



# **Australian General Practice Network submission to the Senate committee inquiry into the Council of Australian Governments reforms relating to health and hospitals**

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AGPN represents a network of 110 general practice networks as well as eight state based entities. More than 90 percent of general practitioners (GPs) and an increasing number of Practice Nurses and allied health professionals are members of their local general practice network. The Network is involved in a wide range of activities focused on improving the health of the Australian community including health promotion, early intervention and prevention strategies, health service development, chronic disease management, medical education and workforce support.

AGPN aims to ensure Australians have access to an accessible, high quality health system by delivering local health solutions through general practice.

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## Executive Summary

The Australian General Practice Network (AGPN) has long advocated for health reform that reorients our health system towards enhanced primary health care and believes that the establishment of regional primary health care organisations (PHCOs) is a key enabler of such a system.

AGPN welcomes the reforms outlined in the National Health and Hospitals Network Agreement (the Agreement) to establish a new National Health and Hospital Network (HHN) of Local hospital networks (LHNs) and PHCOs. We particularly welcome the establishment of PHCOs that will be nationally funded and locally coordinated and drawn from existing general practice networks. This infrastructure represents considerable opportunity to more effectively pool funding, plan and meet need through reconfigured, integrated and better coordinated services.

AGPN has also welcomed recent announcements that Australian PHCOs will be built on the existing general practice network and that funding to support initial transition and then full establishment of these by 1 July 2012 has been committed in the recent Federal Budget.

AGPN congratulates COAG on reaching agreement on a reform agenda that has the potential to vastly enhance the quality and efficiency of the Australian primary health care system. AGPN has however some concerns regarding the details of the approach outlined in the Agreement. Chief amongst these are:

- the lack of clarity around which level of Government will be responsible and accountable for key aspects of primary health care and particularly the apparent enhancement of the role of State Government's in primary health care policy. Rather than realise the reform objective of greater coordination and service integration this may lead to additional bureaucracy and fragmentation of services.
- the seeming enhancement of State Government and potentially hospital authority in primary health care service planning and delivery, which will impede an effective reorientation of our health care system toward primary health care.
- lack of an articulated overall, longer-term vision for PHCOs in terms of their role and function and the lack of alignment between the outcomes PHCOs will be responsible for and the authority and resources they will be given to achieve these. PHCOs require real authority, responsibility and funding to achieve the expectations outlined for them in the Agreement.

These elements of the Agreement are critical to how effectively the national reform agenda will be able to deliver an effective and efficient health system, build on the foundations of a primary health care system, and to enhance population health outcomes through the establishment of PHCOs. Clarity of policy responsibilities for primary health care, the role and function of PHCOs and their relation to Local Hospital Networks (LHNs) is required.

Maximising the suite of primary health care services that are coordinated through PHCOs at a regional level will realise best results through more comprehensive service planning and integration across the sector. There is benefit in transferring funding and policy for the range of primary health care services not covered by the Agreement to the Commonwealth, and, over time, vesting PHCOs with coordination, service planning and fund holding responsibilities for these services.

Likewise, while welcoming the Commonwealth's enhanced investment under the Agreement in supporting better access to primary mental health care services, we advise that access to well-coordinated mental health care could be further enhanced, over time, by investing PHCOs with planning and coordination responsibilities for Commonwealth-funded additional primary health care services, early intervention programs, mental health social support services, headspace sites and 'step up'/'step-down' care services in the sub-acute setting. Recommendations are reflected throughout the submission. AGPN urges the Committee's serious consideration of these in order to achieve the desired goals of the current health reform activity.

## Background and Introduction

The Australian General Practice Network (AGPN) has long been an advocate for health reform that reorients our health system towards stronger, better organised and responsive primary health care (PHC) - a direction that evidence shows lead to improved and more equitable health outcomes and a more cost effective system. AGPN has continually highlighted that the establishment of Primary Health Care Organisations (PHCOs) is a key enabler of such a system.

In Australia, the establishment of PHCOs charged with improving population health at a regional level through service planning and coordination, and provided with the flexibility to deliver locally relevant solutions to address service gaps and health inequities, will drive the achievement of better service integration, improved health outcomes and greater efficiency. Having one organisation responsible for all regional PHC delivery will also stop the cost shifting and blame game that has long hampered Australia's health system through divided government responsibility for health.

