



University of South Australia

Health & Hospital Reform Commission: Prevention Theme

Opinion Piece

A vision for primary care:

Funding and other System Factors for optimising the primary care contribution to the community's Health

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1. BACKGROUND

High quality primary care is a central component of a well functioning health system, working in several ways to improve population and patient health. In the context of chronic disease management and prevention, the delivery of primary care according to clinical practice guidelines - invariably involving multi-disciplinary care - has been shown in randomised control trials across a range of conditions to improve patient outcomes, (Rich et al 1995, Feder et al 1995, McAlister et al 2004, Helman et al 1997, Beck et al 1997, Usitupa et al 2000). This conclusion is not universal, (eg Weinberger et al 1996). But in general, good control of risk factors such as blood pressure and lipids and the adoption of certain behaviours (not smoking, physical activity and good nutrition) are related to improved health, by reducing the incidence of disease in those at risk (DPPRG 2002) and reducing the rates of disease progression and complications in those with an established health condition. The evidence for prevention of accidental injury is also strong.

Whilst it has also been postulated that high quality primary care will reduce the use and cost of hospital services by substituting for less appropriate or more expensive tertiary in-patient or emergency department care and improving the quality of chronic disease management and lowering rates of disease progression and complications the evidence here is equivocal. Some success in small scale intervention trials is observed, but this is not necessarily translated into larger population based interventions. While reasons can be posited as to why the 'expected reduction' in hospital admission did not occur, it is plausible that high quality primary care may be additive to, rather than a replacement for hospital care. In any case, 'ambulatory care sensitive' admissions (potentially avoidable through high quality primary care), for diabetes complications, COPD etc. have been estimated to account for only 10% of hospital admissions, (DHS 2004). Reform of primary care should be justified in terms of its impact on health and wellbeing and equity, rather than presumed 'cost savings'.

A range of structural factors impede the efficient and equitable delivery of primary care. These include the split in funding between the Australian and State governments; differential payment arrangements for distinct modalities of care, which create a privileged position for some modalities and delivery settings and access barriers to others; the dominant fee-for-service payment mode and lack of accountability mechanisms. Taken together these foster an episodic, piecemeal and reactive focus to care, that is medically dominated and where the responsiveness of the service system is severely compromised.

Over the last 15 years in Australia, there have been a range of experiments and demonstration projects seeking to address these barriers. These have typically focused on care coordination, shared care (hospital and community), financial reforms (eg funds pooling), sharing of data, reorganisation of processes. Initiatives have included:

- Trials in enrolled populations, such as the national coordinated care trials (mainstream and indigenous), Primary Health Care Access program (PHCAP);
- 'Hospital Demand Management' programs designed to reduce 'avoidable hospital admissions' in frequent hospital users, often through a better interface between tertiary and primary care;
- Programs to extend access to allied health services and care planning and promote more effective patient self care; such as new MBS items for care planning, case conferencing, cycle of care items, the 'More Allied Health Program' for rural communities, various initiatives to support Practice Nurses, the 'Sharing Health Care' initiative; GP plus centres and super clinics;
- Establishing and Strengthening Divisions of General;

- Programs to support service coordination, including investment in an electronic patient health record (HealthConnect, MediConnect), Primary Care Partnerships, Multipurpose Services Program;
- Disease specific case management programs, some involving funds holding, largely in mental health and disability services;
- Quality of care; for example the Quality use of Medicines program under the Community Pharmacy Agreement, Primary Care Collaboratives (APCC), support for clinical practice guidelines development, publication and distribution.

By 2001 over 20 distinct Australian Government initiatives were identified (DoHA 2001) related to primary health care integration and data sharing, in addition to countless state, area health authority and hospital-based programs. Many of these programs have been short-lived, generating instability and uncertainty in the primary care sector especially for multi-disciplinary care. What we find, after many years of primary care reform a confusing array of sometimes complimentary and sometimes conflicting initiatives, many of which are not sustainable. Rarely are initiatives rigorously evaluated, so evidence concerning performance, despite an extended period of experimentation, is still lacking.

The evidence that is available suggests some successes in response to these initiatives. For instance the National (Australian) Primary Care Collaboratives have seen improvements in management of diabetes and heart disease and risk profile of patients in participating practices (APCC 2008). Similarly, hospital demand management initiatives across the country suggest improvements in care and some reduction in hospital admissions. The introduction of Extended Primary Care (EPC) items on the MBS have altered radically the Medicare items charged by general practitioners at considerably increased cost. However the outcomes in terms of quality of care or the impact on patient health and wellbeing certainly of the EPC items is unknown. Even if improvements in outcomes are identified, this does not necessarily mean initiatives represent good 'value for money'.

Most initiatives are narrow in focus and ad hoc and fail to offer a coherent, coordinated and sustainable approach to improving primary care and its relationship with the rest of the health care system. Despite recognition of the problems created by the split in funding and responsibility between the Australian and State governments and individuals, silo-based approaches to funding, and fee-for-service payment models; primary care remains inflexible in its response to current health issues and accountability is almost entirely absent. (These issues are highlighted in the first report of the Health and Hospital Reform Commission, 2008.)

In order to achieve the desired improvements to primary care including a shift from a reactive medical model of care, the incentives embodied in the system need to operate in a mutually supportive way. The basic proposition of this paper is that effective and sustainable primary care reform requires all key structural barriers to be addressed simultaneously. The challenge is to create a system where the structural elements reinforce high quality, appropriate primary care. The problem is that if only some structural impediments are addressed, perverse incentives that remain can in effect sabotage other initiatives. It is postulated that structural change needs to occur at national, state, regional, community, service, practice and clinician level and with a recognition that if critical factors are not addressed, widespread sustainable improvement in primary care will remain elusive.

Whilst, the focus of this paper was to be on funding models to support prevention in the primary care setting, it is my view that funding cannot be considered in isolation from other system factors. The paper thus adopts a broader perspective, to develop a vision for an optimal primary care system for Australians; one that will support an efficient, equitable and sustainable primary care system that is responsive to community priorities.

2. SOCIAL OBJECTIVES FOR AN ‘OPTIMAL’ PRIMARY CARE SYSTEM

The National Health and Hospital Reform Commission NHHRC (April 2008) identify 12 broad expectations from our health system, many of which are pertinent to primary care and which have been reframed below within the traditional economics paradigm of equity and efficiency:

To promote Equity

Key objectives around equity have been identified by the NHHRC (2008 p12-17) as:

1. *Closing the gap in indigenous health status;*
3. *Ensuring a healthy start to life for all (This should also contribute to efficiency);*
9. *Improving distribution and equitable access to health services;*
10. *Ensuring access to services on the basis of need, not ability to pay.*

The achievement of these objectives requires a health and primary care system that can deliver services that are highly accessible and where access reflects clinical need. Access in this context has several dimensions including:

- convenience of location,
- involve minimal financial barriers (financial barriers are an indiscriminate rationing mechanism, discouraging appropriate and necessary services particularly preventive services in those who are more disadvantaged),
- available in a timely fashion,
- culturally appropriate and ‘pro-disadvantage’ with services targeting disadvantaged groups to reduce health disparities.

