Primary Care Reform in Australia: general practice leading the way

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Australian healthcare system
(an international snapshot !)

- Medicare: universal health insurance (1.5% taxable income)
- Strong and effective public / private mix
- Accessible and capable primary care sector
- High international benchmarks in longevity, chronic disease outcomes, survival rates, access, satisfaction, cost
- ‘Closing the gap’ – our greatest national challenge
- Dual state and Commonwealth funding arrangements, their gaps, inefficiency and duplication has provoked a strong current health care reform focus
Australian primary healthcare: the context

- General practice (our PCMH!)
  - 27,000 GPs (predominantly FFS, SIP, PIP)
  - Over 125 million consultations / yr, 80% ‘bulk billed’
  - see 83% population annually, big practices
  - holistic, ‘cradle to grave’ model, team focus

- Community health (state-funded)
- NGOs – predominantly aged care
- Aboriginal community-controlled health services
Healthcare reform: the 2008-2011 timetable

- National Health and Hospitals Reform Commission report
- Australia’s First National Primary Care Strategy
- GP Superclinic roll out (34 + 30 settings)
- Legislation re personally controlled e-health records
- MBS / PBS access for nurse practitioners and midwives
- PM’s ‘Big Bang’: ‘National Health and Hospitals Network for Australia’s future’ (1 and 2, COAG, 2010 Budget): 2010
- 2011 Council Of Australian Governments (COAG) Agreement

A major national health care reform agenda strongly focussed on primary care
The National Health and Hospital Reform Commission

- Embed prevention and early intervention into every aspect of our health system and our lives, particularly for children and young people
- Connect and integrate health and aged care services for people over the course of their lives
- Strengthen primary healthcare services ... building on the vital role of general practice...creating a platform for comprehensive care bringing together health promotion, early detection and intervention, and management of acute / chronic conditions
- Integrating multidisciplinary primary healthcare services with Commonwealth oversight
- Establishing comprehensive primary healthcare centres and services
- Voluntary enrolment with a ‘healthcare home’
The National Health and Hospital Reform Commission

- Expand specialist services / palliative care support / hospitals in the community
- Establishing PHC Organisations to support population health care planning and coordination
- Create a comprehensive primary healthcare platform under Medicare (including state-health services)
- Mix of funding models
- Reshaping the Medicare Benefits Schedule (MBS) to reflect scope of services to be included, competency and scope of practice, driven by evidence and ‘continuity and integration of care through collaborative team model of care
- Fostering clinical leadership and governance and e-health
- New framework for flexible, competency-based IPE and dedicated $ for clinical placements and teaching
The National Primary Health Care Strategy

• Building a system from a sector
• Increasing relevance, funding and accountability
• Changing dual system governance structure
• Improving integration with acute and aged care
• Building effective teamwork across disciplines
• Advanced and enhanced care opportunities within the community
• Focus on regional integration of care, e-health, workforce growth, infrastructure, and financing and system performance
Key drivers

- Chronic disease prevention and effective management
- Cost containment and ‘efficient costs’
- Building quality
- Improved access especially for marginal groups
- International approaches
- Public pressure and accountability

- Care of ageing Australians conspicuously absent
2011—what does the future hold?

- Council Of Australian Governments (COAG) national health reform Heads of Agreement
- Creation of Local Hospital Networks (LHNs) as direct recipients of Commonwealth and state funds
- Strong performance accountability, measurement and public reporting
- Medicare Locals (MLs): primary healthcare organisations responsible for coordinating and better integrating PHC services in their local region, improving access, preventive health and addressing care gaps (First 15 announced June)
- Strong articulation between MLs and LHNs and a framework for increasing autonomy and accountability
Australian PHC Reform – what are the ‘First 15’ MLs doing?

- Improving integration and coordination of local service delivery
- Supporting clinicians and service providers to improve patient care
- Identifying the health needs of ML geographies, gap analyses, and developing locally focussed and responsive services
- Facilitating the implementation and successful performance of PHC initiatives and programs
- Increased governance accountability
- After hours services
What is the College doing?

