Primary health care in Victoria
A discussion paper

Department of Human Services

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A Victorian Government initiative

Victoria
The Place To Be

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Secretary’s foreword

Internationally, strengthening primary health care systems is increasingly seen as important to tackle the challenges facing health care systems. The Australian Government is developing a National Primary Health Strategy as part of their health reform agenda. This emphasis on primary health care is likely to provide new opportunities for strengthening the role of community-based primary health services into the future. In doing so, it will also improve the equity and efficiency of our health system.

Significant progress has been made to strengthen the primary health care sector in Victoria over the last 8–10 years with community health services improving clinical governance, funding models and targeted effort for key population groups—for example children, refugees, people with chronic disease and Indigenous people. Primary care partnerships (PCPs) have also consolidated their role in facilitating better service coordination, integrated practice in health promotion and chronic disease management, partnerships with general practice and inter-sectoral action. However, more can be achieved.

> Determining the future vision and strategic directions for the primary health care sector in Victoria is an important step forward in ensuring the continuous improvement of the state’s health system.

Both nationally and internationally, policy makers, academics and service providers are exploring ways to enhance, integrate and improve the delivery of primary health care services to provide more effective, efficient and person-centred care for clients.

This discussion paper aims to inform the dialogue with our stakeholders about the future directions for primary health care. It is hoped that this ongoing dialogue will assist in further development of both the national and state primary health care change agendas.

This paper builds on the directions outlined in other policies influencing the primary health care system in Victoria, namely: *Care in Your Community—a planning framework; Rural Directions for a better state of health; Primary Care Partnerships strategic directions; Community Health Services—creating a healthier Victoria,* and initiatives such as the Early Intervention in Chronic Disease program.

Core action areas for change proposed in this paper include the implementation of better integrated chronic disease management models to reduce hospital use and a focus on the delivery of outcomes and better measuring these outcomes. Core actions also cover the development of new workforce models to respond to the changing demographics and needs of our society and to embrace new modalities of health care as e-health opportunities emerge.

Continuing to strengthen partnerships with hospitals, general practice and other health and human services, as well as the people requiring these services, is critical and should be embedded into future directions for our primary health system.

I encourage you to participate in discussion about the future of primary health care in Victoria and Australia and embrace the opportunity to build a strong and robust primary health care system in Victoria.

Fran Thorn
Secretary, Department of Human Services

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1. Introduction

> 'the global imperative is to organise health systems around strong person-centred primary [health] care'
>
> Barbara Starfield May, 2008[1]

The contribution that an effective primary health care system can make to improving the health of a population and reducing health inequalities is supported by international evidence. Primary health care has been shown to have an independent effect on improving health status, reducing health inequalities, achieving better health outcomes for a lower overall cost than systems focused on specialist or tertiary care, and making our health system sustainable.[2,3,4] There is considerable agreement, especially among international organisations and academics, that a strong primary care system is the lynchpin of effective health care delivery and that it can help resolve the lack of continuity and responsiveness in health care in general.[5]

Emphasis on primary health care is supported by the Australian Institute of Health and Welfare (AIHW) report, *The burden of disease and injury in Australia 2003,* which shows that an estimated 32 per cent of disease in Australia is due to poor lifestyle choices that would respond to prevention and early intervention[6]. Chronic health conditions are increasing and are expected to account for about 80 per cent of the overall disease burden in Australia by 2020.

The recently released report from the World Health Organisation, *Primary health care: now more than ever*[7]*,* calls for a return to primary health care to help ailing health systems deliver better performance and equity. The report found that when countries at the same level of economic development are compared, those where health care is organised around the tenets of primary health care produce a higher level of heath for the same investment. The report details how health systems can ensure health equity by contributing to universal access, as well as social health protection and service delivery reforms to reorganise health around people's needs.

In response to such evidence, many countries are investing in strengthening their primary health systems. The Australian Government's release of *Towards a national primary health care strategy A discussion paper from the Australian Government* recognises the important role of primary health care in the broader health care system. The paper acknowledges that primary health care is the frontline of Australia's health care system, and proposes future directions under four key themes.

The Victorian Government supports the proposal to develop a *National Primary Health Care Strategy* but any such national strategy must take into account the unique differences in the primary health care service delivery systems across jurisdictions. Victoria has developed a distinctive primary health system built on the principles of partnerships and service integration that has resulted in some unique features and innovative programs. These include PCPs, Hospital Admission Risk Programs (HARP), Early Intervention in Chronic Disease (EICD) programs and an extensive network of government and non-government community health services servicing local government areas across the state.