It also assumes a health care system that is based on principles of respect and underpinned by a belief in human dignity and an obligation to protect the vulnerable members of society

To support efficiency

Efficiency is about meeting societal objectives such as health gain in a way that makes the best use of society’s limited resources. As identified by the NHHRC (2008 p12-17) this has several components:

2. *Investing in prevention – where proven and cost-effective;*
4. *Redesigning care for those with chronic and complex conditions; to ensure service continuity and integrated care and a system more responsive to multiple health and social problems;*
5. *Recognising the health needs of the whole person – for example to provide access to non-medical services and services from outside the health portfolios where appropriate and adopt a biopsychosocial model of health;*
8. *Promoting improved safety and quality of health care;*
11. *Improving and connecting information to support high quality care;*
12. *Ensuring enough well-trained health professions - with the required mix of competencies, with access to more training places within the primary care setting, especially for allied health and nursing trainees.*

An efficient primary care system would in addition be patient centred and empowering of patients and citizens (see Segal 1998) and have mechanisms to incorporate patient/citizen priorities and be responsive to changing circumstances and new evidence. In short it will deliver health services in a way that makes the best use of societal resources and is sustainable. Sustainability concerns certainly in funding, workforce training, support for clinical and health services research.

Seeking to realise the desirable components of the optimal primary care model represents a considerable undertaking, and is unlikely to be achieved through a piecemeal approach. Rather its achievement will require a set of mutually supportive system enablers at the national, state, local and regional, community, practice and clinician/project worker level.

3. NECESSARY STRUCTURAL REFORM ELEMENTS

An understanding of the function of the health system and the primary care sector, together with a knowledge of health system barriers, suggests four distinct system elements to be addressed. It is postulated that if these four elements can be addressed together, the conditions necessary for an efficient and equitable primary care system will be established. The four system attributes considered core are which need to work in a mutually supportive way are; i) financial drivers, ii) management and accountability process, iii) information and communication systems and iv) health services and health workforce planning. These are discussed below, with a focus on operational issues. Ideally a complementary research activity would be part of the reform strategy for each element.

I Desirable Financial Drivers

Funding of Populations by a needs adjusted capitation formula

It is still the case that for persons living in rural and remote communities and in lower SES suburbs access to primary care clinical services, especially allied health, tends to be lower than average and considerably less than indicated by comparative health status. There tend to be fewer providers in these areas and rates of bulk-billing for medical services are also lower. This means use of primary care services, especially for prevention will be compromised. Population and community based primary care services are also likely to be under-resourced in the most disadvantaged communities. Estimated separations for 'potentially preventable' ambulatory care sensitive (ACS) admissions suggest this is the case. Compared with cities where ACS admissions were estimated at ~30/1,000 persons, in remote communities they were estimated at nearly 60/1,000 persons and in very remote communities at nearly 75/1,000 persons (AIHW 2008, Figure 7.18)

The optimal primary care system will rather incorporate financial and other levers that direct resources to populations according to health care need (NHHRC objectives 9 & 10). Distribution of resources on the basis of a needs adjusted capitation formula is a core plank of an equitable health system. The alternative, in which the distribution of resources depends on the location choices of providers and accidents of history will invariably conflict with the achievement of equity and require a plethora of incentives and penalties to redress the imbalances that emerge. Such imbalances can be considerable. (In NSW prior to adoption of a needs-based model for funding of Area Health Services, it was found that some areas received as much as 30% in excess of their needs adjusted formula allocation and others up to 40% below. Just 10 years after introducing a needs adjusted resource allocation formula for hospital, community, mental health and other state-based services these regional disparities were removed - achieved through differential growth funding).

A 'needs-adjusted' capitation funding formula could be devised just for primary care, or the entire health system (perhaps excluding high level tertiary care). It can include a series of sub-models, as is the case in NSW, and in that way incorporate selected areas of activity. There has been a considerable research program, internationally in developing robust Resource Allocation Formula over some 20 years, in the UK, the USA, the Netherlands and Australia and elsewhere. In Australia this research commenced in NSW (as outlined above) and was a central research task of the National Coordinated Care Trials. It has also been employed in a simplistic way under the Primary Health Care Access Program (PHCAP).

Needs (or risk) adjusted models are now highly sophisticated and a robust way of allocating resources to populations. Typically independent variables include SMR (standardised mortality ratio), % unemployed, age, gender, % indigenous etc.. A measure of individual health status may also be included, especially in competitive insurance models – where risk selection is an issue. (See Segal 2004 for a discussion of the relative merits of competitive and non-competitive fundholding models.)

A 'level playing field' in funding of health services (and other means to promote health)

Given limited societal resources, any preferential treatment, (eg by modality, delivery setting, stage of disease etc.) inevitably means funding of some services at the expense of 'better performing' alternatives. The resultant loss in health and wellbeing can be considerable. The primary distortion in this regard is the privileged position of pharmaceuticals, by virtue of their access to the Pharmaceutical Benefits Scheme (PBS) - provided they demonstrate 'cost-effectiveness'. Medical services are similarly privileged through access to listing on the Medical Benefits Schedule (MBS). Even though access to the MBS has been broadened in recent years particularly through the addition of the Extended Primary Care items which for example provides limited subsidies for selected allied health services access to non-medical primary care services (other than optometry and recently psychology services), is still highly restricted. Whilst Medicare items such as Team Care Planning are purportedly designed to encourage planned multi-disciplinary care for persons with chronic conditions, the care planning item only covers the GP input to the care plan development, leaving unfunded the involvement of other clinicians. Although, once a team care plan has been developed, MBS does fund up to 5 allied health visits annually (across all allied health services). It is, however, still the case that competing (or even complementary) clinical and other services, such as allied health and community based approaches to health care and prevention have no clear pathway to secure funding, regardless of evidence of effectiveness or cost-effectiveness. This inevitably means that non-medical services will be under-funded and under-utilised relative to the efficient solution.