Health reform reviews over the last 18 months and recent government announcements have consolidated these views through new policy that will improve the way health services are planned, coordinated, organised and funded. This includes that the Commonwealth take over full funding and policy responsibility for PHC and a restructuring of the system to establish a new National Health and Hospitals Network (NHHN). The NHHN will comprise Local Hospital Networks (LHNs) and PHCOs.

Of significance is the clear announcement from the Australian Government in April 2010 that PHCOs evolve from the existing general practice network. The Network's established national infrastructure, strong links to general practice and primary health care and sound track record in PHC delivery make them a logical platform from which to build PHCOs and does not add unnecessary layers of bureaucracy to the new NHHN. The Network has subsequently welcomed the recent Federal Budget commitment to invest in establishing a first wave of PHCOs by 1 July 2011 and a national Network by 1 July 2012. The commitment also provides funds to support transition from GPNs to PHCOs as well as funding for a number of other new or expanded primary health care initiatives.

AGPN has been actively working to support this transition through significant bodies of work including independently commissioned reports on boundaries for PHCOs, a PHCO transition strategy and plan as well as options for governance and membership of PHCOs<sup>1</sup>. AGPN has also developed its own Blueprint for PHCOs in consultation with the Network.

### About this submission

The proposed restructure and establishment of the NHHN, including PHCOs and LHNs was taken to the Council of Australian Governments (COAG) in April 2010. This submission represents AGPN's initial response to COAG's subsequent National Health and Hospitals Network Agreement (the Agreement). AGPN continues to support, in principle, much of the broad health reform agenda especially the greater emphasis on primary health care (PHC), and the establishment of PHCOs. AGPN does however have concerns about key details in the COAG agreement regarding responsibility for primary health care, particularly the role and function of PHCOs and the need to ensure that the authority of

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<sup>1</sup> These bodies of work have been independently commissioned through Cranny and Associates, KPMG and DLA Phillips Fox respectively

PHCOs and LHNs is well balanced. There is good evidence that countries with strong primary health care systems have better health outcomes. These details are critical to how effectively the national reform agenda can deliver improvements in health, built on the foundations of a primary health care system that provides all Australians with access to comprehensive and well-coordinated care.

AGPN has outlined its views on the Agreement in more detail on the following pages. Where possible, responses have been provided under the specific terms of reference (TOR) of the Committee (see Appendix A for the TOR). A number of matters cross several TOR however and are addressed more generally in the overall response.

## **Comment on the National Health and Hospitals Network Agreement**

### **Responsibilities for primary health care functions**

*Relevant to: Terms of reference (d) and (k)*

AGPN supports a Commonwealth Government take-over of funding and policy responsibility for all primary health care. More clarity is required however, regarding which organisations and which levels of government will be accountable for key aspects of PHC under the funding structure outlined in the Agreement and including some seemingly residual hospital authority to deliver primary health care services. AGPN considers that a clear delineation in accountability between PHC and the hospital sector is required if the issues caused by Australia's divided responsibilities for health are to be overcome.

### **Role of State Governments in primary health care delivery and policy and the need for well defined accountabilities for PHCOs**

The Agreement suggests that whilst the Commonwealth will assume funding responsibility for primary health care services currently provided by the States, they will pay this money to the States to continue to provide the majority of these services (as reading Clause 16bii and B8a in tandem suggests). It is unclear who will be accountable for the effective and efficient provision of these services or how this will relate to the planning and coordination role that appears to be expected from Primary Health Care Organisations (PHCOs.)

Further, the Agreement appears to suggest an enhanced role for State Governments (albeit jointly with the Commonwealth) in primary health care policy. Clause B6 of the Agreement for example states that in formulating primary health care policy, the Commonwealth recognises the need for ongoing engagement and collaboration with States. In particular:

- a) the Commonwealth and States will work together on system-wide GP and primary health care policy, because it impacts on the efficient delivery of hospital services and other State funded services, and because of the need for effective integration across Commonwealth and State funded health care services;
- b) the Commonwealth will prepare a state-wide GP and primary health care plan to be agreed bilaterally; and
- c) in relation to the services where funding and policy responsibility is transferred to the Commonwealth:

- I. where coordination is required for reasons of service planning or service integration, the Commonwealth and the relevant State will work together to develop an agreed implementation plan; and
- II. the Commonwealth will develop a policy framework for these services in consultation with the States.