1 Starfield B 2008, 'Chronic Care, Chronic Disease Care and Primary Care: One and the same, or Different', paper presented to the Singapore Disease Management Conference, May 2008, viewed September 2008, <http://www.dmconf.com.sg/2008/slides/9_May/9_May_Ballroom2/P9_Barbara_Starfield.pdf>

2 McDonald J, Cumming J, Harris MF, Powell Davies G & Burns P, 2006, *Systematic review of system-wide models of comprehensive primary health care,* Research Centre for Primary Health Care and Equity, School of Public Health and Community Medicine, UNSW.

3 Doggett J, 2007, *A new approach to primary care for Australia.* Centre for Policy Development, occasional paper number 1, viewed October 2008 < http://cpd.org.au/paper/new-approach-primary-health-care-australia>

4 Starfield B, Shi L & Macinko J 2005, 'Contribution of primary care to health systems and health', *The Milbank Quarterly,* Vol. 83, No. 3, pp. 457–502, pp 480–482.

5 Boerma W 'Coordination and integration in European primary care', in Saltman RB, Rico A & Boerma W (eds) 2006, *Primary care in the driver's seat?* Open University Press, p 15.

6 AIHW 2007, *The burden of disease and injury in Australia, 2003,* AIHW, viewed September 2008, <http://www.aihw.gov.au/publications/hwe/bodaiia03/bodaiia03.pdf>

7 World Health Organisation (WHO) 2008, *The World Health Report 2008: Primary Health Care—Now More Than Ever,* WHO, Geneva.

The Department of Human Services proposes that the optimal primary health care system should:

- **focus on wellness and person-centred care**—keeping people well and designing seamless care and population health action that considers the person's holistic needs and enables their participation
- **address inequalities in primary health care access**—people access the health professional they need, when and where they need it through an appropriate mix of public and privately funded services
- **enable people with chronic and complex conditions to have well-planned, integrated care in a community setting that supports people's capacity to self-manage and reduces avoidable hospital admissions**—people are supported to better manage their own chronic conditions and have reduced acute exacerbations.

Such a system should be available for people regardless of where they live, their socioeconomic status, cultural and social background, Indigenous status or the complexity of their health needs.

It is timely to envisage an optimal primary health care system, assess current arrangements and identify areas of change. However, it is important that changes are not considered in isolation; it is critical that system reforms address the key structural barriers simultaneously.[8]

When seeking to improve primary health care systems it is important to acknowledge the effect of the preventive and curative components of the health system on the overall health status of individuals. Access to and appropriate use of services such as public health, dental services, hospitals and pharmaceutical services are critical factors in relation to health outcomes. In addition, the primary health care system cannot respond to all aspects of an individual's health needs; however, an effective and efficient primary health care system can facilitate appropriate and equitable access to other health and broader human services as required. Consequently, partnerships are a core principle underpinning an optimal primary health care system and need to encompass more than the traditional set of inter-professional relationships.

Reform in the primary health care system should be considered in terms of its societal impact on health, wellbeing and equity, rather than only on presumed 'cost savings'.[9]

This paper:

- proposes several overarching priorities for action to reform and develop primary health care in Victoria **(Section 2)**
- outlines a population-focused response to improve access and integration, service delivery and performance monitoring models, specific workforce initiatives and sustainability **(Section 3)**
- provides the context for primary health care in Victoria, including a definition and guiding principles **(Section 4)**.

It is recognised that action on the overarching priorities and actions identified in section 3 may require changes in response and investment by the Australian Government and the Victorian State Government and change of practice by the Victorian primary health sector.

8 Segal L 2008, *A vision for primary care: funding and other system factors for optimising the primary care contribution to the community's health,* National Health and Hospitals Reform Commission, viewed August 2008, <http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/discussion-papers>.

9 ibid.

2. Overarching priorities

In seeking to improve and reform the primary health care system, the following are proposed as overarching priorities.