That current funding arrangements distort patterns of care was confirmed in a recent study of 250 Australian health economic evaluations, by Dalziel and Colleagues in an ARC funded research program, (Dalziel et al 2008). Key results from that study are illustrated in Figure A1.1 (Appendix 1), which found that access to lifestyle and allied health interventions is almost always restricted relative to clinical need. Other analyses from the same study confirm that this difference is not explained by cost-effectiveness, with the relationship between funding and cost-effectiveness negative but weak, see Figure A1.2 (Appendix 1). In short, access to multi-disciplinary care is seriously compromised by current funding models.

A move towards a 'level playing field' in which all services competed equally for societal resources could be achieved in one of three ways:

- Adopt a regional fund holding model, (See Figure 1), in which the regional fundholder makes resource allocation decisions across the entire health portfolio, or perhaps just primary care sector, doing away with funding silos;
- Modify current priority setting mechanisms, eg PBAC so that all services, in this case pharmaceuticals, are required to consider explicitly the opportunity cost of any decision, and compare the drug proposed for listing with the best alternative regardless of modality. This could see the PBAC and MSAC process combined and open to all health services, and provide an opportunity for non-medical, including preventive services to be scrutinized but with access to secure funding if found to perform well. Such a process would provide an incentive to gather robust evidence of effectiveness and cost-effectiveness for a wide range of therapies and other service options;

- Establish a priority setting mechanism and schedule for those health services not covered under the PBS/PBAC system or MBS/MSAC system to provide a clear funding pathway for such services, if they demonstrate ‘cost-effectiveness’. This might constitute the proposed ‘Prevention Benefits Schedule’. If this incremental approach were taken, a review of funding thresholds would also be necessary to pursue consistency across all schemes (adjusted for other societal values if pertinent). In estimating a ‘value’ of a life or QALY to determine a funding threshold, budget constraints need to be incorporated, as unconstrained estimates will almost certainly suggest funding thresholds that are unsustainable.

Greater flexibility in payment arrangements

Payments to providers are a source of income, but also affect the nature and scope of practice. Payment options include fee-for-service, salaried, performance-based (eg for meeting specified targets or benchmarks) or capitation and can involve a combination of methods. The aim is to derive a set of payment models (and level of pay) that promote desirable provider behavior, in terms of the nature of clinical practice, efficiency in care delivery and ensures security of service provision (will attract providers).

Primary care in Australia is dominated by fee-for-service payment arrangements, especially for general practitioners; but less so for allied health and community-based care where salaried practice is also important. Fee-for service payments tend to promote patient throughput, potentially at the expense of quality of care and a holistic, proactive and planned approach to care. In addition, in defining the services and delivery modes that will be reimbursed, creativity in approaches to delivery of health care and prevention is inhibited.

Salaried practice or capitation payment models on the other hand allow for innovative approaches to promoting health. Whilst salaried practice may be associated with lower throughput, it is consistent with a more flexible response to patient/community needs. (Even in small ways, such as the use of email and phone contact with patients and family members).

The incentives associated with capitation payment arrangements (such as previous UK style GP Fundholding) are complex – and will depend on scheme details. GP fundholding tends to encourage role substitution, for instance greater use of nurse practitioners, practice nurses and allied health staff, as has happened in the UK.

Under fee-for-service arrangements, specific MBS items can be introduced with attractive fees to encourage certain activities, with the expected effect of quite radical changes in billing behaviours. (For example in 2006-07 645,882 GP management plans were billed under MBS item 721, whilst standard GP ‘time-based’ consultations have plummeted from over 12 million in 1993-94 to just over 4 million in 2005-06). However, a positive impact on quality of care has not been demonstrated - changing billing behaviours is simple, changing the nature of patient care is more complex. In an audit of GP care of patients with diabetes, under the previous multi-disciplinary care plan (MBS item 720, equivalent to the current Team Care Item 723) it was found that key clinical indicators improved for patients who received multi-disciplinary care. However, it was found that 27% of patients did not receive multi-disciplinary care, despite a multi-disciplinary care plan item having been charged, (Zwar et al 2007, Segal 2007). Patients who have the now more common GP care plan are less likely to receive multi-disciplinary care.

The use of Practice Incentive Payments (PIP) form an increasing, but still small component of GP salaries, as a performance based payment to promote particular activities related to the process of care and participation in specific chronic disease management initiatives. Their success depends on whether targets can be precisely specified in a way that is clinically meaningful and can potentially contribute to the achievement of particular benchmarks.

Allowing a range of payment arrangements, including mixed approaches is likely to offer the best chance of promoting high quality and appropriate primary care and prevention.

Consistent with equity objectives; whatever model is adopted for paying providers, it is desirable that direct fees to patients/citizens are minimized, through a predominantly taxation or compulsory social insurance funded health care system. Even though primary care might not seem as critical as emergency care, its can have a considerable impact on patient outcomes and downstream consequences. In this regard the current mixed funding model of private, public and publicly subsidized private can create anomalies in terms of relative access to services, if not aligned with community objectives. For instance those with private health insurance (PHI) on 'general treatment benefits' (previously referred to as extras) are subsidised in their use of primary care services through the 30% rebate on premiums. In 2006-07 PHI funds spent for instance \$1,234million on dental services, \$185million on physiotherapy services, \$74 million on naturopathy and acupuncture services, contrasting with just \$4.3 million on dietetic services and \$11.8million on preventive services. In this way the Australian government in effect contributed over \$800 million on non-medical primary care services (including a contribution to profit and administrative costs of the private insurers), (Phiac 2008). This spending occurs without any accountability, without the benefit of any formal assessment of value, and provides differential support to persons on higher incomes (who are the main purchasers of private health insurance). The current arrangements thus conflicts with equity as well as efficiency objectives. Removal of such anomalies is necessary if primary care is to be funded in way that is fair and reflects available evidence on performance.

II Management and accountability processes - practice administrative arrangements

Management and accountability processes are required at all levels; between funders and fund-holders and fund-holders and providers to monitor and drive best practice care and prevention and more broadly the achievement of social objectives. It is a core structural element to promote desirable behaviours in service providers. Accountability processes can include service delivery targets, quality of care benchmarks, targets for access to care and financial results. Accountability can be facilitated by a range of strategies including the use of quality audit managers, clinical governance models and community engagement (eg via community controlled Health Boards).

Examples of effective accountability processes for primary care provide insights concerning how to proceed. The United States Veterans Health Administration in the mid 1990s set up a comprehensive accountability and quality audit process, as part of broad system change to enhance patient outcomes and efficiency of care delivery, (Kizer et al 2000). (Other components included the introduction of needs based capitation, creation of integrated regionally based service networks, promoting the use of primary care.) Key components of the VHA accountability model related to primary care are outlined in Box 1.

