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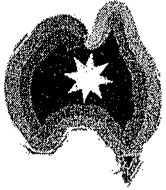

Australian Healthcare Reform Alliance

Australian Healthcare Reform Alliance

Submission to

Parliament of Australia
House of Representatives Standing Committee on Health and Aging

Inquiry Into Health Funding – Public Hearing

Sydney – Friday 26 May 2006

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Moving from a Provider- to a Patient-Focused Health Care System: The Health Reform Imperative

John Dwyer

Australians are only too well aware that their health care system is increasingly unreliable, indeed dysfunctional. Public hospitals have major problems because of ever-increasing demand, under-funding, and shortages of appropriately skilled health professionals. The essential continuum of care that should link primary, community, and hospital services is made all but impossible because of the jurisdictional inefficiencies associated with the great divide between Canberra and the states. Planned surgery is rationed, general practitioners must raise their fees to survive, and specialists' fees make it increasingly difficult for a large number of Australians to benefit from their care. Personal finances are increasingly a major determinant of health outcomes. This is not good enough for a wealthy country like Australia, particularly when the major barrier to progress is political intransigence, rather than lack of policies to address these issues. This article outlines those reform policies generated at the Australian Health Care Reform Alliance's Summit meeting of health professionals and consumers involved in this area.

Ideology

What sort of a health care system do Australians want? A broad consensus at the Australian Health Summit in August 2003, reaffirmed what most have assumed – namely that Australians want to provide health insurance to each other through payments indexed to taxable income so that timely access to quality health service is available universally on the basis of need, not personal financial circumstances. It is true that at no stage has Australia perfected a system based on these principles, but until the last 10 years, the nation was certainly moving well in that direction, and was committed to doing so. Now an obvious ideological divide sees Australia at a crossroads.

By contrast, the conservative Australian government is, through both its words and, more importantly, its actions, comfortable with the concept of government providing its definition of a safety net to help less economically advantaged Australians, while the rest move increasingly to supporting their own health care in a 'user pays' system.

Critics of a universal scheme, which advocates equity of access and outcomes for all Australians seeking health care, claim that the model is utopian. That argument, however, will only be worthy of debate when the obvious efficiencies that could so markedly improve quality and cost-efficiency have been implemented. There is between $2–4 billion to be saved annually in ridding the country of unnecessary duplication and creating a system that would be far more successful in preventing illness.

Towards a Patient-Focused Integrated National Health Care System

Space does not permit a discussion here of the numerous and obvious major health-related problems that urgently need to be addressed. Australia's mental health care programs are grossly inadequate, the Indigenous population continues to have disgraceful health outcomes, there is an urgent need for a national dental health scheme, and far more attention should be paid to the health care needs of Australians with disabilities. There is much that can be done to improve quality and safety, with an excellent first step being the introduction of modern information technology into the health care system. What follows, however, is a discussion of the four main areas of reform required to facilitate improvements in all these areas. They are the federal-state divide, workforce issues, primary care and hospitals.

1. Bridging the Federal-State Divide

Australian consumers, of course, are only too well aware of the constant bickering between the state and federal governments over who is responsible for the problems in the health care system. Under the Australian Constitution, the federal government can purchase health care for its citizens, but not provide it directly. This they do through a

variety of arrangements, such as the Medical Benefits and Pharmaceutical Benefits schemes. The federal government contributes tax dollars to the states to help them with their health care responsibility, namely the running of public hospitals. The Prime Minister has acknowledged that, if policy makers were to start from scratch to design a new Australian health care system, they would not do it this way again. The federal Health Minister, Tony Abbott, has described the current arrangements as a 'dog's breakfast of a system'.

Within the current system, consumers' needs are often neglected in the constant efforts of state and federal governments to 'cost-shift' various sections of their health care portfolios to each other. If the Commonwealth government supplies too few nursing home beds in a particular area, a local public hospital may find itself unable to discharge patients who no longer need an acute care bed. This increases the hospital's cost and decreases its efficiency. On the other hand, many public hospitals are loath to continue to offer specialist out-patient clinics, preferring patients to seek such help outside the hospital, wherein the federal government would be required to pick up the Medicare costs involved.

For these and many other reasons, no single reform is more important than developing a mechanism by which the country can have a single source of funding for the planning and implementation of the health care system needed by contemporary Australia. Fundamentally, such reforms are crucial and will require considerable political leadership to achieve them. They must involve the pooling of all federal and state funds for redistribution by one planning authority that acts in a patient-focused manner to ensure that health care is targeted, integrated, fair, and cost-effective.

The pooling mechanisms could be played out in one of three scenarios. First, the states could relinquish all responsibility for running hospitals, with the federal government taking responsibility for the national health care scheme. This would certainly remove the inefficiencies discussed, but constitutional issues make it difficult, as it would require a referendum to seek approval from Australians. In the current climate, it is unlikely that the states would willingly hand over all of their hospital funding to the federal government.

A second scenario would see the reverse happening, with Canberra providing the states with all of the dollars it currently spends on health, and the states offering a full range of health care services to their citizens. This is close to the model the Labor Party proposed at the 2004 election with talk of a Medicare partnership between all states and the federal government.