Similarly positing an enhanced role for the States in primary health care policy, Clause B25 states that the final number and boundaries of PHCOs will be primarily a matter for the Commonwealth to resolve, however:

- a) as a transitional matter to establish the new system, the boundaries will be initially resolved bilaterally between First Ministers by 31 December 2010; and
- b) beyond this date, the Commonwealth will continue to consult with the States on PHCO structures and boundaries as changes are made.

These arrangements appear to provide States with continued responsibilities to deliver primary health care services and with new policy responsibilities which impact in areas where previously States had little or no role. They have the potential to further complicate the system for patients and confuse delivery at the local and regional levels - so worsening, rather than reducing the fragmentation of care that the reforms aim to overcome. Whilst State Governments will remain a key stakeholder in primary health care policy and should be consistently engaged to ensure that primary health care policy is well coordinated with other State health services, AGPN recommends that the role of State Governments is that of advising on, rather than determining or authorising, primary health care policy.

Similarly, whilst State Governments will retain a role in service delivery, at least in the short term to ensure a smooth transition of responsibilities, effectively realising the benefits of the new NHHN that is funded nationally and run locally should see over time, a greater role for PHCOs in service delivery, coordination, planning and funding, and a reduced role of State Governments.

AGPN recommends that to realise the benefits of all PHC being organised through a single national funder and regional entities the Commonwealth should:

- clearly define the roles and accountabilities of the States in general practice and primary health care policy and service delivery with primary responsibility for PHC resting with the Commonwealth and PHCOs
- clearly stipulate that the role of State Governments in primary health care policy and service delivery will be reduced over time and will not be extended through implementation of the Agreement
- clarify that the role of State Governments is that of advising on, not determining or authorising, primary health care policy

### **PHCO boundaries**

AGPN notes that the Agreement includes provision for the "Final number and boundaries of PHCOs [to be] resolved, consistent with LHN boundaries where appropriate ... [by] 31



December 2010 bilaterally between State...and Commonwealth Health Minister[s].”<sup>2</sup> While AGPN appreciates that States will need to be consulted on this matter as important stakeholders and in order that existing and emerging service architecture is taking into account, AGPN strongly recommends that general practice networks are equally fully consulted on PHCO boundaries. The Network is uniquely well placed to provide input into planning decisions on PHCO boundaries as:

- by their very nature, GPNs have the necessary local knowledge and experience to provide expert input into workable PHCO boundaries
- AGPN has already commissioned independent work on PHCO boundaries that is based on sound and objective planning logic and health service planning principles.

Similarly AGPN also recommends that the Commonwealth commit to engaging the Network in determining the process by which the first wave of PHCOs, due to be operational by July 2011, are identified and supported. This start date also further reinforces the need for PHCO boundary determination to be expedited ahead of the 31 December 2010 date stated in the Agreement.

AGPN recommends that:

- the Commonwealth works in partnership with the Network as a key stakeholder in determining the most appropriate boundaries for PHCOs and processes by which the first wave of PHCOs will be identified and supported

### **Role of Local Hospital Networks in primary health care service planning and delivery: a sustainable, well coordinated health system must be built on PHC - planned and delivered through PHCOs**

The Agreement also appears to support delivery of PHC services through Local Hospital Networks (LHNs). It states that “States will be responsible for...negotiating and agreeing with the Commonwealth for the delivery of relevant GP and primary health care services, where the Commonwealth agrees to provide those services through LHNs...” It further notes that in the eventuality that the Commonwealth’s responsibility for health system growth is not as large as the predicted \$15.6 billion, States will spend the residual as additional funding on services such as chronic disease management, prevention and mental health. This suggests an intent to expand the role of the States and potentially the hospital system in providing primary health care services.

Evidence shows that a sustainable and effective health system will only be realised by embedding the foundations of the system in primary health care. AGPN’s views are in keeping with this. Primary health care is where the majority of Australians seek health care and primary health care professionals are best placed to effectively manage chronic disease and provide preventative health care to improve health outcomes. Strengthening primary health care system capacity is fundamental to the success of this reform process.

AGPN is concerned that the suggested PHC role for LHNs in the Agreement detracts from, rather than boosts, PHC capacity as well as risks duplication and poor coordination. History shows that systems run from hospitals put hospitals first; reorienting the system toward primary health care requires the primary health care sector to play the leadership role.

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<sup>2</sup> Agreement page 52

The authority of LHNs and PHCOs must be balanced if the aims of the reform process – to improve health outcomes and equity more cost effectively – are to be achieved. We know that significantly increasing the capacity in the PHC sector is the only way to do this.