In the Northern Territory, the Katherine West Health Board and Aboriginal Central Australian Congress in Alice Springs together with other health services have in recent years adopted well defined and comprehensive clinical governance models. These set up an accountability framework to guide health service delivery, as part of a process to enhance quality of care and improve patient outcomes. Typical components of these accountability and quality audit systems include; dedicated quality managers, defined bench marks for care combined with a defined peer review process, use of an electronic health record, decision support systems. They may also include participation in wider quality of care initiatives such as critical incident reporting, Quality Use of Medicines program, and the Australian Primary Care Collaboratives. Such models embody a commitment, at the community and practice level to a more flexible response to patient and community needs, which is then facilitated by supportive organisational arrangements

Box 1. Key Components of the USA Veterans Health Administration accountability and quality assurance process relevant to Primary care

Quality indicators/benchmarks to establish and monitor performance and encourage the adoption of best practice care; through

- A Prevention Index - immunisation, cancer screening, tobacco & alcohol screening and counselling etc.,
- Chronic Disease Care Index, - patient access to best practice care in diabetes, chronic heart failure etc.
- Palliative Care Index - measures care of severely ill patients; eg enrolment in home based primary care, plans for pain management, access to hospice, access to psychosocial and caregiver support

Quality Enhancement Research Initiative for 8 disease/health problem areas (eg cardiac, diabetes, drug and alcohol, mental health) – encompassing a Steering Committee for each disease; identification of best practice; definition of existing practice and outcomes across the VHA and variation from best practice; identification of interventions to promote best practice (via literature review and commissioned research); implementation of initiatives; and finally monitoring and feedback using a comprehensive data management system.

Accountability system for managers (fund-holders) - via a 10-dimension quality of care accountability framework and a set of performance measures for nominated clinical and administrative processes. Performance contracts were entered into with all VHA managers.

Source Kizer et al 2000

III Information systems.

High quality information systems, incorporating as a central feature an electronic patient health record are necessary for several reasons:

- to support quality audit and clinical governance and accountability processes between funders, fundholders and providers, and to monitor care practices, allocation of resources and health outcomes of patients and populations
- for effective patient self care and to empower patients to engage more fully in their own care decisions,
- to support coordinated and multi-disciplinary care, as well as continuity of care between agencies and setting, based on shared information
- to better target prevention service to those at high risk
- to inform Health services and health workforce planning
- for clinician decision support and best practice care and prevention.

Considerable progress has been made on the development and application of comprehensive high quality IT systems and associated decision support systems. These are now widely utilized in hospitals and increasingly, in primary care. Although in primary care, the role of IT is often still quite limited. There are initiatives to extend the use of IT for example to enhance decision support and quality assurance and accountability. (For example a government funded research program in Victoria, Barwon Region, is developing and piloting a web-based decision support system for persons with diabetes, involving assistance with care planning and follow-up of implementation and patient outcomes).

IV Health services and workforce planning

The fourth system level plank in an efficient and equitable primary care system is a commitment to evidence-based health services and health workforce planning. Delivery of primary care and prevention consistent with best practice can only be achieved through a health workforce with the necessary skills and competencies.

Ideally, training and education will be based on an understanding of the health needs of the population and associated competencies to meet those needs. Greater flexibility in how competencies are matched to occupations would increase capacity to meet health care needs. This particularly applies to chronic disease management and prevention, where several health professional groups may be competent to deliver quality care/meet the broader health needs of the community. A focus on competencies can also be used to discourage those who do not have the required competencies from delivering particular services.

4. THE COMPONENTS OF AN ‘OPTIMAL’ PRIMARY CARE MODEL

A Primary care model is described here which incorporates the four strategic system features outlined above and that should be capable of delivering on the specified societal objectives for health. The primary elements of the proposed model are:

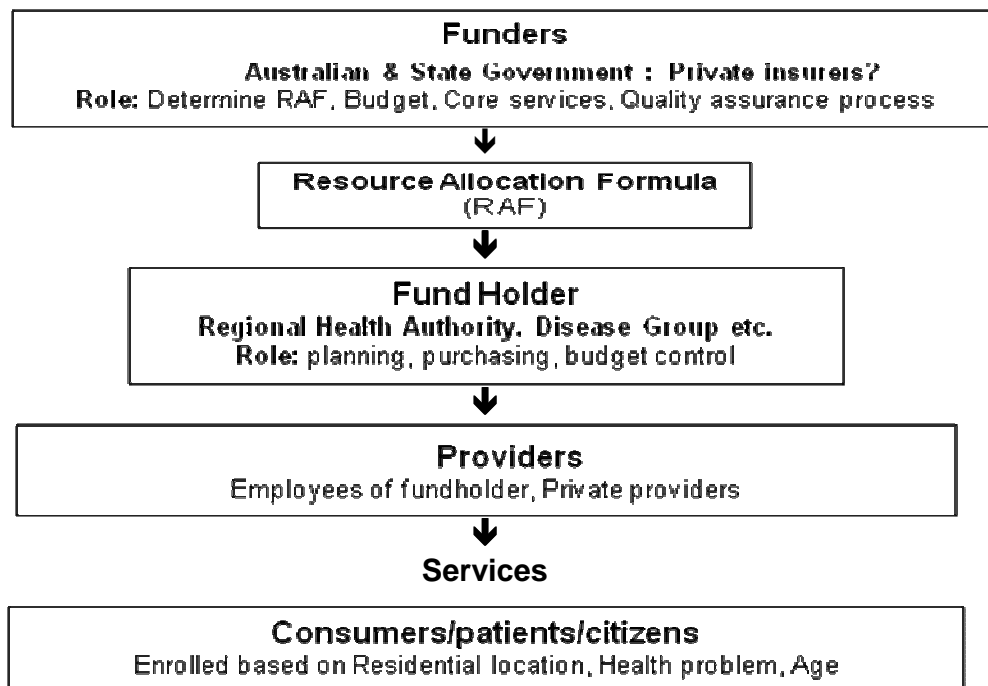
1. A non-competitive single fund holding – as described in Box 2 below, (See also Segal 2004).
2. Needs adjusted capitation payment.
3. Citizen/Patient enrolment/participation by virtue of place of residence.
4. A strong governance and accountability process, including assessment and monitoring of population health status.
5. Community control/involvement, for instance through , in part, a community controlled health board.
6. High quality IT system for information sharing, decision support, more effective patient self care.
7. Administrative systems and processes that support protocol driven care – eg clinical audit, patient recall, feedback etc.
8. Option for Salaried remuneration of clinicians and other service providers.
9. Universal cover/universal access achieved through predominantly taxation or compulsory insurance based funding, combined with low or zero co-payments on core services – including preventive interventions.
10. Commitment to empowerment of patients/citizens and a patient/citizen focused health service.
11. Health workforce planning, based on required competencies and including a coordinated approach to training.
12. Health services planning based on system wide priority setting studies.