The third model would see pooled funds made available to a third party; for example, an Australian Health Care Corporation that would be owned by Australians, but not by either state or federal governments. The Corporation would have a board with very heavy consumer involvement and report to a governing body of state and federal political leaders. This latter model has many attractions, including the abolition of current inefficiencies associated with health care provision across state borders. In reality, current political tensions make it necessary for those who advocate such a model to accept that Australia must immediately embark on a journey toward a single source of funding, starting with individual states and the Commonwealth agreeing to pool funds. Such trials could be regarded as experiments, with lessons learnt continuously improving the model and perhaps attracting other states to embrace a similar approach. Australians must not let this essential reform remain in the political 'too hard basket'. Recent and significant improvements in the provision of health services in both the United Kingdom and New Zealand were made possible because these countries have all their health care dollars in a single 'pot'.

2. Addressing Workforce Shortages

The nation already has a major shortfall in the number of skilled health professionals needed to prevent illness and deliver health care to Australia's communities. So often now, governments find themselves in the media spotlight, as headlines detail the lack of

beds available in public hospitals. Governments typically react by providing additional monies to correct the situation, only to find there are no nurses available to utilise that money and open hospital beds. The average nurse in Australia is 47 years old. It is increasingly difficult to attract young Australians into a profession wherein, at least in hospital-based service, shift work is inevitable, and daily duties are intellectually and physically demanding. Remunerations and conditions must be made attractive to those who are drawn to this vocation, and Australia needs at least 1,800 more places for nurses in the country's universities.

A number of issues need to be addressed urgently. These include insufficient numbers of doctors due to the increasing casual nature of the medical workforce; misdistribution of the workforce; and increasing reports of professional dissatisfaction, which might deter young people from a medical career. The current reliance on doctors trained overseas is troublesome for a number of reasons. It is clearly preferable for a doctor not only to be skilled in the science of medicine, but also to be culturally attuned to the patients for whom he or she must care. This is obviously far easier to achieve with health professionals trained in Australia to care for Australians. Looking at a very significant proportion of doctors imported from developing countries, one must stop and query the ethics of trying to solve Australia's workforce problems with professionals who are even more urgently needed in their home countries.

Allied health professionals are also in short supply and this is particularly true in the public sector because remuneration for such professionals is now very much more attractive in the private sector. Until pharmacists, radiation technologists, physiotherapists, and others are paid the same amount they would earn working outside the public health system, Australia is not going to solve the current shortage and all the problems in terms of quality, safety, and efficiency, that that generates.

The federal government must commit itself to ensuring that Australia is self-sufficient in the provision of its health care professionals within six years.

3. Remodeling Primary Care in Australia

The recent senate Inquiry into problems surrounding the Medicare system missed a golden opportunity to ask, "What does contemporary Australia need from its primary health care professionals that they are not currently receiving?" Rather, the senators dealt with the less important issues of what remuneration would be made available to general practitioners. If the above question had been addressed funding models could have been generated to ensure that Australia's primary health professionals can meet those needs.

Two much-needed reforms will require the remodeling of primary care. The first demands that much more emphasis be placed on preventing illness. The second necessitates the restructuring of primary health care so that doctors can care for many patients in a community setting who are currently being sent to hospitals. Bulk-billing rates are very important to Australians, with consumers only too well aware that it is the quality of the service that one receives from his or her doctor that is all-important. Needing to pay out-of-pocket after a ten-minute consultation that has not satisfactorily addressed one's health care needs is a source of frustration for anyone in that situation.

In the delivery of primary health care, the Australian system is becoming increasingly less fair. In many poorer socioeconomic areas, doctors have little choice but to bulk-bill. When pressures force them to attempt to ask for co-payment, we know that a number of patients will stay away from the doctor's surgery. The situation exists where, in some areas, doctors have to make their income through the volume of services they provide, whereas elsewhere, where the average person can readily afford a co-payment, doctors can provide a better quality service. This means that, increasingly, those Australians whose lifestyles are putting them at risk for the development of major illnesses and who need the most quality time with their doctors often receive the least. This is why epidemiologists report that Australians in poorer socioeconomic suburbs are five times more likely to die prematurely of a preventable disease that those in wealthier suburbs.

The divide is even greater between country and city, and far greater between Indigenous Australians and other Australians.

Australia needs to explore alternative models of remunerating general practitioners so that these difficulties can be overcome. To do so, the country must experiment with programs that see a move away from the exclusively 'fee-for-service' payments that currently characterise the primary care system. This involves exploring, as other countries have done and are doing, the appropriateness in contemporary Australia of offering general practitioners up-front payments—'contracts' to care for patients with chronic and complex diseases, with such remuneration making it possible for them to look after patients at home rather than sending them to hospital. This is the ultimate solution for addressing the hospital crisis.

This model of care, however, requires another major development. Doctors need to be part of primary health care teams where health care professionals, such as specialist nurses and other allied health professionals, are available to provide many of the services currently provided by doctors. This means extending Medicare payments to health professionals other than doctors. The primary health care team would focus on personal needs of the patient and pay a considerable attention to individual health plans to help people prevent illness.

Only part of a general practitioner's work needs to be remunerated in this way, with a number of standard services continuing to be available through a 'fee-for-service' mechanism. In New Zealand, such a system exists and, without any coercion, 80% of general practitioners have embraced such a model of care. Seventy-five per cent of New Zealanders are now registered patients of primary health care teams. Hospital admissions have fallen, and a genuine partnership between hospitals and doctors has emerged. Many general practitioners in Australia have already indicated their enthusiasm for trying such modeling. The major stumbling block is that federal and state governments must pool funds to allow the appropriate business plans to be developed.