Further, enhancing hospital responsibility and authority in primary health care will negate the benefits of a national approach to primary health care supported by regional planning through PHCOs. The dispersal of primary health care responsibility and authority across States and LHNs will perpetuate current problems with service duplication and poor service integration, so promulgating the blame game and fragmentation that these reforms are intended to overcome.

Greater clarity and further stipulation of the roles and responsibilities for primary health care planning, coordination, service delivery and policy is required, including clarifying the relationships between PHCOs and LHNs. A clear statement of commitment to reorientating the Australian health system towards primary health care is also needed. To be effective this reorientation needs to be general practice and primary health care led, and, at the least, place PHCOs in a position of equivalent position of power and authority to LHNs.

AGPN recommends that to realise the aims of the reform in PHC:

- the Commonwealth make a clear statement of commitment to reorientating the Australian health system towards primary health and ensuring that it has sufficient capacity
- Governments ensure that the authority of PHCOs is at least equal to that of LHNs
- Clarity is provided regarding the varying roles and responsibilities of PHCOs and LHNs in primary health care planning, coordination, service delivery and policy

### **Primary Health Care funding channels**

The Agreement is silent on the funding pathway for those services for which the Commonwealth is to take direct funding and policy responsibility from 1 July 2011 (those outlined in B10.) It could be inferred that funding will flow directly through the Commonwealth, through the National Health and Hospitals Network Fund, through PHCOs, or in some cases, through LHNs.

As discussed throughout this submission, there are clear advantages to supporting PHCOs to assume, over time, increased fund holding and administration responsibilities. This provides the flexibility to support the provision of services best matched to community need and to introduce innovative measures to drive enhanced performance in primary health care.

As noted, AGPN has significant concerns about funding for primary health care services flowing through LHNs. This reduces capacity within the PHC sector itself and also further continues the divided responsibility for PHC that underlies many of the current issues with the health system, including fragmented care. This is not to say that there should not be improved joint planning and coordination regionally between PHCOs and LHNs particularly on areas of service delivery that occupy the nexus between primary health care and acute care such as sub-acute services and various hospital avoidance initiatives.

AGPN recommends that the Commonwealth clarify in the near future funding pathways for those primary health care services listed in B10 of the Agreement, and make clear an

intention to support increasing fund holding for these services by PHCOs in the medium to longer term.

## Primary Health Care Organisations

*Relevant to: Term of reference (e)*

### **PHCO roles and functions**

The roles and functions of PHCOs in the Agreement are welcome however they need to be much clearer and more defined. PHCOs need to know what they will be required to deliver and what they are accountable for.

The Agreement states that "PHCOs will deliver better integrated and responsive local GP and primary health care services to meet the needs and priorities of patients and communities" including by:

- ensuring services cooperate and collaborate with each other,
- facilitating allied health care and other support for people with chronic conditions
- better targeting services to respond to ...gaps and
- delivering targeted health promotion and preventative health programs"

However, it is not clear what authority, responsibility or funding PHCOs will have to perform these roles.

The Agreement suggests the Commonwealth will assume responsibility for funding, planning and (in cooperation with the States) coordination of general practice and primary health care services. It stipulates that the Commonwealth will be responsible for:

- undertaking planning for the provision of transferred general practice and primary health care services;
- maintaining funding levels and indexation for transferred GP and primary health care services, as agreed with the States, unless they choose to divest responsibility as outlined in provision B.8(a); and,
- coordinating service provision to ensure service integration and improve the continuity of patient care, as outlined in provision B.6(c)(i).

The Agreement further notes that States will continue to ensure the operation of transferred GP and primary health care services as outlined in provision B10, and the Commonwealth will not substantially alter delivery mechanisms for these services, without agreement by the relevant state or territory, for 5 years from 1 July 2011.

If the Commonwealth performs these critical roles in planning and coordination it is unclear what the key roles and functions of PHCOs will be and how they are to deliver through greater service planning. We note that whilst the Commonwealth can set broad planning and coordination parameters, GPNs (and future PHCOs) are the only organisations with a regional presence through which the planning and coordination functions can be performed locally.

AGPN recommends that, to achieve the stated aims of health reform, the Commonwealth commits to an approach which ensures that, over time, PHCOs have appropriate authority and sufficient resources to achieve the changes identified in the Agreement. This includes giving PHCOs a clear mandate for population health planning and for the development and implementation of Healthy Community strategies and plans.