Box 2 Single Fund-holding

Single fund holding brings together the health funds for a defined (enrolled) population into a single planning and budget framework, with the budget based on a needs adjusted formula.

The role of the Funder includes; definition of core services, developing the needs adjusted capitated formula, support quality assurance processes, monitoring outcomes of the community: (health status, access etc.), monitoring the financial performance of fund-holders and developing a health services and health workforce planning framework and supporting its application.

The role of the fundholder includes: management of capitated funds (budget control), purchase of services from providers, implementation of health services planning and health workforce planning, implementation of quality assurance processes, monitoring and ensuring community outcomes.



Postulated advantages of the 'optimal model'

Contribution to Equity objectives is achieved through a number of mechanisms but primarily by allocating resources across populations and regions based on a needs adjusted formula, and the predominant funding of 'core services' through taxation or compulsory insurance (ie based on capacity to pay).

A whole of life approach to care and a holistic/cross portfolio approach to promoting health is encouraged through single fundholding and the associated clear responsibility for the on-going health of a defined population and command over resources. It also embodies incentives for and a capacity to deliver population level services and to work more creatively across portfolios. Population health and other approaches to enhancing health and wellbeing would compete more fairly for societal resources. Multi-disciplinary care becomes easy to deliver. Single fund holding facilitates substitution between services and providers and resource shifts between program areas, and should make it easier to act on health services and workforce planning.

There would be less opportunity for cost shifting and thus cost savings would need to be achieved through real efficiencies, promoting technical efficiency.

Quality of care should be protected by the threat of reaping the consequences of poor quality and the formal accountability and quality audit processes.

Greater citizen and patient involvement through a community controlled health board and other initiatives, would provide a vehicle to more fully incorporate community expectations into service planning and delivery.

Key Challenges

There are not insubstantial challenges in the establishment and implementation of the proposed model. The most serious is the high level management skill, competence and integrity required in the community controlled Board and in service managers. Gaining the required support for this type of non-incremental reform is also critical as well as enlisting dedicated and highly competent clinical leadership.

At a technical level, most components of the model are well developed, either in isolation or as part of a comprehensive primary care (or health system wide) reform initiative. The area of health workforce planning still needs further development.

Feasibility

The Katherine West Health Service in the Northern Territory has a primary care model that incorporates the central features of the proposed 'optimal' primary care model and illustrates its feasibility. Not with-standing the observation that the Katherine West Model (described below) required a considerable commitment at Commonwealth, State and Local level, active support and involvement of clinical staff and the community, and considerable time and resources. Sunrise Health Service (Katherine East) has also successfully implemented a similar model and other, especially rural services, incorporate many of the defined features.

A description of key features of the Katherine West Health Service is provided below. As it combines the core elements of the proposed primary care model it represents an interesting case study and gives a sense of the type of health service that emerges when a desirable set of structural elements are in place. Whilst Katherine West is not typical of Australia as a whole, there is no reason to believe that application of the model to other settings, especially in provincial, rural and remote Australia would not be possible. It is also the case that each application will face its own set of challenges, which may in some applications be less than those faced in Katherine West.

5. AN AUSTRALIAN EXAMPLE – KATHERINE WEST HEALTH SERVICE

The Katherine West Health Board incorporates all of the features of the proposed 'Optimal Primary Care Model' and demonstrates the feasibility of the model for Australia, at least in some contexts. It also demonstrates that the incentives work broadly as expected, to yield citizen engagement in service priorities, a far more flexible and innovative supply response, cross portfolio initiatives, greater certainty in funding, incentives for quality and a greater emphasis on prevention. The material here is drawn directly from the Katherine West Health Board web site, www.kwhb.com.au and presentations by and personal communication with Dr Andrew Bell, Medical Director of Katherine West Health Service.

History

Katherine West Health Board provides a clinical, preventative and public health service to residents from remote communities in the Katherine West Region (west of Katherine to the NT/WA border). The Board is made up of representatives from the community. The Katherine West Health Board Aboriginal Corporation (KWHB) was incorporated in February 1998 to implement the Katherine West Coordinated Care Trial (CCT). It was part of the National CCTs

characterised by the pooling of funds from State/Territory and Commonwealth Governments and the development of 'care plans' for individuals with multiple co-existing morbidities. Prior to involvement in the CCTs all health services in the region were delivered by Territory Health Services (THS), (ie NT Government), with little involvement or funding by the Commonwealth Government. Under the arrangements of the Trial, both Governments contributed funds to a 'pool' which was put under the control of the KWHB. The Commonwealth Government contributed funds based on a 'cash-out' of the entitlements of the residents of the region to MBS and PBS. This was calculated as the mean payment to all Australians and resulted in a higher Australian government contribution that had been limited by the lack of Medicare funded providers in the region. The KWHB in effect took over on the role of fund-holder for the health services of the region.

Initially most health services were purchased from THS, but from late 1999 the Board moved to direct management of clinical and public health services. The capacity of the elected KWHB members to take on the complex and challenging fund-holder role has been supported through intensive and on-going training. The Board emphasises "a community development" view of health, characterised by increased community participation and a many-faceted, holistic view of health. The structure was continued through participation of Katherine West in the Primary Health Care Access Program (PHCAP), an Australian Government initiative to support more appropriate level of resources and more creative delivery of health services in predominantly indigenous communities, by funding primary care services via a simplified needs adjusted capitation formula. The funding formula provided additional Australian Government funds into Katherine West. This has allowed health services expansion, including a residential GP service for the first time, more Staff in clinics, a large increase in Aboriginal health workers and a many fold expansion in Public health services, particularly environmental and nutrition services.

Current Programs

In response to community priorities, the KWHB now delivers a wide range of health programs in the fields of Environmental Health, Aged Care, Nutrition, Maternal and Child Health, Chronic Disease Self Management, Dental and Mental health. Health Centres in the region provide school age screening, healthy skin, healthy ears, immunization, antenatal, adult health assessment, STD/HIV, non emergency acute care, emergency care, infectious diseases, community consultation and health education to school children. All Health Centres have a team of resident health professionals and visiting specialists, allied health professionals, community development and public health personnel.