There is a corollary to such modeling that is all-important. Currently in Australia, the majority of patients do not have one doctor to conduct their health care orchestra. The concept of a family doctor is fading. There is also little discussion of the mutual obligation Australians have to each other to pay attention to staying well, given that someone else's tax dollars will support them when they are sick. The concept of 'minimal obligation', which may be no more than the need to be a registered patient of a primary health care team that would provide specific advice on lifestyle, would be an all-important development from such remodeling of primary care.

4. Hospitals

Particularly in recent years, there has been insufficient political honesty about problems within the hospital system. Many consumers feel that no matter which public hospital they attend, they will find a broad range of services available, including those for the management of emergencies, and that all these services will be of similar quality. Given the workforce situation, this is certainly not true and, indeed, is never likely to be true. Nothing is more important in Australia, in terms of improving quality and safety, than exploring with the public the reality that role delineation for individual hospitals will ensure that the services they do offer, although not the full range, are of the highest quality. Hospitals should be networked so they create, in a given region, 'a string of pearls,' with each hospital offering programs of excellence where the workforce skill mix is available to do the job properly. Certainly, no matter where an Australian enters the hospital system, they should be triaged and assisted in moving to a facility that does have the capacity to care adequately for their current problem.

Increasingly, evidence suggests the benefits of this 'centre effect'. If a person requires a major gynaecological cancer operation, for example, that surgery should be performed in a centre where an extensive team of experts can provide the patient with world's best practice. To provide such quality, it is necessary to restrict the service to a very small number of sites. Consumers understand that while services they access frequently (e.g.,

dialysis three times a week) need to be provided close to home, for those once-in-a-life major events, geography is far less important than quality.

Even if Australia had the appropriate number of health professionals, the opening of additional public hospital beds so critically needed at the moment is not the ultimate answer. The primary care remodeling discussed above will provide the best solution for the pressure on the country's hospitals, a pressure that sees Australia operate more hospital beds per capita than any other OECD country.

Current data proves beyond doubt that the almost $3 billion tax dollars used each year to support private health insurance does not achieve the goal of relieving pressure on the public hospital system. Private hospitals provide a range of very different services to those that place pressure on public hospitals. The vast majority of emergency department services in Australia are only available in the public sector. Most sophisticated tertiary and quaternary services are again only available from the public hospital system. The federal government has consistently confused increased activity in private hospitals (not in itself a bad thing) with a reduction in pressure on the public hospital system. What is needed is a genuine partnership between private and public hospitals, with considerably more of the private health insurance dollar going directly to hospitals rather than to third party payers. With appropriate leadership, policy makers can do far more to promote synergy and collegiality between private and public sector hospitals.

The Way Forward

At the Health Care Summit, delegates agreed unanimously that the federal government should immediately establish an Australian Health Care Reform Commission. The Commission would be composed of leading policy bureaucrats from state and federal departments of health, experts in change management, and clinical and consumer leaders. The job of the Commission would not be to generate policies, but to work on implementation strategies (e.g., if state and federal funds are to be pooled, how can historical rates of spending be determined?). By its very nature, this would be a collaborative effort between state and federal governments, the bureaucracy, clinicians, and consumers.

Crucial to both achieving and sustaining reform is accelerating the development of 'first among equal' partnerships between front line clinicians and consumers. Of course, consumer representation on committees making major decisions about the future of our health system and its components is essential. Numerous studies have highlighted the constructive nature of such involvement. Consumers need to understand better the workings and structure of our current health system while clinicians and administrators need to continually focus on the often rapidly changing health needs of consumers. In the past, consumer participations could have been described at best as 'tokenism'; now however, we must have consumer involvement fully integrated into policy deliberations. Informed consumer are best placed to explain to a concerned public why it is that so many changes need to be made to the way we prevent illness and deliver health care in this country.

Without the best brains available coming to work every day to work diligently on the reform agenda, it is hard to imagine progress being made with these urgently needed reforms. Of course, the first step involves a degree of political leadership and courage to make this happen. That courage should be boosted by consistent polling, which makes it clear that there is no domestic issue as important to the Australian community as restructuring and improving the health care system to provide Australians with the care they want, very much need, and can afford.

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Do we have any chance of curing the ills that plague our health care system?

Only if Australians speak up indeed get angry at the lack of health care reforms urgently needed

After the last Federal election, the Productivity Commission echoed what health professionals and informed consumers were saying before the election, namely that the current costly dysfunction that is a by product of the wretched jurisdictional inefficiencies that have State and federal Governments responsible for different sections of our health care system , is intolerable and must be addressed. Minister Abbott, after examining the intricacies of his knew portfolio described what he saw as a "Dog's breakfast of a system"! The Prime Minister admitted that were we starting over with a clean slate we would never organise health care delivery using the current model.

All well and good but health care reform to solve this problem was promised by all parties 15 years ago .We continue to wait with needed reforms still buried at the bottom of the politically too hard basket.

In response to the Productivity Commission's urgings the Prime minister asked Andrew Podger a senior and respected bureaucrat with much health care administration experience to review the situation and suggest possible solutions. This apparently he has done as a "closed door" exercise consulting neither that States nor the community. While leaks to the press have been devoid of sufficient detail to allow constructive comment the emphasis on opening up to competion the provision of services purchased for Australians by the Australian Government is not encouraging and does not address the basic problem No reform process can ignore the integration of the country's hospital and primary care systems.