1. Streamlining funding and financing arrangements, incorporating regional level organisations
2. Strengthening the primary health care workforce
3. Planning and developing appropriate infrastructure
4. Embracing and broadening the use of e-health systems
5. Continuously improving quality and performance
6. Strengthening the primary health care evidence base and its use

2.1 Streamlining funding and financing arrangements incorporating regional level organisations

The Victorian Government's report, *Next Steps in Australian Health Reform,* which forms part of the Government's submission to the National Health and Hospital Reform Commission, states a commitment to 10 key reform proposals, including:

- Establish sub-regional 'Healthy Living Partnerships' to strengthen and coordinate local efforts to keep people fit and healthy.
- Establish more integrated primary care 'super-clinics' in highest priority areas.
- Further consider significant reform to health financing, in the context of a new national health care agreement, including:
  - more consistent funding arrangements across preventative health, primary, emergency departments, acute and aged care, which reduce distortions and create incentives for the efficient allocation of resources
  - in the longer term, regional funding models which would see each state or territory providing for area-based decision making on service 'purchasing' and investment priorities across preventative, primary and acute care, and interim regional approaches which may support a transition to this model.

The Medicare Benefits Schedule (MBS) fee for service continues to provide the majority of individual primary health care for the Australian population. Expansion of scope to access the MBS, for particular services, by other health professionals would enable greater access to care planning for people with chronic and complex conditions. However, reform is needed to address mal-distribution of practitioners (including any broadening of scope) accessing the MBS. This is a significant impediment to achieving a universal scheme and disadvantages those Australians who are already disenfranchised (for example, people with socioeconomic disadvantage).

Consistent with the reform proposals above, a new model for funding and financing arrangements for primary health care in Australia should be explored. Such a model could incorporate the establishment of regional level primary health organisations (RLPHOs) for the planning and purchasing of population preventative strategies and primary health care. This will enable, in particular, targeted effort for people with chronic conditions requiring ongoing and multidisciplinary care (see example model at attachment 1).

The creation of RLPHOs could:

- reduce duplication of population health initiatives and programs funded by different jurisdictions, and the burden of coordinating multiple funding and reporting streams at the provider level
- improve regional or area based planning to support optimal purchasing
- identify and resolve issues of access and timely responsiveness for particular population groups in the regions
- support the planning and purchasing of programs to be led by provider networks such as PCPs, Divisions of General Practice and/or Healthy Living Partnerships
- enable better service coordination, particularly for people with multiple service needs; including with other relevant funded services (for example, acute and sub-acute care, mental health, drug and alcohol, disability, and child and youth services) and local private providers
- identify and address workforce issues such as recruitment and retention and training
- develop appropriate infrastructure and e-health plans
- support innovative practice.

RLPHOs, through their population planning, would identify priority population groups using a life course approach. Priority population groups may include: those most likely to benefit from prevention and early intervention actions (for example children and young people); those who under-utilise MBS items (particularly those likely to have difficulty accessing appropriate primary health care); people at higher risk of chronic conditions; people who use hospital emergency departments to access their health care[10]; and/or those who require support to coordinate care from multiple providers to stabilise their conditions. Through their purchasing role, RLPHOs would be able to identify which providers are best placed to respond to the needs of these groups.

Given the jurisdictional differences in population distribution and existing service systems, states and territories, in partnership with the Commonwealth Government, could determine how the regional level organisation model will be organised in each jurisdiction. In Victoria, the Department of Human Services regional structure, including sub-regional entities such as PCPs, could be used with limited additional investment for organisational development.

In addition, as part of the MBS review, exploration of flexible funding provision for areas with low MBS uptake per population (mainly due to mal-distribution of general practitioners) would be welcomed. This flexible funding could be provided, via the National Health Care Agreement (NHCA), for states and territories to distribute to RLPHOs with areas of need. RLPHOs would then determine appropriate models to provide improved access to primary health care that may include strategies such as capitation funding; funding the use of other appropriate health professionals; or visiting medical and other practitioner services. Alternatively, the allocation of Medicare provider numbers based on population and geographical factors would enable more equitable access to MBS-funded services.

To support better area-based planning and coordinated care (between state and territory funded services, general practices and private providers), alignment of RLPHO boundaries with relevant state and territory regional or sub-regional boundaries should be considered. Access to, and reporting of, epidemiological data for general practice attendances (MBS or RLPHOs) would also support better planning.

2.2 Strengthening the primary health care workforce

Short supply of health care professionals, particularly in rural and remote locations, low socioeconomic areas and some outer urban areas, could be addressed through implementing concerted programs to broaden the practice scope of remote nurses and other accredited primary health personnel. As indicated above, identified funding by the Australian Government could be combined with state or territory funding via the NHCA to maximise coordinated effort.