- Defining the Vision for General Practice 2020

- Building our e-health supports, National Faculty of Specific Interests and QICPD initiatives to fit

- Re-shaping our curriculum / training / organisation / support services to meet the new challenges – new skills in IT, clinical leadership, teamwork

- working closely with United General Practice Australia and important national stakeholders including HWA
The Vision Splendid 2020

What is the ‘ideal’ general practice framework to lead our future…
The Vision Splendid

• Is accredited and driven by the patient ‘value proposition’
• Good in-hours access and availability outside the traditional 9 - 5
• Visits residential aged care / home / hospital visits if relevant to patient need
• Provides effective after hours cover for the practice
• Delivers high quality preventive healthcare and health education and promotion
• Is involved in undergraduate and/or postgraduate teaching
• Provides high quality electronically-generated and appropriate referrals
• Is available for appropriate hospital / community complex care liaison.
The Vision Splendid

- Has a broad skilled team appropriate to patient population
- Undertakes regular TQI cycles / research relevant to practice need
- Uses effective e-consulting / e-communication
- Delivers an advanced skill / special interest care service relevant to local population in practice teams
- Demonstrates clinician leadership and cohesive service delivery – in-practice and out-of-practice

- The practice has a business case to match its excellence in service delivery
The Quality General Practice of the future is about:

- Quality care for individuals, families and communities
- The right services for their community
- Evidence, quality, safety and innovation
- Culture, leadership and the teamwork to grow
- Education, training and research for tomorrow’s workforce
- The Infrastructure for integrated primary health care
- Connections and capacity building with the wider community
The Quality General Practice of the future:

Empowers and builds capability in patients, parents, families and carers through engagement, education, e-access, resources and self management tools.

Provides and/or coordinates the provision of accessible care face-to-face, by phone or e-consultation, in hours and after hours, in practice, home or health facility, as needed.

Maintains well defined clinical pathways, referral and transfer of care processes, pre-admission, booking, hospital in-reach and specialist outreach services, hospital-in-the home, and new integrated service models including community hospitals and multi-purpose services.
The Quality General Practice of the future:

Provides patient care through shared care and advanced skills networks including acute care, child and family, chronic and complex, palliative and leads aged care services

Collaborates with other health services and sectors to reach significantly disadvantaged groups and communities, develop innovative service responses, and advocate for additional services

Utilises advanced clinical software systems to support incorporation of best evidence, delivery of quality care and continuing quality improvement
The Quality General Practice of the future:

Enables team members to acquire and apply formally recognised specific advanced skills according to community need and personal interest

Contributes to local health service workforce planning and infrastructure renewal

Incorporates teaching and research as integral elements of quality practice,

Ensures that medical students and general practice registrars experience and acquire the skills of team leaders, teachers, mentors, researchers, community planners and change agents
The Quality General Practice of the future:

Is a valued resource and a welcoming place for its local community

Is connected to its local environment at community, professional, service and regional level

Works with other health networks to utilise de-identified practice data and professional expertise to contribute to local health service planning, development, innovation and evaluation
Watch this space!

- A lot is happening Down Under which offers opportunities for international collaboration and policy development.
- Significant professional concern re Divisional activity in areas which now will be ‘de-funded’.
- Concerns re governments’ track record in delivering such large scale reform and small budgets from Medicare Locals.
- But … first ever serious focus on funding, organisation and accountability around integrated care delivery.
- Recognition than improving primary care capacity and access a life line to retaining high quality, affordable healthcare in our country.
“Curing sometimes, relieving often, comforting always”
The future is not a result of choices among alternative paths offered by the present, but a place that is created – created first in the mind and will, created next in activity.

The future is not some place we are going to, but one we are creating. The paths are not to be found, but made, and the activity of making them, changes both the maker and the destination ‘

John Schaar, futurist
EXHIBIT 1.

Per Capita Health Spending And 15-Year Survival For 45-Year-Old Women, United States And 12 Comparison Countries, 1975 And 2005

SOURCE Authors' analysis based on data from the sources described in the text. NOTES The dashed line separates 1975 values (blue circles) and 2005 values (red squares). Values are presented for the percentage of forty-five-year-old women surviving fifteen years.