## **PHCO authority**

There is a lack of alignment in the Agreement regarding the authority PHCOs will have over time and expectations about what they will achieve. For example, it is not clear if PHCOs will have full population health and primary health care service planning and funding responsibility for their regions. The Agreement states an ambiguous 'potential' fund holding role for PHCOs which can be read either as their being able to undertake population level planning as needed, or as indicating that PHCOs will fund-hold only as needed in areas of market failure.

AGPN advises that over time, PHCOs require full fund holding responsibility for primary health care services (with the exclusion of MBS and PBS) with the flexibility to respond to local need, if they are going to meaningfully fulfil their roles as outlined in B.2 of the Agreement. Without sufficient authority and resources PHCOs will be unable to perform these roles effectively and the potential benefit they offer to population health will not be realised. AGPN recognises that it will take some time for PHCOs to build to this level of regional capacity, capability and accountability. Our blueprint contemplates a 2-5-10 year outlook that would see PHCOs develop and embed their roles and responsibilities progressively over this timespan.

If this is the long term vision and PHCOs are to achieve the expectations outlined for them then they must be given real authority, responsibility and funding to carry out broad responsibilities for their local populations. The current wording of the Agreement needs to reflect this. Without this, the overall reform goals of enhanced PHC capacity and delivery will not be achieved and may actually lead to a reduction in regional service planning and coordination. For patients, this in turn means ongoing or increased service gaps and care pathways that are difficult or impossible to navigate.

AGPN calls on the Government to commit to a PHCO model which over time ensures PHCOs have appropriate roles and responsibilities, backed up by sufficient resources, to achieve the changes identified in the COAG Agreement.

## **Performance and monitoring of PHCOs**

AGPN supports, in principle, the implementation of robust performance and monitoring arrangements to drive greater performance and accountability across the health system. The Agreement suggests that monitoring of PHCO performance will be coordinated through the new National Performance Authority (NPA) and focused around assessment of new Healthy Communities Reports.

AGPN is concerned that this monitoring process will not provide a reasonable measure of PHCO performance unless PHCOs are given sufficient responsibility and resources to impact on population health at regional levels. As noted above, the level of responsibility and resources that will be devolved to PHCOs under the terms of the Agreement currently remains unclear. PHCOs cannot reasonably be held accountable for achievements identified in Healthy Communities Reports unless their powers and authorities enable them to achieve the outcomes and targets identified in those reports.

AGPN recommends that PHCOs are given a clear mandate for population health planning and for the development and implementation of Health Community strategies and plans that enable them to realise achievements to be measured through Health Communities Reports as outlined in Schedule D (particularly D (3)) of the Agreement.

## **Leadership and support through an independent national organisation**

In addition to national governance arrangements outlined in the Agreement, AGPN believes that supporting the effective and efficient introduction of a national Network of PHCOs and facilitating their ongoing high performance will be best achieved with leadership and support from an independent national organisation with PHCOs as its members.

The Prime Minister, the Hon. Mr Rudd MP, has announced that the new Network of PHCOs will be built on the existing national infrastructure of the General Practice Network by 1 July 2012. A transition of this scale requires national leadership and support. Such leadership will ensure the establishment of consistently high performing organisations through a timely and efficient change process. It will also help achieve 'early wins' for the new national health network by implementing best-practice approaches to population health and health service planning and promoting evidence-based models of care and innovative service re-design.

Ongoing leadership and support will be necessary to ensure:

- continual improvement and high performance across the new network of PHCOs
- the promotion and implementation of best-practice approaches to system change, health service design and workforce support
- integration of PHCOs across the health sector through national leadership, policy and representation.

AGPN has welcomed the Commonwealth's announcement through the Federal Budget 2010-11 of dedicated funding to support the GPN to transition to a national network of PHCOs. This investment is essential to support the required degree of change. AGPN understands that there is Commonwealth support for the development of a national organisation as part of the Network infrastructure to assist transition and the ongoing performance of PHCOs.

### **PHCO naming and branding**

Recent Federal Budget announcements have suggested that PHCOs will be known as 'Medicare Locals.' AGPN imagines that the intent behind this name was to convey that PHCOs were local entities with a local presence. However, this name is strongly associated by both consumers and health professionals with Medicare Australia and the current Medicare Benefits Schedule. AGPN has some concerns that this association may lead to confusion regarding the role and function of regional PHCOs and notes that it has already been a source of confusion amongst GPNs and GPs regarding the relation between PHCOs and Medicare Australia.