In addition, financial and non-financial rewards currently being offered to attract health professionals to remote, disadvantaged and outer urban areas could be expanded. Alternatively, as discussed above, allocating Medicare provider numbers based on population and geographical factors could be explored. Further investment is also needed in research, education and change management that promotes evidence-based chronic disease management, integration and multidisciplinary teamwork.

To improve recruitment and retention in primary health care settings, the following could be explored: supporting better student placement initiatives; improving clinical supervision opportunities for workers in community health services; and promoting primary health care services as an employer of choice.

Additional workforce actions are outlined in section 3.

10 Primary care type (PCT) presentations constitute 45 per cent of presentations in Victorian metropolitan Emergency Departments (EDs) and 51 per cent of ED presentations in larger Victorian regional hospitals. The proportion of PCT presentations is higher in areas that correlate with decreased accessibility of GP services, particularly outer metropolitan, regional and rural areas.

PCT presentations occur more frequently in the evenings and at weekends. Over the past five years, the demand for after-hours PCT services in metropolitan hospitals has increased by a total of 18 per cent or 3.6 per cent per annum.

In 2007, New South Wales collaborated with four states, including Victoria, purchasing a joint study from Booz Allen Hamilton Ltd to examine the key drivers of ED demand. The findings confirmed the link between demand and GP access and highlighted changed patient attitudes towards GPs. The under 25 years age cohort were found to be driving PCT service demand, using EDs as a primary care substitute, seeking convenience and wanting to access services all in one place (Booz Allen Hamilton Ltd, *Key drivers of demand in the emergency department—A hypothesis driven approach to analyse demand and supply,* Sydney, 2008).

2.3 Planning and developing appropriate infrastructure

There is a need to develop both funding structures and capital investment to support multidisciplinary care and care planning more effectively to overcome the fragmented nature of the health care system. Further infrastructure investment should be directed to organisations/clinics that provide general practice, nursing and allied health services; have systems to ensure the provision of an integrated and multidisciplinary approach to care; and explore new roles and workforce models.

2.4 Embracing and broadening the use of e-health systems

Service integration can be enhanced by the adoption of supporting technology that is developed around the needs of individuals with a chronic and/or complex condition. Electronic health (e-health) records designed to reflect a patient's journey of care and support effective interaction across health service providers, including general practitioners and allied health providers, with consent, would provide improved service coordination. To this end, the Department of Human Services supports fast tracking the national e-health system.

The PCPs and the Victorian Department of Human Services have put in place the necessary building blocks to enable and evolve e-referral and, as a result, more than 450 services are undertaking e-referral.[11] There is a need to continue to support capacity building in e-referral to ensure further uptake and use.

Use of the internet, mobile phones and telehealth are areas that could be further developed to support the provision of health education, promoting self-management and even treatment. Government and primary health care providers need to be in tune with and embrace the scope of opportunities presented by these developments, including creating incentives for vendors to devise relevant solutions. Research and development and workforce implications will need to be at the forefront of actions in this area.

2.5 Continuously improving quality and performance

Consumers of primary health services have a right to safe, high quality and appropriate health care, to have the opportunity to set goals for their care in dialogue with clinicians, and to receive information to enable them to participate in decisions about their care.

Improving the quality of primary health care services is a continuous improvement process that requires support and direction from government and commitment from service providers. Systematic mechanisms to enable maximum consumer, carer and community participation in service planning, development, delivery and review are critical to building a strong person-centred primary health care system. Improving capacity and embedding practices that support such participation need to be built into these activities at every level.

Ongoing improvement in clinical governance is required in community-based settings and is discussed further in section 3.3.

Measuring waiting times and developing appropriate demand management responses requires primary health care services to reflect upon their models of care and business processes. The implementation of HealthSMART, with an improved data management system recording essential service delivery information, will support the implementation of the demand management framework. It is expected that as the system is implemented, ongoing improvement and refinement will occur.

Primary health data collections in Victoria are being redesigned to better capture the business of delivering best practice primary health intervention. This redesign will enable the development of a greater variety and sophistication of measures to more accurately reflect the performance of the sector. By aligning to the Common Service Data Model being developed for all health collections by the department, over time the data will more accurately report against best practice concepts such as case management and courses of care. These data entities will significantly increase the department's ability to analyse and evaluate the way primary health care is providing improved health outcomes to clients.