The favoured suggestion from the Podger review will be presented to Premiers and the community at the June 3rd Council of Australian Government (COAG) meeting. A gathering which has the potential to disintegrate into chaos with a walkout by Premiers not an unlikely scenario. Disquiet about Federal pressure to remove state taxes to receive GST payments and the lack of consultation about health care reform could fuel such a destructive outcome We need to make it clear now that such an outcome would be greeted with public disgust for the issues on the table are too important for "grandstanding" political gestures. We must have progress on healthcare reform.

The COAG meeting should provide the staring point rather than the finish line for serious attempts to improve our health care system so that Australians can benefit from a fairer, better, contemporary and cost effective approach to supporting the health of the nation. The Podger suggestions would be included in that debate.

Needed reforms are not a matter of "tinkering at the margins" of a basically excellent health care system. Major changes are needed and one can report without fear of controversy that three major adjustments would provide the structure from which could flow the improvements to specific programs such as mental health, indigenous health and the care of those with disabilities.

The first involves a new governance model to solve the State/ Federal divide described above. At the end of the reform process we must have a system in which one set of brains controlling one pot of public money can provide for Australians an integrated seamless health

care system. The Prime Minister commented recently that centralised care from Canberra could not involve hospitals as the community would not want these institutions run remotely. No major reform would envisage such a scenario for a unified State /Federal effort would of necessity divide Australia into sensible health care regions managed by local authorities removing the current state boarder inefficiencies. Two to four billion dollars could be saved each year by the massive reduction in duplication and the size of the current bureaucracy.

The second area of major reform involves addressing our work force crisis made all the harder to accept when there is no plan on the table to see Australia self-sufficient in the supply of its health professionals. The average age of Nurses is forty seven years and to sustain this profession we need 1800 more places for Nurse training in our Universities. The Qld Government has announced a major enquiry into the scandal that alleges patients in Bundaberg were cared for incompetently by an overseas trained surgeon who had been denied the right to practice in another country but was able to practice unsupervised in our country because of the desperate shortage of Australian trained doctors. We need at least 800 more places for medical students in our Universities. Similar problems beset many Allied Health training programs. Dependency on the importation of needed health professional poses major quality, ethical (many are from third world counties who need them far more than we do) and cultural problems and is not acceptable as a long term strategy.

The third major reform would see us reorganise our primary health care system to emphasise prevention of illness, the earlier diagnosis of disease and the capacity to care for some patients in community settings who currently are dispatched to swamped public hospitals. Reform here would no doubt see the creation of Primary Care teams in which a number of different health professions working as a team would integrate your care. Medicare benefits would be available to team members and flexible arrangements would be possible so that GP's for example could elect to work on contract rather than depend on "fee for service" arrangements. This would in turn allow doctors to do what only doctors can do and that would include caring for sicker patients in the community or in hospital a model that, in Metropolitan areas at least, has disappeared.

How much better to have GP's rather than itinerant "locum" physicians helping with our shortage of hospital medical staff? This is an approach that is producing excellent results in New Zealand where 80% of GP's provide part or all of their service on a contractual basis. The improved predictability of costs involved in care provision is a major request from treasuries all over the world. Without such reforms the cruel rationing of planned surgical services forced on hospitals because of demands from the acutely ill will continue to worsen with increased suffering for many and increased costs for all tax-payers. Care while on a "waiting list "is very expensive.

Around the world many countries have recognised that primary not hospital care should be the major focus for any modern health care system. Canada, New Zealand France and Sweden are but a few of the countries that have seriously addressed this issue. In the United Kingdom the Blair Government has just announced a major change in direction for the UK National Health Scheme. In their very important paper "Choosing Health"they have agreed to a major restructure to place appropriate emphasis on Primary Care.

Importantly the UK Government made a serious effort to involve the community in designing the reform agenda asking people what they wanted from their health care system in what the called" The Big Conversation.". Canada and Sweden are two countries that have recently engaged in the same process of community consultation. We need to do the same in our country and urgently at that .Perhaps the "Citizens Juries" approach used with success in

Western Australia could be expanded to help with the consultation.. Ideally we believe the Federal Government should establish a Health Care Reform Commission to control the entire process but as that is unlikely to occur and the issues are urgent we will facilitate the engagement.

In a "Big Conversation" with Australians we would be asking ourselves very important questions the answers to which would provide direction for necessary reforms. Do we want a health system where increasingly users pay for their care with less and less government (Tax payer) support with a safety net for those of us defined by Government as poor and incapable of climbing the ladder to self sufficiency? Alternatively would we prefer to keep and strengthen a system where access to a quality service in a timely fashion is available to all on the basis of personal need not personal financial well being? Are we willing to pay for such a system with tax dollars used to insure each other? Does such collective largesse impose on us as individuals any obligation to pay attention to our health? If the answer is yes would we be willing, as is the case in other countries, to have Government supply us with maximum Medicare benefits only if we were registered patients of a primary health care team who would help us avoid risks to our health? Is the nature of the way we care for each an important element in how we judge what modern Australianism is all about? Do we wish our Government to use our wealth to supply more services and smaller tax cuts? Do we want to see develop a genuine partnership between public and private health care sectors? The ignorant indeed quite ridiculous suggestion from the Productivity Commission that privately insured patients should not be allowed to use public hospital reveals how little is understood of the need for a genuine partnership that would emphasise role delineation not duplication.. Every Australian may need the sophisticated highly specialised services only available (and appropriately so) in our major public hospitals..