Further consultation with health professionals and consumers is advised to ensure that PHCOs are named and branded in a way that promotes a positive image to health professionals and consumers and does not confuse either groups understanding of the role and function of these new organisations. AGPN would be pleased to work with the Commonwealth Government to develop a branding and marketing strategy for PHCOs based on comprehensive market testing with health care professionals and consumers.

AGPN recommends that broad consultation with health professionals and consumers is undertaken to ensure PHCOs are named and branded in a way that promotes a positive

image to health professionals and consumers and clearly conveys the role of these organisations.

## **National consistency in primary health care systems**

*Relevant to: Term of reference (f)*

AGPN notes that Western Australia is not party to the Agreement and that there are a number of instances where, under the Agreement, one State retains responsibility for aspects of primary health care that have been delegated as a Commonwealth responsibility in other jurisdictions.

AGPN believes that where possible it is preferable to take a nationally consistent approach to the distribution of responsibilities between State and Commonwealth Governments. A nationally consistent approach will benefit coordination of services in the longer term and will best support a consistent national performance and accountability framework.

AGPN understand that as the Western Australian Government is not party to the Agreement, PHCOs may not be established in this State. The Commonwealth has also clearly indicated its intention to cease funding to the existing General Practice Network as of 1 July 2012. AGPN has significant concerns that this could mean that Western Australian communities, primary health care providers and primary health care professionals will not only miss out on the benefits of enhanced planning and coordination of regional primary health care associated with PHCOs, but will also lose the benefits of service coordination, professional support and direct service provision, currently provided by the Western Australian General Practice Network.

AGPN recommends that the Commonwealth and Western Australian Governments seek to work beyond the current impasse to ensure that the broad terms of the NHHN Agreement, and the benefits it will deliver for communities, can be applied in Western Australia.

If this is not achievable, AGPN recommends that the Commonwealth supports the Western Australian General Practice Network to evolve into a network of PHCOs with broad service planning and coordination responsibilities, and explores alternative ways to realise the cooperation between PHCOs and State Governments regarding State-controlled primary health care services, that will be necessary for these PHCOs to realise their objectives.

## **Projections associated with new and enhanced funding arrangements for care of patients with diabetes or in residential aged care**

*Relevant to: Term of reference (c)]*

As part of its reform announcements the Commonwealth Government has announced that it will increase financial incentives to GPs to deliver services to residents in residential aged care facilities (RACFs) through the Practice Incentive Program (PIP). The Commonwealth has projected that this will support an additional 105,000 GP services to be provided to residents of RACFs.

The aged care PIP is targeted at overcoming one key barrier to GP provision of services in RACFs – the additional cost in terms of lost income of leaving the surgery, travelling to, and providing services in an aged care facility. AGPN has concerns that for many GPs with full patient loads this incentive, like the current incentive, will not provide a

sufficient financial incentive to leave their practices and reduce their availability to provide care to patients through their clinic, particularly if their patient load within the RACF remains minimal. Recent changes to the MBS items have reduced the number of MBS items that may be counted toward incentive payments which will further reduce the capacity of this measure to achieve its objectives.

Other significant barriers for GPs to deliver services in these settings remain, including insufficient infrastructure to deliver clinical care in an appropriate setting and limited access to appropriately skilled RACF nursing staff to provide patient updates, clinical support and discuss the implementation of care plans. AGPN believes that achieving the service targets set will also require measures designed to address these barriers and will be most effectively supported by innovative approaches to brokering GP access for RACFs. PHCOs would be well placed to perform this role through the provision of locally-tailored access facilitation.

As part of its reform announcements the Commonwealth has also announced its intention to introduce a new funding system to support the provision of comprehensive care for patients with diabetes. Eligible patients will be able to voluntarily enrol with a general practice that will take responsibility for managing their care needs and be provided with an annual payment to cover the costs of doing so. Practices who enrol patients will also be able to access an annual incentive payment linked to performance and patient outcomes. The Commonwealth expects that more than 4,300 general practices will sign on to the program in its first year of operation and approximately 260,000 patients will be enrolled under the program by the end of its second year of operation.

