to better promote healthy lifestyles and prevent and intervene early in chronic illness
- improve the provision of health services in rural areas
- improve indigenous health outcomes
- provide a well qualified and sustainable health workforce into the future.

To date, the Commission has released proposed design and governance principles for the Australian health system:

www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/principles-1p

These are proposed as the basis from which to shape the whole health and aged care system – public and private, hospital and community based services. Comment has been invited on these as part of the Commission’s consultation process. Numerous submissions have been made to the Commission and these are available publically on the website www.nhhrc.org.au. Highlights from key submissions are outlined elsewhere in this paper.

The Commission has also released its first report, *Beyond the Blame Game: Accountability and performance benchmarks for the next Australian Health Care Agreements*. Key recommendations in this report centre on the next generation of Australian Health Care Agreements (AHCAs) and the development of performance benchmarks. Changes to three key elements - scope, funding approach and accountability - are canvassed. The Commission advises that the next AHCAs should be about the Commonwealth and States jointly sharing responsibility for the health system. Of note is the Commission’s assumption that the scope of the AHCAs will be broader than hospitals and their recommendations for a common accountability framework comprising 44 benchmarks organised around twelve ‘health challenge’ areas such as closing the gap in Indigenous health status, ensuring a healthy start, ensuring timely hospital access and improving distribution and equitable access to services with an assignment of accountabilities to the responsible level of government. The benchmarks are based on state governments having clear responsibility and accountability for public hospitals, mental health, public health, and maternal and child health services, and the Commonwealth government having clear responsibility and accountability for aged care and most other health services, including all primary health care services and prevention.

An interim report from the Commission is expected later in 2008. This is expected to provide some early indications of the Commission's thinking. AGPN will be coordinating a response on behalf of the divisions network to the interim report.

National Primary Health Care Strategy

AGPN has long advocated for a national primary health care policy. The Australian Government has committed to the development of a National Primary Health Care Strategy. The Strategy will look at how to deliver better frontline care to families with priorities including:

- better rewarding prevention
- promoting evidence based management of chronic disease
- supporting patients with chronic disease to manage their condition
- supporting the role GPs play in the health care team
- addressing the growing need for access to other health professionals, including practice nurses and allied health professionals
- encouraging a greater focus on multidisciplinary team based care.

An Expert Reference Group has been convened to support the Government develop the Strategy.

A review of the Medicare Benefits Schedule primary care items is also being undertaken alongside development of the Primary Health Care Strategy – with a focus on reducing red tape for doctors, simplifying the schedule and giving more support to prevention. A consultation paper on the Primary Health Care Strategy is expected in late 2008. Consultation plans on options for change with regard to the Medicare Benefits Schedule are still being developed.

National Preventative Health Taskforce

The Preventative Health Taskforce will provide evidence-based advice to government and health providers – both public and private – on preventative health programs and strategies, and support the development of a National Preventative Health Strategy. The Strategy will provide a blueprint for tackling the burden of chronic disease currently caused by obesity, tobacco and excessive consumption of alcohol. It will be directed at

primary prevention and will address all relevant arms of policy and all available points of leverage, in both the health and non-health sectors in formulating its recommendations.

The Taskforce will also:

- support the further development of the evidence base on preventative health to reform what works and what doesn't
- provide advice to policy makers on what strategies work best at a population level, and on best buys for government investment in primary prevention
- provide advice on the most effective strategies for targeting prevention in high risk sub-populations including Aboriginal and Torres Strait Islander peoples and people living in rural and remote locations
- provide guidance and support for clinicians *particularly in primary care settings* to play a more effective role in preventative health care
- provide advice to Government on options for *better integration of preventative health practice into the Medicare Benefits Schedule and other existing government programs*
- support the development of intergovernmental and public-private partnerships for preventative health.

The Taskforce will produce a 3 year work program by September 2008, a draft National Preventative Health Strategy in March 2009 and a final Strategy by June 2009. A discussion paper for public consultation is expected from the Taskforce in September 2008³ to which AGPN will make a submission.