11 For more information see the 2006–07 e-referral capacity building through primary care partnerships summary report at www.health.vic.gov.au/pcps/downloads/ehealth/2006_07_ereferral_summary_report.pdf

As a result of better data linkage, it will be possible to understand how people receiving primary health services also use other human services by analysis of primary health collections in relation to other data collections such as health and aged community care, alcohol and drug treatment and mental health services. In addition, the development of spatial analysis and mapping tools for analysis of primary health trends for area-based planning will assist local services to more powerfully forecast and evaluate the delivery of primary health in Victoria.

2.6 Strengthening the primary health care evidence base and its use

While there is a significant body of evidence pointing to how effective primary health care systems can reduce overall health system costs and health inequity, evidence regarding performance measurement and evaluation to drive service quality and practice change is limited. The translation of local research into meaningful evidence for use by other services facing similar issues would be beneficial to extend the reach of proven effective models, many of which are currently being implemented by individual agencies. Examples of this include locally relevant service models, enhancing the effectiveness of working with particular population groups, or effective integrated health promotion models.

Evaluation in primary health care is a major challenge given the broad scope of interventions and interrelated action. In particular, there is a need to develop and trial new methodologies to best capture the effectiveness of multidisciplinary and multi-sectoral approaches employed in primary health care. The development and evaluation of outcomes-focused service models and frameworks will assist in better understanding the complexity of primary health care and differing client journeys. Evaluation of new initiatives must be resourced to develop and improve the evidence base.

A survey conducted by the Australian Institute for Primary Care to consider the research agenda needs for Victoria found that 53 per cent of respondents were dissatisfied with the research evidence they accessed. Key concerns included lack of relevance, gaps in the literature and lack of time to access and sort through literature. The gap in research evidence most often cited was the provision of locally relevant data and research that could be used for planning and service development. Data at local government area level was most commonly required. Identification of the core areas for research to enhance the primary health care system in the future will be important as will the development of a stronger outcome-focussed service system and data collection models.

Developing stronger partnerships between universities and TAFEs, the department and the primary health care sector will result in improved evaluation and transferability of the research into practice. Emphasis should be given to research that expands the effectiveness and efficiency of the system and practice. Participation in research by health service staff can broaden the workplace experience, skills and satisfaction, encourage postgraduate research opportunities, and improve the evaluation of primary care services and projects.[12]

Development of the research capacity of funded services requires leadership from government and organisations supported by policy and organisational reforms, and partnerships with academic institutions.

12 Australian Institute for Primary Care 2005, *Community Health Services Teaching and Research Program Model,* La Trobe University, Melbourne, p. 14

3. A population-based approach to primary health care reform and development

The national discussion paper highlighted four key themes for reform:

i) **access**—all Australians should have access to primary health services that keep people well and manage ill-health

ii) **service delivery model**—service delivery arrangements should be safe, of high quality, responsive to evidence, new technology and local community needs

iii) **workforce**—the primary health care workforce is supported by attractive working environments and flexible education and training

iv) **sustainability**—primary health care is fiscally sustainable, efficient and cost effective.

This section considers how actions in these areas can improve how the primary health care system functions for each of three broad health status groups:

i) people who are healthy

ii) people with chronic conditions

iii) people with complex or unstable chronic conditions.

This approach does not mean that the groupings are mutually exclusive. Rather, people may 'move between' these groups when, for instance, a person requiring intensive case management for unstable chronic disease and other complexities also needs episodic care for an illness or injury unrelated to their chronic disease. Moreover, reforming how the primary health system works for people in group 1 builds the foundation for preventing people moving into the next two categories as well as planning effective care for people in groups 2 and 3.

3.1 People who are healthy

The well population encompasses the vast majority of Victorians for most of their lives, who mainly require timely **episodic** care alongside access to relevant health promotion, prevention and early detection interventions. This group of people may seek only a response to a presenting problem and in many cases these problems are resolved or managed in an ongoing way in general practice. For example, this may include treatment for 'one-off' illnesses or injuries (such as eye infection, toothache or cold); ongoing management of non-symptomatic conditions such as elevated blood pressure with appropriate medication; health maintenance interventions (for example, screening, disease prevention, maternal care) and/or specific multi-sectoral health promotion action.