AGPN supports, in principle, voluntary patient enrolment, however, believes it will achieve its greatest benefit in terms of patient health outcomes and system efficiency when applied to a broader patient cohort. AGPN also recognises a blended funded system, which include a mix of fee-for-service, capitation and performance incentive payments, as likely to best support greater efficiency and effectiveness in our primary health care system.

AGPN understands that it is currently intended that practices will not be able to claim other MBS items for enrolled patients, and is concerned that the annual payment to support general practice to coordinate and provide care for these patients will be insufficient to justify a business case for enrolling patients, particularly those with multiple co-morbidities and more complex care needs. This will reduce the likelihood of reaching the ambitious target of over ¼ million enrolled patients.

To ensure that the new funding approach reaches its service targets and broader goal of more effective management of diabetes within the community, it will be necessary for the Commonwealth to work closely with general practice, allied health and nursing groups to develop program guidelines that will promote broad uptake of the initiative across general practice.

AGPN recommends that to maximise the new investments to support GP service provision in RACFs and new arrangements for care of patients with diabetes:

- over time, PHCOs are provided with authority and resources to introduce locally-tailored models to support better access to GP services for residents of RACFs that
- the Commonwealth work closely with general practice, allied health and nursing groups to develop program guidelines for new diabetes care initiative to ensure broad uptake of the initiative across general practice

## Primary health care services for which responsibility has yet to be determined

Through the Agreement COAG has committed to further considering the funding and policy arrangements for a range of primary health care services not covered by the Agreement, particularly:

- drug and alcohol treatment services
- child and maternal health services
- specialist community mental health services
- community palliative care
- community health promotion and population health programs.

The Agreement suggests that these services will either transfer to the Commonwealth or be otherwise reformed.

### **PHCOs as coordinators and planners of all PHC services over time, with appropriate accountabilities**

AGPN recognises that there are aspects of these service domains that could be delivered in primary health care and/or community settings or through sub-acute 'step-up, step-down' care arrangements. AGPN believes there is benefit in carefully considering which aspects of these domains of service delivery could transfer to the Commonwealth, and, over time, be vested in PHCOs for coordination, service planning and funding. This will ensure that the benefits of PHCOs in identifying and addressing service gaps and health inequities will apply to all PHC services enabling, for example, innovative solutions to poor regional access to child and maternal health services from Aboriginal and Torres Strait Islander infants and their mothers. Critically these are all services that can offer maximum benefit to the community only when they are well integrated with other primary health care services, such as general practice, and PHCOs will be best placed to support the required integration.

Maximising the suite of primary health care services that are coordinated through PHCOs at a regional level will also provide the best vehicle for driving system-wide change and improvement. This may, for example, include uptake of new ehealth technologies or the use of continual quality improvement approaches across health care teams working together but through multiple different service providers.

Supporting these services through the nationally funded, regionally coordinated approach will have the additional advantage of driving performance by enabling the performance of these services to be monitored nationally under the national performance and accountability framework.

AGPN recommends that COAG seeks to incorporate appropriate aspects of these service domains with other related primary health care services, under the nationally funded, locally coordinated approach. Particularly, we recommend that over time PHCOs are given responsibility and authority to plan and coordinate these services, and are held accountable for performance in these areas.



## Primary mental health care

*Relevant to: Term of reference (j)*

AGPN is pleased COAG has agreed to a Commonwealth take-over of funding and policy responsibility for primary mental health care services for common mental health disorders, and that the Commonwealth has subsequently made it clear that PHCOs will be charged with responsibility for service planning and coordination of primary mental health care services. This will enable regional service planning and coordination to support better service integration and better consumer access to well coordinated, comprehensive care. Sufficient resourcing – including through programs such as Access To Allied Psychological Services (ATAPS) – will also enable PHCOs to address service gaps in mental health care and address inequities in access to services and in health outcomes.

To maximise the benefit of regional planning and coordination, it will be vital to integrate key social support programs for people with mental illness – including Commonwealth programs such as the Support for Day to Day Living program and Personal Helpers and Mentors services which provide community support and some service coordination for people with severe mental illness- with primary mental health care. This will ensure easy consumer access to services, improve the coordination and model of care, and reduce the inefficiencies associated with service duplication. The required level of integration will be best supported by, over time, investing PHCOs with planning and coordination responsibilities for these Commonwealth support services.

AGPN has also welcomed the Commonwealth Government's commitment as part of the Agreement to delivering better access to care in the community for people with a mental illness and the announcement of an enhanced Commonwealth investment in primary mental health care services.