Review of rural health programs and RRMA

In conjunction with the release of an audit of Australia's rural and regional health workforce in April 2008, the Government has established the Office of Rural Health in the Department of Health and Ageing to drive reform in the rural health sector. Other key commitments made by the Government in response to the audit include:

³ Preventative Health Taskforce – Media Release 7 July 2008

- reform of the remoteness classification structure (RRMA) to ensure that incentives and rural health policies respond to current population figures and real need. Given the funding formula for divisional 'core' contracts are based on RRMA, as is many division run programs and practice level incentives, this is likely to have a wide ranging impact on divisions and general practice
- an examination of all existing programs that support rural health professionals to determine how to better support communities in most need of assistance.

Both of these activities are scheduled to be completed in mid 2009. AGPN is advised that stakeholder consultation is planned on these activities with details yet to be released.

Other government developments of interest

2020 summit

In April 2008, the Australian Government hosted the 2020 Summit which brought together over 1000 of the best and brightest Australians from across the country to discuss Australia's long term challenges and discuss a potential strategy to address these challenges in the future. The summit covered 10 critical areas, one of which was a long-term national health strategy.

This health stream of the summit focused on the following issues:

- healthy lifestyles, health promotion and disease prevention
- health workforce and service provision
- addressing health inequalities
- future challenges and opportunities in health
- health research, research translation and research training.

Many innovative ideas were canvassed at the summit which may have the potential to impact on the shape of the future health agenda. Some of these included creating a health equalities commission, creating a national preventative health agency, and rethinking the shape of the health workforce.

Council of Australian Governments (COAG)

COAG has an ambitious health and ageing reform agenda including a substantial program of hospital reform (including the primary care interface and activity-based funding reform), improvements to Indigenous health, chronic disease management and preventative health care through measures such as the Australian Better Health

Initiative. COAG also continues to guide and oversight the national action plan on mental health (2006-2011).

Recent progress made by COAG includes the signing of an intergovernmental agreement on the health workforce in July 2008 to provide a single national registration and accreditation system for nine health professions: medical practitioners; nurses and midwives; pharmacists; physiotherapists; psychologists; osteopaths; chiropractors; optometrists; and dentists (including dental hygienists, dental prosthetists and dental therapists). This measure aims to increase workforce mobility, reduce red tape, and promote a more flexible responsive and sustainable workforce.

Reform driven by COAG in other sectors also has implications for Australia's health. For example in the productivity agenda (encompassing Education, Employment and Early Childhood) COAG has committed to fund more vocational education and training places in the health sector. In Indigenous reform, COAG has committed to work towards closing the life expectancy gap within a generation and halving the mortality gap for children under five within a decade.

Views of other stakeholders

AGPN is clearly not the only non-government health organisation or GP group seeking to influence policy. There are a number of other organisations actively contributing to the health policy debate at a national level. These include the other GP groups, allied health organisations and various academic think tanks. It is useful to be aware of the stances taken by other organisations. The following is a *general* summary of key points made in submissions to the NHHRC (or other publically available submissions by these groups) in order to give a flavour of the range of advice and the extent to which is converges or not. Please note that the NHHRC secretariat is progressively putting submissions on the website.

GP groups

- The RACGP has called for:
 - reform that will expand the scope, function and effectiveness of general practice, and have suggested that some government programs constrain the opportunities for general practice to contribute in a more integrated way to the health system, such as the complexity and disincentives of the MBS

- reform of the MBS to create a simpler payment schedule that also addresses relativities, remuneration for general practice involvement in preventative medicine, profession-led development of quality improvement indicators
- increased payments to GPs for teaching medical students and an expansion of rebates for services delivered by nurses and allied health professionals for and on behalf of GPs.
- patient registration for high risk and other cases.
- Key calls from the RDAA include:
 - health funding models that build capacity and capability in rural health services
 - MBS reform and payments over and above fee-for-service that provide additional support and rewards for practices that put in place best practice models of care (e.g. diabetes cycle of care)
 - support for rural health professionals to educate and train the next generation and support for rural procedural services delivered in rural hospitals such as obstetrics, surgery and emergency care
 - rural specific financial incentives that address both the isolation of rural practice (in the form of a rural isolation payment) and rewards doctors that undertake the procedural work usually performed by specialists in the city (in the form of a rural procedural and emergency / on call loading)
 - expansion of the GP and rural generalist role, including being a consultant to other members of the health care team.
- Major comments from the AMA include:
 - the need to enhance and sustain the capacity of private health insurance and open the door to more innovative private sector health financing options
 - radical reform may do more harm than good. Careful, incremental change that takes the patients and providers along for the ride as active participants in system redesign is required. Change must not compromise the quality and safety of patient care