Increasingly, a life course approach is playing an important role in understanding population health and wellbeing. This perspective views health as the product of risk behaviours, protective factors and environmental agents that are encountered across the life course and that have cumulative, additive and even multiplicative impacts on specific outcomes. It provides a construct for interpreting how people's experiences in their early years influence their later health and functioning.[13] Such an approach could enhance opportunities to improve system capability to extend services to incorporate routine screening and early detection, recall and review, and holistic support to promote healthy lifestyles and behaviours.

Effective population health planning, well researched best practice guidelines, appropriate information management systems and incentives that drive a service model focused on the health and wellbeing of the population, not just the episodic care needs of mostly 'well' individuals, would result in a more proactive system. This change would improve the ability of primary health care providers to understand the health status of the population and better position the system to respond quickly to changes in that population's health status.

Partnerships between the formal health sector and the health and wellbeing sector (including gyms, leisure centres, personal fitness providers, dieticians and nutritionists), as well as other partners able to promote and influence access to healthy lifestyles and environments (including, local government, schools, sporting clubs), will also be important to promote prevention action.

Such a population response would require a primary health workforce that could reflect a broad range of competencies required to deliver a comprehensive primary health care model rather than an historic discipline-specific profile arising from the curative model of primary medical care. Currently access to such a workforce is limited by a number of factors, including inequitable

13 Yu S 2006, 'The Life Course Approach to Health', *American Journal of Public Health 768*

distribution of primary health care services, limited access to after-hours services, insufficient supply of appropriately skilled health care providers and, for some groups, inability to pay for services which affects access to the primary health workforce.

For most people in this group, the current funding model in primary health care is adequate; however, for others the fee for service (FFS) and co payment models result in inequality. The recent paper by the National Centre for Social and Economic Modelling[14] found that when socioeconomic characteristics are investigated using the Index of Relative Socio-Economic Disadvantage (IRSD), there is a clear separation of households in regards to health expenditure. The report states that 'those living in the most disadvantaged areas have relatively low health expenditure'.[15]

Access to dental services, especially for the most disadvantaged people, remains problematic because, unlike medical care, most dental care is not publicly funded[16]. The high cost of private dental care is a major barrier for disadvantaged people to access timely preventive care.

This group of people may limit their expenditure on primary health care services resulting in an under-utilisation of service, with adverse effects on health outcomes. For example, individuals on a limited income who consider themselves 'well' may be unwilling to access primary health services for routine health screening if a FFS or co-payment is required. This under- utilisation of service may result in health issues being undetected and, therefore, untreated at early onset. Such a delay could result in more complex treatment required in the future, a decline in health status that may have been avoidable, or inappropriate presentation at a hospital service as symptoms appear.

In addition to household income factors that may limit access to primary health care service, there is also evidence to suggest that where a person lives may result in considerable inequity with regard to accessing MBS and Pharmaceutical Benefits Scheme (PBS).[17]

Victoria has a strong focus on tackling the broader determinants of health described in its whole-of-government policy, *A Fairer Victoria*[18]. This includes Neighbourhood and Community Renewal initiatives, and a myriad of population health promotion actions such as the Aboriginal Health Promotion and Chronic Care Partnership program[19] and the 'Go for your Life' population specific initiatives[20]. In addition, prevention and early intervention initiatives such as the WorkHealth initiative[21] are proactively screening and following up people identified as at risk of chronic disease.

The Victorian Government acknowledges that the system works quite well for most people who are healthy; however, better population planning and purchasing at a regional level would contribute to improved health outcomes (particularly for those at risk of poor outcomes) and more efficient use of the health resources.

Action areas

Access

- Provide financial and other incentives, such as access to infrastructure and training support, to improve the distribution of primary health service providers, particularly in areas of low coverage such as rural areas and lower socioeconomic areas.

14 Brown L, Payne A, Lymer S & Armstrong A 2008, *Distribution of expenditure on health goods and services by Australian households,* National Centre for Social and Economic Modelling, Canberra.

15 ibid., p. 42

16 Whereas 78% of funding for medical services is public, only 18% of dental funding is public. Of this public dental funding, 40% goes to the private dental insurance rebate for families who can afford private dental insurance (AIHW 2008 Health Expenditure Australia 2006–07).