The creative way that programs have been able to develop is illustrated by a more detailed description of a few of these programs:

The Nutrition Program is focused on the food supply (eg through working with store managers), training and support of community based Aboriginal Nutrition workers, and training and education for staff at the Health Centers, Women's Centers, crèches and schools, (including assisting with a school canteen policy). The aim is prevention of chronic disease and improvement in the nutritional status of the community. Promotion of healthy foods also occurs through regular nutrition education sessions in the communities, targeting women of child bearing age, mothers and children, working closely with the Child and Maternal Health program. Employment, training and support for Aboriginal Nutrition workers is central, as they have a key role in improving food and nutrition through health promotion activities and education to their own communities. Working with schools in enhancing existing nutrition education and promotion activities through professional development with the teachers is another focus. The Nutrition Program continues to evolve through ongoing community consultation and feedback.

The *Environmental Health* Program through an Environmental Health Officer (EHO) is taking a proactive approach to disease control; including insect control, monitoring of water supplies, waste management, health education, response to communicable diseases and addressing housing standards. Strategies are being adopted that aim to improve the conditions that people are living in, supported by education. The intention is to provide a sustainable impact upon disease levels by empowering people to take control of their living environment. Community based programs include a community based healthy skin program and school education sessions. Where necessary the Environmental Health team advocates for change with other providers.

A *Chronic Conditions Self Management* (CCSM) program evolved from the Chronic Disease Self Management (CDSM) Demonstration Project funded under the Commonwealth's Sharing Health Care Initiative. It is not now operating as a separate program but has contributed to the KWHB approach to the management of Chronic Conditions. The project was funded for two years to research and develop an appropriate model for increasing knowledge and use of self-management principals and practice within KWHB and the communities, families and individuals it serves. Learnings have now been incorporated into the core business of KWHB and extended through on-going capacity building activities.

A *child health program* is managed by the Child Health Program Coordinator and has a strong public health and health promotion focus. The Community Health Centre teams offer preventive health assessments, including growth monitoring, ear checks, skin assessment, immunisation and parental information and education, for all children aged 0-5 years in the region. School aged children are screened annually for common conditions that affect their learning such as otitis media and early signs of chronic disease such as proteinuria. When early signs of ill health are identified through preventive health assessment, the aim is to offer timely, appropriate interventions to improve health and prevent further disease. Health centre teams work together with families and through women's centres and crèches and parental education and support. Children are referred to Allied Health Professionals, Paediatrician and other specialists when appropriate. Regular mother's groups are facilitated by the Child and Maternal Health Team, Nutritionist and Community Health Centre teams. These group activities are an opportunity for two-way sharing of knowledge, education and support. Often a healthy meal will be prepared as part of the session to develop cooking skills and encourage healthy infant and young child feeding practices. Local initiatives to promote healthy children are supported through crèches, schools and women's centres. The Child and Maternal Health team provide in-services, professional development, support and guidance to Community Health Centre teams. Regular communication with communities, through women's camps, community meetings and informal discussions, is used to consult with the community about the direction of the child and maternal health program.

A *Maternal Health* Coordinator is establishing and running a maternal health program, supported by health workers in some communities. This program is beginning to take women's health care into the community; into the women's centres and crèches, with emphasis being placed on education and information sessions for young women and young mothers. Consultation with women in the community women will also occur through women's camps and involvement of female Board members.

Other policy initiatives

Katherine West has participated in the Australian Primary Care Collaboratives, a nation wide program operated through Divisions of GP to support the adoption of clinical best practice, with a focus on diabetes and heart disease. A feature of the collaboratives is sharing information on health practices of clinicians and clinical risk profiling of participating patients. Some of the results of Katherine West involvement in the PCC are presented in Appendix 2. Figures summarise results for key clinical risk markers for the participating Timber Creek, Katherine West community for the period of involvement in the PCC. Results are also shown for Central Australia/Top End/ Kimberly and the mean for all participating practices across Australia. This shows considerable improvement in Timber Creek over the period of the collaborative but also that Timber Creek in general outperformed the mean for all participants. The collaborative model has since been incorporated into the operational approach across the KWHB communities, at this stage for chronic disease management, men's health and child health. The primary mechanism is weekly team meetings of key staff creating a 'quality culture' within a framework of continuous quality improvement.

It is still the case that further service improvements are considered desirable and additional funding would assist in meeting complex health problems around domestic violence, self harm, mental health and drug abuse.

In summary

The Katherine West model has evolved through the national coordinated care trials, PHCAP, Primary Care Collaboratives plus a range of one-off program initiatives, such as the Sharing Health Care Program.

The key structural components of Katherine west Model are:

- Single fundholder for primary care
- A community controlled Local Management Board - Katherine West Health Board Aboriginal Corporation
- All persons in designated region covered
- Funding to the KWHB through a simple needs adjusted formula under PHCAP,

Key Service Aspects, include

- Service expansion supported by needs adjusted capitation-based funds
- Multi-disciplinary teams
- Cross portfolio approach
- Strong emphasis on public health and prevention
- Participation in pertinent programs , such as Chronic Disease Self Management, APCC
- Training and capacity building activities to support the service model supported by

Comprehensive IT & clinical governance system to support a quality focus

- Electronic health record (that allows sharing of patient data between providers and with the patient)
- Decision support, including patient recall
- Dedicated quality manager
- Quality use of medicines program
- Critical incident reporting

The key lessons from Katherine West are that comprehensive structural reform in primary care is feasible, but takes considerable time plus an exceptional commitment from the community and all levels of government, together with dedicated clinical leadership. On-going training and capacity building is also necessary for Board members and others who take on the fund-holding and service planning role. An appropriate funding formula that will deliver both sufficient funds and certainty of funding is also crucial.

It is also clear is that such a model does encourage a creative supply response that allows the service system through that flexibility to better meet the needs of the community, with the expectation of better health outcomes. A stronger public health and prevention focus is also apparent, and is consistent with the incentives inherent in the model..

6. CONCLUSION / OVERVIEW

Primary care is currently undermined by a number of system level factors, including funding models which distort patterns of care and fail to offer incentives for a high quality, appropriate mix of services which will promote the health of the community. Despite numerous individual initiatives over more than a decade that aim to address particular aspects of system failure, current reform elements present a series of ad hoc uncoordinated initiatives.

In order to move primary care to a different level, a set of inter-related and reinforcing system level initiatives are required that together will create an environment in which system factors support an efficient and equitable and sustainable primary care system.