Health care in Australia is overly bureaucratised and hospital centric. Indeed we have more hospital beds per capita than any other country on earth? Sadly we need every one of them as we have not provided sufficient attention to prevention and care in the community rather than in a hospital. The doomsday scenario presented recently by the productivity commission in which in the near future we will need to spend trillions of dollars to care for very sick very old Australians may become a reality if we continue to do no more than pour more money into a highly dysfunctional system. With the necessary reforms in place it is realistic to envisage a future with more healthy and productive older Australians than ever before, fully enjoying the extra years of life that will be commonplace....

So how do we overcome the political intransigence that has stopped us from being as successful as other countries in modernising healthcare? Only by demanding that all governments commit now to a bipartisan program in which there is the widest possible consultation over a brief but defined period of time with the conclusions reached to become national policy.

To this end the Australian Health Care Reform Alliance (AHCRA) composed of more than thirty responsible professional and consumer organisations speaking with one voice on major reform issues will hold a second national health care reform conference in October .at which fully developed plans for reform in the areas discussed above will be presented to government and community. Between now and then AHCRA will engage Australians in our version of "The Big Conversation" to determine current community attitudes to health care.

While that process is underway we have suggested to all health ministers that it would be most constructive for them to allow us to utilise the skills and experience of their senior policy bureaucrats in state and federal departments of health as we include them in working parties bringing together the best available experts to address the major reform issues. Australians would no doubt welcome such a mature apolitical approach to achieving progress at last. . The community forums would provide information to steer the thinking of the working parties.

Pie in the sky? Perhaps but at this stage we are cautiously optimistic that we will have State and Federal support for the process. We will of course invite the media to help us with our conversation and request that politicians from all parties, State and Federal participate in our public discussions. With such wide community participation, bipartisan support and the deliberations of the best students of contemporary health care initiatives surely we would at last find the system that is right for 21st century Australians. We would then challenge our political leaders as never before to deliver to our country the health care system we need, can afford and most certainly deserve.

EQUITY AND ECONOMICS ARE BOTH IN TROUBLE AS AUSTRALIA FAILS TO RESTRUCTURE IT"S DYSFUNCTIONAL HEALTHCARE SYSTEM.

WILL FRIDAY"S COAG MEETING PUT US AT LAST ON THE ROAD TO REFORM?

The dysfunction that unfortunately characterises Australia's current healthcare system is acknowledged by all our governments and troubles them. They have inherited a "Dog's breakfast of a system"(Tony Abbott) in which the wretched jurisdictional inefficiencies associated with the Australian Government buying us Primary Care while the States provide us with hospitals has, to date, produced an insurmountable barrier to cost effective integration of the numerous State and Federal programs that should belong to one world. So it is that 23 million people in the most homogeneous of countries have nine departments of health and more than 6000 bureaucrats spending 9.5% of our GDP on programs that are increasingly inequitable and cost ineffective. Solutions are but a handshake away but sadly the leadership that should rise above politics to produce the trust and cooperation needed for that handshake continues to elude us.

The Productivity Commission has warned of the cost, in terms of both health and dollars, associated with our failure to address these problems, concerns which have been verbalised by professional and consumer organizations for many years. In response the Prime Minister asked respected bureaucrat Andrew Podger to look again (he did the same exercise ten years ago) for solutions. The deliberations of his team, a closed door affair, have not been released but Cabinet has, we believe, considered them and its conclusions are due to be announced to Premiers and Chief Ministers at Friday's COAG meeting. It is of concern that in recent days the Prime Minister has challenged Premiers to table their own solutions perhaps reflecting the reality that since Podger did not look at the hospital/community interface his conclusions can only be of limited benefit.

Rumours abound that the Howard government will work to extend Private Insurance to cover ambulatory care and that those who avail themselves of that opportunity would not need to pay a Medicare levy! The first part of the plan may have merit depending on how it is structured but the second would signal a major ideological swing away from the concept of tax dollar funded universal health insurance. Given these rumours (trial balloons?) and data telling us that health outcomes are increasingly related to personal financial well being we may well have reached an ideological crossroad. Down one-path lies the continuance and strengthening of a system dedicated to providing quality care in a timely manner to all Australians based on need not the ability to pay; we all share the burden. The other road leads to a two-tiered system characterised by a "user pays" approach while government cares for the truly disadvantaged. If this is so then it is urgent that Australians be asked to clearly define the philosophies they wish to see underpin their healthcare system into the future.

In recent times many countries struggling with the need to bring their health systems into line with contemporary needs have asked their citizenry for their views? Canada, Sweden, France and the UK are but some of the countries engaging in such a democratic exercise. Given that health is so inextricably related to both individual and community health and productivity, few issues are more important for a society to contemplate. From such a process the Blair government felt it had a community imprimatur to swing the NHS around to maintaining wellness, a philosophy driving the reforms in the white paper "Choosing Health"

The Australian Healthcare Reform Alliance (AHCRA), the largest coalition of professional and consumer organizations championing the need for reform, have voiced this opinion in letters written to the Prime Minister and Premiers ahead of their Friday meeting. In addition we have put forward a plan to break the decades long impasse that has seen healthcare reform buried somewhere at the bottom of the politically "too hard" basket.