The enhanced investment in the ATAPS program will enable services to be further developed to:

- provide access to mental health care for population sub-groups for whom there are barriers to accessing appropriate care through standard fee-for-service arrangements
- provide better access to comprehensive care in the community for people with severe mental illness.

ATAPS is a long standing program that has undergone continual improvement through local adaption and alteration informed by independent, national evaluation. Recent enhancements to the program reflect recommendations made through a recent national review to further develop the program to ensure it best complements the Better Access fee-for service program. The flexible model of service delivery supported through ATAPS has proven itself well suited to addressing service gaps at regional levels and delivering models of care suited to population sub-groups whose needs are not well met through Better Access.

AGPN also welcomes the increased investment in youth-focused primary mental health care services based on the successful **headspace** collaboration model. We are a founding member of **headspace** and have been strong advocates for the expansion of this model which has proven to be effective in supporting access by young people to mental health care and support.

We also acknowledge and welcome the Commonwealth's commitment to implement 'step-up', 'step-down' mental health care services as part of their additional investment in sub-acute care. These services will address a long standing service gap and support those experiencing an exacerbation of their mental health condition to be cared for in the community and those no longer requiring tertiary care to be supported to transition from acute services to life in the community. We are concerned, however, that mental health will need to compete with other areas of equal need for these beds eg. aged care.

To maximise the benefits of these enhanced investments it will be important to work with regional organisations to ensure services are established in communities of high-need, and to ensure that they are integrated with other primary health care services, and mental health social support programs, at a regional level through PHCOs. Again, we note that these benefits of these services will be maximised if they are integrated with other primary mental health care services at a regional level through PHCOs.

AGPN recommends that, in order to enhance access to primary mental health care:

- over time, PHCOs are vested with, at a minimum, planning and coordination responsibilities for Commonwealth-funded mental health social support services to ensure their integration with primary mental health care services
- PHCOs are consulted as key stakeholders in establishing new **headspace** sites and introducing 'step up'/'step-down' care services, and, over time these are integrated with other primary health care services at a regional level through PHCOs

## Appendix A: Terms of Reference

The key outcomes agreed by the Commonwealth Government and five states and two territories at the Council of Australian Governments (COAG) meeting on 19 April and 20 April 2010 and the process of consultation between the states and Commonwealth prior to these agreements and related matters, including but not limited to:

- (a) the new financial arrangements between the Commonwealth and states and territories over the forward estimates and the conditional requirements upon the states for receipt of additional Commonwealth funding;
- (b) what amounts of the \$5.4 billion Commonwealth funding is new spending, what is re-directed from existing programs/areas, the impact on these existing programs and what savings are projected in existing health programs across the forward estimates from these new financial arrangements, including the inputs, assumptions and modelling underpinning these funding amounts;
- (c) the projected number of additional/new services this additional funding will provide in elective surgery treatments, in emergency department treatments, in expected numbers of patients to sign up to the diabetes spending measure, in additional general practitioner (GP) treatments in aged care facilities, including the inputs, assumptions and modelling underpinning these projections;
- (d) the \$15.6 billion top-up payments guaranteed to the states by the Commonwealth in the period 2014-15 to 2019-20, including exploring the breakdown of expenditure relating to hospitals, outpatient services, capital expenditure, GP and primary healthcare, aged care and other areas of health expenditure;
- (e) the names, roles, structures, operations, resourcing, funding and staffing of any new statutory bodies, organisations or other entities needed to establish, oversee, monitor, report upon or administer the National Health and Hospital Networks, Primary Care Organisations and the funding channels to be established under the COAG agreements;
- (f) what arrangements are in place, or are being negotiated for states that have not signed up, nor fully signed up to the COAG agreements, including what contingencies have been put in place for states that may want to alter agreements in future;
- (g) the intent of the state and territory governments and their preferred number and size of Local Hospital Networks in each state and territory;
- (h) the number of hospitals which will receive: activity-based funding, block grant funding, or a mix of both;
- (i) aged care:
  - (i) the 2 500 new aged care beds to be generated by zero interest loans,
  - (ii) the 2 000 beds for long stay older patients to be established,
  - (iii) the funding for the above, and
  - (iv) the establishment of the Commonwealth Government as responsible for full funding, policy, management and delivery responsibility for a national aged care system;
- (j) mental health matters; and
- (k) any other related matter.