The key features of the Proposed Optimal Model are:

- A commitment to universal cover - funding primarily via taxation or compulsory health insurance derived from income related contributions
- An Enrolled (or at least defined) population
- The use of a Needs adjusted capitation formula to allocate funds to populations (for instance within a geographic area)
- A single Fundholding body with responsibility for the health of the community
- Funding models that ensure a 'level playing field' and eliminate preferential treatment of particular modalities (eg pharmaceuticals and medical services), settings and approaches to service delivery
- Payment models that promote a flexible, responsive and innovative service system, which means a reduced reliance on Fee-For-Service payments
- An accountability system based on sound principles of clinical governance and including a comprehensive quality audit component; supported by quality officers in each region
- Regional health workforce planning, including a coordinated approach to training
- Regional priority setting to guide the health service mix – supported by a research program to collate and/or gather pertinent evidence of performance. (This might link with National priority setting activities).
- Support community controlled Health Boards and other means to engage patients, citizens and communities, to ensure community input to service priorities

- A comprehensive high quality IT system to share patient level data, for decision support, benchmarking, accountability

Such a model should generate a primary care system that is more effective, more efficient and more equitable. One that facilitates resource shifts between care models, modalities, health delivery settings and that will support public health and long term population-based preventative strategies. However it is recognised that there will be considerable challenges in moving towards such a system,

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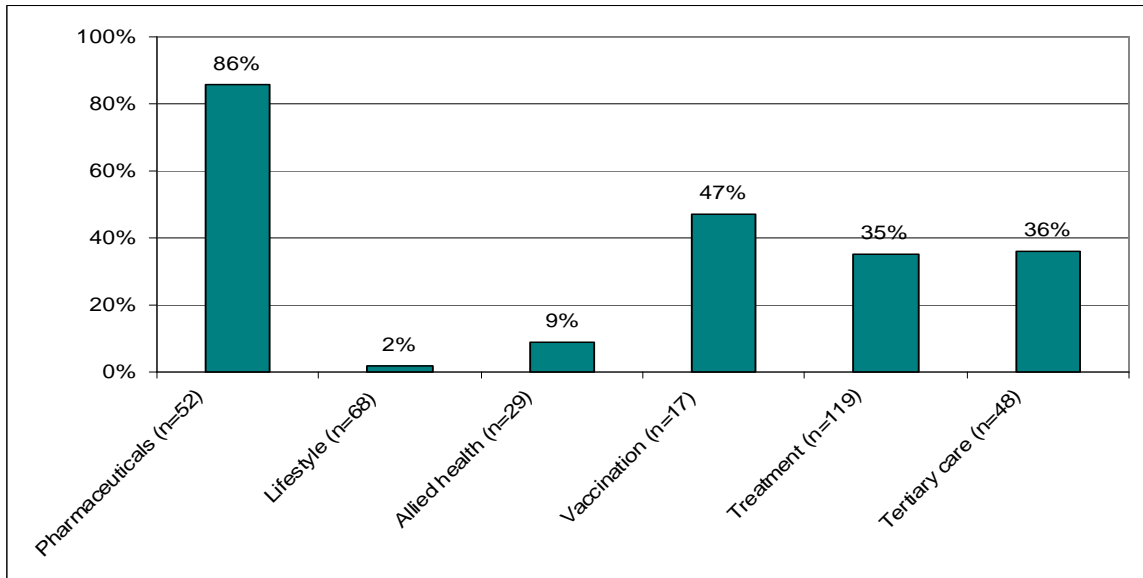
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Appendix 1.

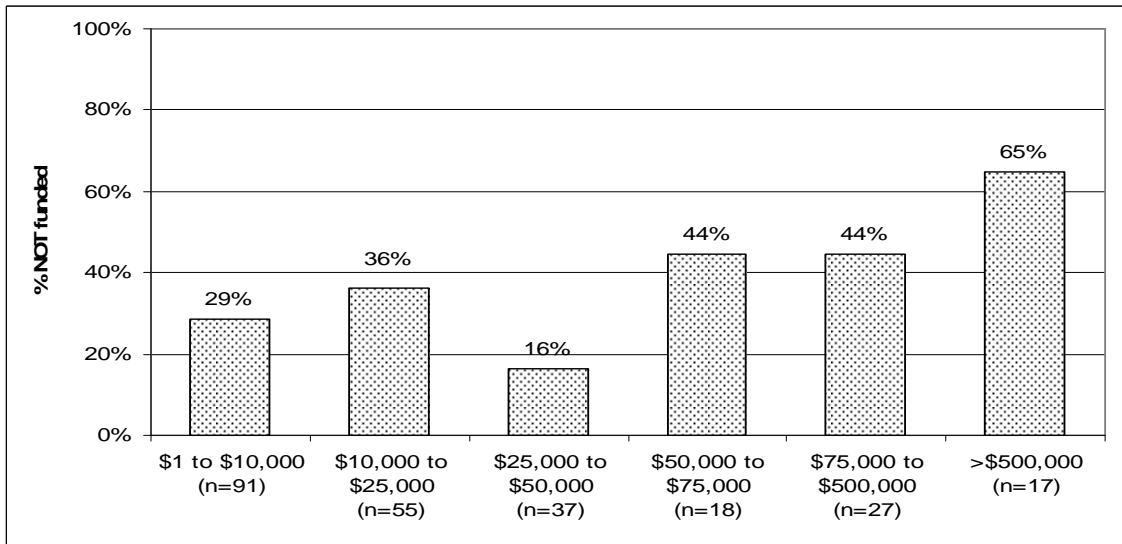
Selected Observations drawn from the collation and analysis of evidence of performance, and other attributes from 250 health interventions

Figure A1.1 Percent of interventions by modality/type eligible for government subsidy to meet all clinical need