On Friday the Podger review should be released to Premiers and the community for detailed analysis and comment. That should signal the start of six months of intensive and collaborative work to develop solutions in four major areas. These solutions would be developed by unique taskforces who would at the end of that period present their suggestions to a special meeting of all Health ministers. Premiers and the Prime Minister should, in the national interest, agree that these taskforces would have available to them relevant policy experts from BOTH State and Federal bureaus. Working with frontline health professionals, academics involved in relevant research and consumers they would tackle four major issues the importance and primacy of which are beyond controversy.

We must restructure and resource Primary Care so we too can "Choose Health". We must develop and implement a plan to see our wealthy first world country train our own healthcare professionals. All too often we steal professionals from third world countries who need them far more than we do. Our work force situation is critical with the much publicized and tragic case of an incompetent surgeon wreaking havoc in Queensland bringing home to us all the need to be self-sufficient. We must solve the inefficiencies associated with the jurisdictional divide and a taskforce could work on developing a journey towards a destination where one bureaucracy with one pot of dollars extracts as much health from them as possible. Undoubtedly this journey should start with a series of bi and tri lateral agreements between the Australian and State Governments. Finally given the enormous rewards in terms of safety and quality, we must accelerate the introduction of an electronic national health record.

Such a collaborative process could fail but no other approach has any chance of success, it has never been tried and Australians, we feel, will be as disappointed as we will be if our leaders shun such an opportunity. These think tanks and an in depth conversation with the Australian people could see us at last develop a popular, sustainable, cost effective, pro health program that could see us triumph over the potential problems associated with our aging and desire to afford the best that Medicine will offer us into the future.

Primary Care – Challenges and Recommendations

Australian Healthcare Reform Alliance Principles

- Modern health care systems should be designed to maximise the utilisation of health promotion and preventive strategies and those that allow early diagnosis and treatment to minimise the development of chronic disease.

- Health care systems should provide support so that individuals can maximise their own health.

Primary Health Care and Primary Care – Let's be clear what we are talking about

Primary health care

Primary health care, as defined in the declaration of the **Alma-Ata International Conference on Primary Health Care** in 1978, is "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self-determination.

> *"It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process."*

Primary care

Primary Care is a component of Primary Health Care and can be defined as:

> *"the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practising in the context of family and community."* (Institute of Medicine 1978, WHO 1978)

Features of Primary Care

There are four main features of primary care services

- First-contact access for each new need
- Long-term person-focused (not disease-focused) care
- Comprehensive care for most health needs
- Coordinated care when care must be sought elsewhere (Starfield 1998)

Benefits of Primary Care

A greater emphasis on primary care in Australia can be expected to

- Lower the cost of care
- Improve health through access to more appropriate services
- Reduce the inequities in a population's health. (Starfield et al, Milbank Quarterly 2005; 83: 457-502)

Why we need strong primary care

The reasons we need strong primary care are obvious.

Primary care is the basis of any good health system.

Strong primary care is the only way we will be able to effectively contain rising health care costs, especially through support for preventive care, health promotion and improvements in chronic disease management and the management of co-morbidities.

Strong primary care is the only way we will be able to effectively manage the health care needs of the increasing proportion of elderly people in our nation.

Strong primary care is the only way we will be able to take the pressure off our hospitals and emergency departments.

Strong primary care, especially through teamwork between primary health care professionals, will enable us to tackle the workforce shortages affecting health care provision across Australia.

Strong primary care is the only way we will be able to effectively address the continuing rise in mental health problems affecting our population.

Strong primary care is the only way we will be able to effectively tackle the epidemics of both communicable and non-communicable diseases affecting our populations. This includes cardiovascular disease and cancers and also new and emerging diseases.

Strong primary care will also enable us to ensure that high quality health care is available to all people in Australia, including those who may be disadvantaged. This includes many aboriginal and Torres Strait Islander people, many people living in rural and remote Australia, people with disability, especially those with intellectual disability, people from culturally and linguistically diverse backgrounds, people on low incomes, people with mental health problems, people who are homeless, people who are refugees, people seeking asylum.

Social determinants of health
In designing primary care systems we need to recognise the connection between social determinants of health and prevention and health promotion.

Socio-economic factors are some of the strongest influences on health. They cannot be ignored.

Behaviour change programs often fail to reach lower socio-economic status groups.

Lower socio-economic status groups often have less access to preventive health programs.

Solutions

National Health Care Policy

Australia needs an agreed National Primary Care Policy and an accompanying strategy to allow strong planning for the future.

Governments need to work together to ensure access to primary care services by all people in Australia. Australia needs national coordination in primary health care and shared responsibility by the Australian, state and territory governments.

National coordination

Australia needs to break down the barriers between federal and state and territory funded health services.

These barriers can impede quality care and can mean that our patients are at risk when they cross barriers in our health care system. This was brought out in a paper released in the international journal Health Affairs this month showing that 36% of patients with serious health problems in Australia reported poor discharge coordination accompanying their discharge from hospitals back into the care of their general practitioners, and 23% reported the failure of hospitals to make arrangements for follow up doctor visits.

Ensure sustainability

Australia needs our governments to work with health professionals and the community to strengthen our system of primary care.

We need our governments to heed the evidence for supporting investment in primary care and to appreciate how this investment will result in longer term savings.

We need to ensure that primary care remains viable and sustainable.

Implementation of primary care policy requires adequate resourcing. Funding of primary care services should be on a sustained basis rather than one-off provisions.