17 Dwyer J & Eagar K 2008, *Options for reform of Commonwealth and State governance responsibilities for the Australian health system,* National Health and Hospitals Reform Commission, viewed August 2008, <http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/discussion-papers>

18 Victorian Government *A fairer Victoria* available at http://www.dpc.vic.gov.au

19 Department of Human Services Victoria, 2009 (last updated), Department of Human Services, viewed January 2009, <http://www.health.vic.gov.au/communityhealth/aboriginal_health.htm>

20 Initiatives such as 'Well for life' (for older people), 'Kids Life', and Life! (preventing diabetes) available at http://www.goforyourlife.vic.gov.au

21 WorkSafe Victoria, 2009 (last updated), WorkHealth, viewed January 2009, <http://www.workhealth.vic.gov.au/wps/wcm/connect/WorkHealth/Home/>

- Expand incentives to improve uptake of health promotion, early detection and preventive health services across the lifespan, particularly for those people with low socioeconomic status. This could include targeted and integrated health promotion effort and access to affordable services for immunisation, health screening and related treatment services, and participation in health behaviour modification programs.[22]
- Invest in sector infrastructure to support integrated e-health and the use of clinical information systems to provide data for planning and monitoring purposes.
- Develop and expand incentives to encourage an area-based planning approach to better respond to population health priorities and priority groups.
- Expand partnerships with other key sectors that can promote and improve access to healthier lifestyles and environments.

Service model

- Provide incentives for service delivery models that promote after-hours primary health care, appropriate use of telehealth, particularly for rural clients, and team-based care arrangements using a range of appropriately skilled providers and early detection and health promotion activities as well as treatment services.
- Encourage population planning using a life course model.[23]
- Develop targeted service models and health promotion effort, requiring integrated approaches for identified population groups in neighbourhood renewal and community renewal places.
- Engage with high risk and hard to reach population groups to develop service models that:
  - take a more targeted approach to improving access to appropriate services and health promotion efforts to impact on the health inequalities of the Indigenous population
  - target action for other high risk and hard to reach populations (newly arrived and refugees, the homeless, young people, people with disabilities and others with significant access issues).
- Encourage extended involvement by private health insurers and other health maintenance programs, as well as workers' compensation-based initiatives, such as WorkHealth.
- Develop clinical pathway tools to support professionals and their clients through diagnosis, treatment and other decision-making processes.
- Implement e-health standards and infrastructure required for shared electronic health records.
- Invest in strategies to promote health literacy that recognise widely variable levels of health literacy and strike a balance between self-responsibility and professional advice.

Workforce

- Expand the existing workforce through the removal of medico-legal impediments that limit the capacity and scope of new health professionals within primary care services to deliver health care activity.
- Deliver additional training through a range of education providers, such as TAFE and registered training organisations, to ensure adequate provision of competency-based certificate and diploma health training in disciplines prioritised by the National Health Workforce Taskforce: allied health, Indigenous health, dental assistance and nursing.

22 Despite higher rates of chronic disease and lower rates of preventive care uptake, people in low socioeconomic status areas receive fewer longer consultations from GPs than patients in more advantaged areas (Furler JS, Harris E, Chondros P, Powell Davies PG, Harris MF & Young D, 'The inverse care law revisited: impact of disadvantaged location on accessing longer GP consultation times', *MJA* 2002 177 (2): 80–83)

23 The life course approach can help to identify the health needs of the population, from infants and young children to the elderly. This approach, when applied to the development of appropriate service models, can assist agencies to better plan an evidence-based response. Increasingly, the life course approach is playing an important role in understanding population health and wellbeing. This perspective views health as the product of risk behaviours, protective factors, and environmental agents that we encounter throughout our entire lives and that have cumulative, additive, and even multiplicative impacts on specific outcomes. It thus provides a construct for interpreting how peoples' experiences in their early years influence their later health and functioning (Yu,S, *American Journal of Public Health* 768, 2006)

- Improve access to funding for an expanded workforce, which is linked to a competency-based framework to ensure the delivery of safe and effective health care.
- Provide support for additional clinical placements to address gaps in workforce distribution especially in rural and low socioeconomic areas. A key focus should be on improving the quality and experience of placements, providing greater support for clinical supervision and the necessary infrastructure.[24]

Sustainability

- Provide funding incentives that complement the current activity-based payment models (MBS and PBS) to target preventive action, including health promotion and early detection at higher risk and harder to reach populations (Indigenous, newly arrived and refugees, the homeless, young people, people with disabilities) and the use of clinical pathway tools.
- Consider further payment schemes to include dental and allied health services.
- Explore the merit of allocating a proportion of funds on a regional basis to promote alternative models of service delivery, particularly where use of the MBS and PBS is limited by poor access to health providers, in order to address inequities in resource use across states.
- Consider the allocation of future Medicare provider numbers on the basis of population and geographical factors.