Source Dalziel, Segal, Mortimer 2008

Figure A1.2 Percentage of interventions not funded by cost/QALY band

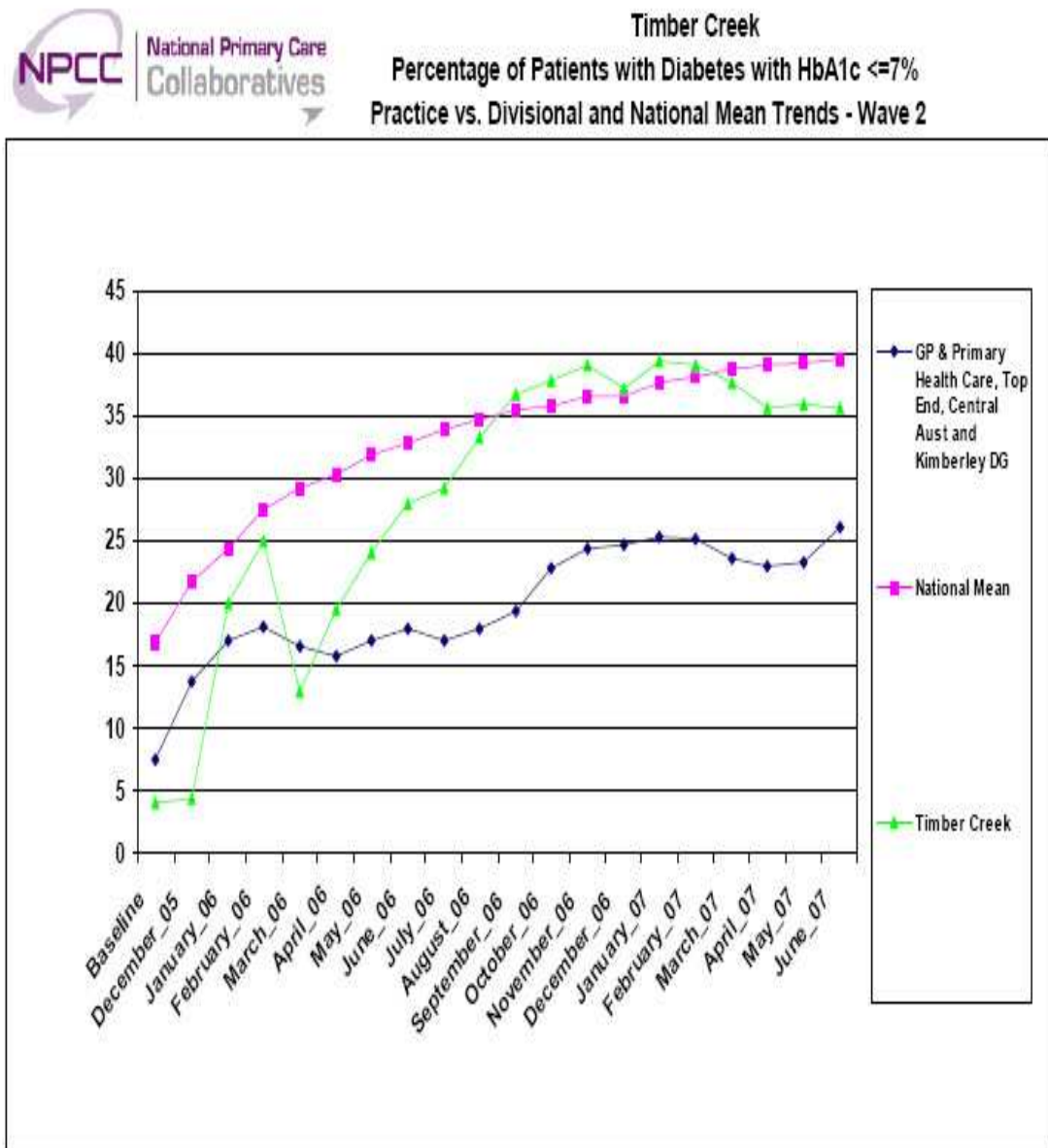


Source Dalziel, Segal, Mortimer 2008

Appendix 2

Selected Results for National (Australian) Primary Care Collaboratives: Wave 2 (2005 to 2007).

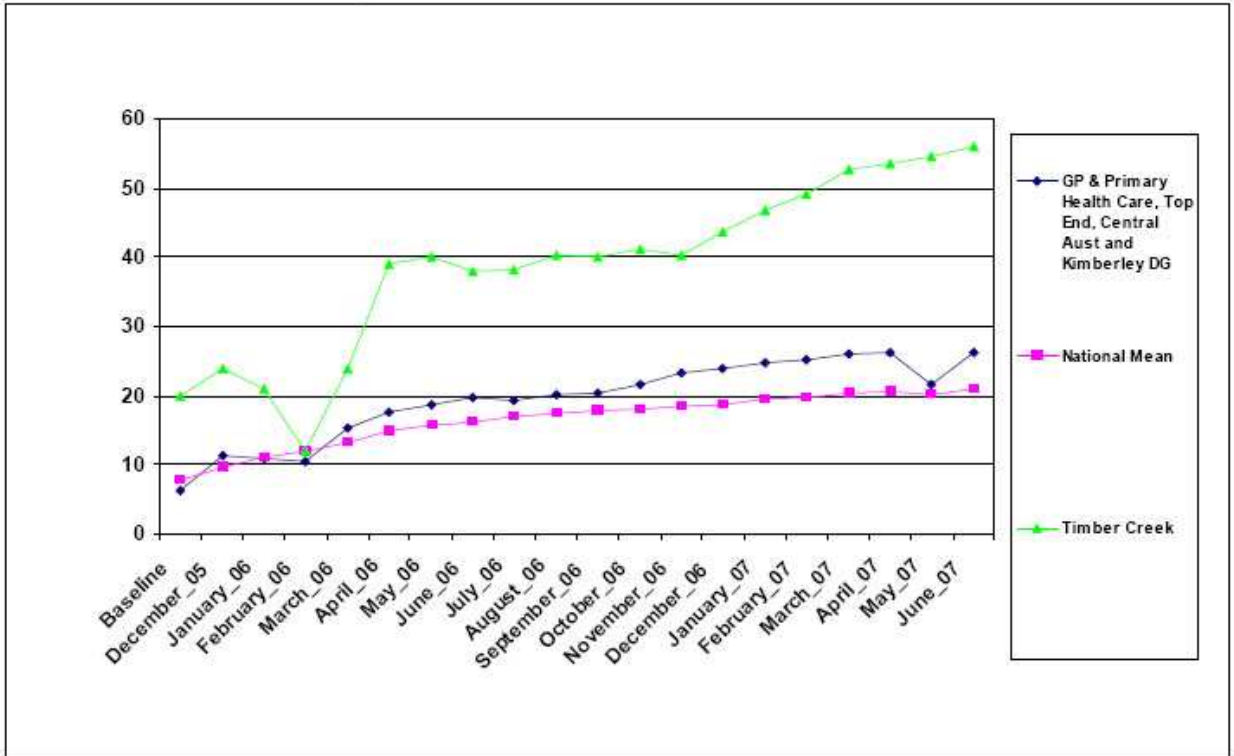
Timber Creek compared with National mean, mean for all Top End, central Australian and Kimberley participants.



Source:

Presentation by Dr Andrew Bell, 'Effective Management of Chronic Disease in Remote Communities' KWHB, at the Rural and Remote Chronic Disease Conference held Broken Hill May 2008, Primary care

Timber Creek
Percentage of Patients with Diabetes with Cholesterol <4mmol/l
Practice vs. Divisional and National Mean Trends - Wave 2



Timber Creek
Percentage of Patients with Diabetes with BP <=130/80 mm Hg
Practice vs. Divisional and National Mean Trends - Wave 2