- general practice plays a key role in the Australian health care system, providing primary and preventive care and acting as the “gatekeepers” to the tertiary healthcare system. There is scope to improve support for general practice
- investment in training resources and infrastructure, the use of expanded clinical settings in the private sector (including general practice)
- opposition to substitution of lesser-trained health professionals
- MBS rebates for patients be properly indexed to avoid an ever-widening gap between aggregate fees charged and aggregate benefits paid, that the Medical Services Advisory Committee (MSAC) processes be improved via an interim listing process and that MBS GP items be reviewed and simplified to enable patients to receive rebates appropriate to the high quality acute care, complex care and chronic disease management and preventive care from general practice
- a substantial program of incentives to attract and retain doctors in rural areas, scholarship programs to attract young doctors to rural areas and further investment in outreach services
- a significant boost in the capacity of primary care services for Indigenous people including infrastructure, capital works and equipment, significant expansion of the medical and health workforce and sustainable improvements in the social correlates of health, including education, employment and community.

Allied health and practice nurse groups

- Allied Health Professions of Australia (AHPA) have recommended:
 - the Government should require divisions of general practice to become divisions of primary care to reflect the multidisciplinary nature of care
 - changes to the EPC items to make GP referrals easier, increase the number of allied health professional consultations and allow direct access to allied health professionals where appropriate.
- The Australian Physiotherapy Association (APA) support a funding model that reimburses outcomes rather than inputs, noting that the distribution of health workforce is inequitable and contributes to the problem that access to the MBS is poorest where health need is greatest.

- The Australian Practice Nurse Association (APNA) and the Royal College of Nursing Australia (RCNA) have called for a revision to payment models, citing task-based fee for service as limiting the role of the general practice nurse and a salaried base model as more likely to provide options for extending the scope of nursing practice.

Research think tanks

Key centres such as the Menzies Centre for Health Policy, the Australian Health Workforce Institute and the Australian Institute of Primary Care commented more on system and funding reform options, rather than general practice specific issues. Key thinking includes:

- A health workforce development strategy that not only fills gaps in service provision but also addresses long term planning, education, training, re-skilling, recruitment, retention and modernisation of the health workforce and workplace
- New service models need to be funded and some existing incentives need reshaping
- National leadership to translate pockets of innovation that is occurring locally through divisions and area health services, for example, into national scale implementation
- The Medicare system delivers adequate sub acute and episodic care – but not for all populations:
 - It does not deliver proactive chronic disease care as specified in the Chronic Care Model endorsed by the National Chronic Disease Strategy. A funding system, that includes patient registration, and that supports all aspects of this model is required.
 - Fee for service limits the choice of business models that can occur in general practice, resulting in inefficiency in overall patient health care. For example, there is not a source of funding to support health care for those who do not generate an item of service during the consultation.
- The establishment of Integrated Primary Health Care Centres
- Funding for chronic disease prevention and management in primary health and community care be integrated into a single Commonwealth-funded Medicare program:

- Existing Medicare programs (PIP, EPC), community care (e.g. HACC) and state community health should be brought together for this purpose. Existing Medicare arrangements should be maintained for the general population not requiring coordinated chronic disease management.
- Funding should be tied to patients assessed as being entitled to participate in the chronic disease program depending on their level of need. Performance payments could be developed based on both patient outcomes and adherence to good practice processes.
- The divisions of general practice could be redeveloped to manage performance based agreements with GP practices, GP Super Clinics and community health services for chronic disease prevention and management. Reformed divisions would have a key role in implementing system reforms and separate capacity building funding for this purpose would be necessary.

Other opinions of interest come from the WA Chamber of Commerce and Industry advocating for a fund holder model or approach to regional purchasers to manage health risks and achieve health objectives of specific populations more flexibly and more efficiently. The National Rural Health Alliance have called for a national rural health plan, a rural health service commitment and a response to the rural health workforce audit, noting in particular that the free market and fee-for-service alone will not deliver fair health care.