Policy needs to be applicable and adaptable to local circumstances resulting in a diversity of locally applicable models.

Research and evaluation need to be integral, ongoing features of our primary care system.

Community engagement

Community engagement is an essential component of primary care policy development

We recommend community engagement and involvement in decision making about primary care reform at all levels.

Ensuring equity

Measures are required to ensure equity of access to a reasonable range of primary care services by all people in Australia.

We need to ensure that our primary care services have a focus on meeting the needs of those who belong to specific populations which may be at higher risk or which may encounter barriers to access.

To this end need to support the examination of new models of integrated comprehensive primary care provision, especially to ensure equity of access and that high quality primary care is available to all people in Australia.

Safety and quality

We need to ensure the continuing quality and safety of our system of primary care and that all players, including consumers, work together on improvements.

We need to ensure the standards of the quality of care provided in each location where primary care is delivered in Australia. This requires increased support for:

- the quality use of medicines
- the management of complex co-morbidities
- the rational use of pathology

Quality care takes time

Our governments need to recognise that primary care services, including preventive care and health promotion and improved chronic disease management and the management of co-morbidities and mental health care, all take time

Our current systems of health care remuneration do not reflect the need to value sufficient time with patients. MBS reform is required to support longer consultations.

Workforce

We need to support our primary care workforce, including supporting them to maintain their morale and their yearning for excellence; and we need our governments to support and grow our primary care workforce and support multidisciplinary teams and groups.

We recommend governments value our primary health care practitioner workforce. They need appropriate levels of recognition and reward and support.

We need to ensure the standards for education and training and registration and continuing professional development of all members of our primary care workforce. We need to ensure that we are able to attract the brightest and the best of our young people to work in primary care.

There is strong evidence that happy doctors are better doctors, and the same applies to other health professionals. Our communities cannot afford to lose health professionals who would otherwise continue working in primary care providing high quality care.

Support for multidisciplinary teams and groups in primary care needs to includes evaluation of other professionals who may join primary care teams of health professionals. The teams can include other medical specialists, diabetes educators, exercise physiologists, and professionals with specific roles in health promotion.

Respect for the breadth of primary care

We must maintain the generalist skills of our primary care workforce. This includes our skills at prioritisation of health care problems. We must embrace and celebrate the breadth and strength of primary care in Australia.

Health promotion

Our governments need to recognise that health promotion and preventive health care are core components of the work carried out in primary care.

Funding models need to support preventive care and health promotion. All health promotion campaigns should include a component of how they will be linked to primary care provision, especially to hard to access groups.

Wellness approach

We need to ensure that our primary care system supports individuals to maximise their own health.

Governments need to examine how we can fund wellness models of health in our communities as well as illness models of health.

Oral health

We need a focus on oral health reform

Governments must ensure timely access to public funded services for those who cannot afford or access private services.

Mental health

We need to continue a strong focus on improving our primary care mental health services.

This has been an area of significant neglect in the past

Financial savings

We need to heed the evidence for supporting investment in primary care and how investment will result in longer term savings

We recommend substantial increase in investment in primary care by the Australian Government, States and Territories.

We recommend government-funded programs in primary care are better coordinated with less bureaucratic red tape and more focus on the services being delivered and the resulting health outcomes and more support for local models to be developed to meet local community needs.

Infrastructure reform

We need evaluation of new infrastructure models to deliver primary care especially to populations which experience access difficulties

We recommend continued support for trials of new models of integrated comprehensive primary care provision – may be mix of private/public, and may include non-fee-for-service models

- **NSW Integrated Care Model**
- **Victoria model of primary care partnerships**
- **One stop primary health care shop**
- **Cape York model**
- **Wellness Clinic Model**

Integrate primary care throughout our healthcare services

Primary care should be an integral part of all health care – including tertiary care (e.g. nurses providing primary care with attention to health promotion and preventive care to patients in surgical wards)

Benefits of new technology

We need to examine the potential benefits that new technology, including e-health solutions, may bring to improving the quality and safety of our nation's primary care services.

We need to ensure our primary care health professionals have ready access to the best available evidence to support clinical decision making. This includes support for access to sources of clinical evidence and access to key patient information through shared electronic health records.

Capacity to adapt to new challenges

There are many exciting advances in primary care just around the corner.

The impact of genomics will surely have a major impact on primary care in ways none of us can predict. In the words of Professor Keith Williams from the Human Genome Project:

> *"The (mapping of the) human genome was just the end of the beginning."*

Information technology will have a major impact in supporting improvements in the safety and quality of the care we provide.

Evidence-based health care will continue to develop and guide our clinical decision making.

Conclusion

All these initiatives will depend on strong primary care if the benefits are to be shared by all the people of our nation.

While implementing each of these and other innovations, we must ensure that equity of access remains a fundamental principle of strong primary care in Australia.

Primary Care – summary of discussions

Government initiatives
We commend Australian and State and Territory governments on their commitment to primary care and their work towards developing new multidisciplinary models of primary care.

We know you have acknowledged that better targeted investment in primary care will lead to improved health of all people in Australia and long term reductions in health care costs.

We know that you recognise that strong primary care services will take the pressure off our hospitals and emergency departments.

Features of primary care
The main features of primary care services include:

- First-contact access for each new need
- Long-term person-focused (not disease-focused) care
- Comprehensive care for most health needs
- Coordinated care when care must be sought elsewhere.

Models of primary care
Whatever we do needs to be within the context of wider population health needs and addressing social determinants of health. New models need to deliver primary care especially to populations which experience access difficulties, and need to have community ownership and control.

New models need to based on multidisciplinary care teams that are either co-located or as networks of health providers.

There needs to be a "tight/loose" approach to governance

- Tight on outcomes expected by the funder
- Loose on how local community develops models to best meet local needs.

We recommend government-funded programs be well coordinated with minimal red tape and a strong focus on the services being delivered and the resulting health outcomes.

Australia needs to break down the barriers between federal and state and territory funded health services.

These barriers can impede quality care and can mean that our patients are at risk when they cross barriers in our health care system. This was brought out in a paper released in the international journal Health Affairs this month showing that 36% of patients with serious health problems in Australia reported poor discharge coordination accompanying their discharge from hospitals back into the care of their general practitioners, and 23% reported the failure of hospitals to make arrangements for follow up doctor visits.

Benefits of primary care
A greater emphasis on primary care in Australia can be expected to

- Lower the cost of care
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(Starfield et al, Milbank Quarterly 2005; 83: 457-502)

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Primary care is the only way we will effectively manage the health care needs of the increasing proportion of elderly people in our nation.

Primary care is the only way we will tackle the workforce shortages affecting health care provision across Australia, especially through teamwork between primary health care professionals.

Primary care is the only way we will effectively address the continuing rise in mental health problems affecting our population.

Primary care is the only way we will effectively tackle the epidemics of both communicable and non-communicable diseases.

Primary care is the only way we will ensure that high quality health care is available to all people in Australia, including those who may be disadvantaged.

Social determinants of health
In designing primary care systems we need to recognise the connection between social determinants of health and prevention and health promotion.

Socio-economic factors are some of the strongest influences on health. They cannot be ignored.

Behaviour change programs often fail to reach lower socio-economic status groups. Lower socio-economic status groups often have less access to preventive health programs.

Any reform must ensure equity
Measures are required to ensure equity of access to a reasonable range of primary care services by all people in Australia.

We need to ensure that our primary care services have a focus on meeting the needs of those who belong to specific populations which may be at higher risk or which may encounter barriers to access.

To this end need to support the examination of new models of integrated comprehensive primary care provision, especially to ensure equity of access and that high quality primary care is available to all people in Australia.

Solutions

Health promotion and preventive care

We need our governments to recognise that health promotion and preventive health care are core components of the work carried out in primary care.

Funding models need to support preventive care and health promotion. All health promotion campaigns should include a component of how they will be linked to primary care provision, especially to hard to access groups. We need to support the time needed to deliver quality care.

Wellness approach

We need to ensure that our primary care system supports individuals to maximise their own health.

We must examine how we can fund wellness models of health in our communities as well as illness models of health. This needs to include support for appropriate evidence-based screening activities, and support for lifestyle risk factor education, not only treatment services.

Exploiting new technologies

We need to examine the potential benefits that new technology, including e-health solutions, may bring to improving the quality and safety of our nation's primary care services.

We need to ensure our primary care health professionals have ready access to the best available evidence to support clinical decision making. This needs to include access to key patient information through shared electronic health records.

We need to embrace benefits of new technologies in primary care such as telemedicine and point of care pathology testing.

Ensuring sustainability

We need to focus on resourcing and supporting multidisciplinary teams, networks and co-located services.

The implementation of primary care policy requires adequate resourcing. Funding of primary care services should be on a sustained basis rather than one-off provisions.

Policy needs to be applicable and adaptable to local circumstances resulting in a diversity of locally applicable models.

Some essential primary care service provision, especially in allied health, currently receives no public funding. This needs to be addressed in the interests of equity and access.

Workforce

To sustain our primary care system we need a focus on supporting all members of our primary care workforce.

We recommend that governments express how much they value the primary health care practitioner workforce. We recommend high level commitment to our primary care workforce from our governments with appropriate levels of recognition, reward and support.

We need to ensure that we are able to attract the brightest and the best of our young people to work in primary care; and to ensure the standards for education and training and registration and continuing professional development of all members of our primary care workforce.

Safety and quality

We need to ensure the continuing quality and safety of our system of primary care and that all players, including consumers, work together on improvements.

Thus, we need to ensure the standards of the quality of care provided in each location where primary care is delivered in Australia.

We need a national program of safety and quality in primary care as part of the work program of the new Australian Commission on Safety and Quality in Health Care.

There also needs to be increased support for:

- quality use of medicines
- the management of complex co-morbidities
- the rational use of pathology
- a focus on integration of services across primary and secondary health care systems.

Areas of need that need a special focus include ...

There are a number of areas that need a special focus, including:

- expanding Aboriginal community controlled primary health care services
- improving our primary care mental health services

- better meeting the primary care needs of people with disability, especially intellectual disability
- oral health reform to ensure timely access to public funded services for those who cannot afford or access private services
- early childhood development
- refugees and people seeking asylum
- people on low incomes
- people living in rural and remote areas
- people from culturally and linguistically diverse backgrounds.

National Primary Care Policy

Australia needs an agreed National Primary Care Policy and an accompanying strategy to allow strong planning for the future.

Governments need to work together to ensure national coordination in primary health care and shared responsibility.

Research and evaluation should be integral and ongoing features of our primary care system.

Policy should safeguard the universal access demanded by the Australian community.

National policy should be a partnership between governments, consumers and clinicians.