24 Successful student placements can play an important role in recruitment and retention of health professionals in primary health services, particularly in rural areas. Students can be encouraged to return to an agency after graduation, if their placements are educationally worthwhile, delivered in pleasant and supportive environments, and a broad range of relevant and challenging experiences offered. Student placements can also support staff retention rates by staff gaining experience in teaching and supervision roles.

Establishing positive working partnership arrangements and viable networks between neighbouring health services and training organisations can expedite placement coordination. Examples include shared clinical calendars, shared supervision across disciplines and students rotating through a number of services during placements.

3.2 People with chronic conditions

Chronic diseases are long term and persistent, leading to a gradual deterioration of health and quality of life through physical limitations and disability. While they are usually not immediately life threatening, they often lead to a gradual deterioration of health and compromise quality of life. People with chronic disease often use health services over extended periods of time and require support from a number of health practitioners and services. As the likelihood of multiple chronic conditions increases with age[25], a generic approach to chronic disease management is used. Chronic disease represents over 70 per cent of the burden of disease in Victoria.

Reducing the burden of chronic disease requires interventions across the care continuum. Service responses need to be proactive, integrated and multidisciplinary. Many people with a diagnosed chronic disease can be effectively and safely managed within the primary health care system. Ideally, the service system should address the needs of people with chronic conditions by:

- stabilising chronic disease at the earliest stage
- reducing the likelihood of exacerbation
- supporting self-management and behaviour change.

A structured care model based on integrating services to meet the needs of patients (such as the Wagner Chronic Care Model), underpinned by e-health systems for referral, clinical decision-support and shared health records, is required for those people who will most benefit from effective management of their illness within the primary health care system. An enhanced version of the model (The Expanded Chronic Care Model[26]) supports better targeting of hard-to-reach populations and complementary health promotion action, which are necessary to tackle health inequalities.

While timely access is very important to stabilise chronic illnesses, problems arise because people with chronic disease usually require more frequent contact with multiple services and are more often on low incomes.

25 Walker A 2005, *Multiple Chronic Conditions: Patient characteristics and impacts on quality of life and health expenditures,* ANU, http://hdl.handle.net/1885/44433

26 Barr VJ, Robinson S, Marin-Link B, Underhill L, Dotts A et al. 2003, 'The expanded Chronic Care Model: An Integration of Concepts and Strategies from Population Health Promotion and the Chronic Care Model', *Hospital Quarterly;*7(1):73–82

Barriers to timely access may arise due to the person's capacity to pay, difficulty in navigating the best care from multiple providers, or multiple psychosocial issues.

Future actions must focus on improving the system's capacity to intervene early, provide proactive and high quality chronic disease care, support client self-management and ensure that client care is effectively coordinated across a mix of state, Commonwealth and privately funded health and other human services.

These actions will require a focus on systems improvement (including pathways, health practitioner resources and tools), workforce innovations, and workforce development strategies.

Primary health care providers in Victoria are advanced in improving service coordination for people with multiple service needs. PCPs have developed uniform practices, processes, protocols and systems to improve service coordination (intake, initial needs identification, referral, including e-referral and care planning) within and between service providers. Introduction of the Victorian Early Intervention in Chronic Disease Management program in 36 local government areas (LGAs) across Victoria[27] has seen improved planned, coordinated and well-managed care for people with chronic disease.

The actions below are additional to those needed to address the needs of 'people who are healthy'.

Action areas

Access

- Implement a client registration (enrolment) scheme for clients identified with chronic conditions. RLPHOs would be responsible for selecting a registration scheme provider for that region, as well as supporting and purchasing coordinated care practice and programs for those registered.
- Provide incentives that promote partnerships between providers at local/regional levels to deliver interdisciplinary service coordination for registered clients. Incentives should support mandatory practice and use of agreed referral platforms as well as encourage timely, responsive care for registered clients by primary health care providers.

Service model

- Support quality improvement by developing systems (such as decision support tools) to ensure evidence-based care becomes routine.
- Implement recall and review systems to support continuity of care for identified clients.
- Promote engagement with harder to reach and higher risk population groups to design appropriate service models and targeted approaches.
- Consolidate PCP implementation of service coordination integrated health promotion and early intervention for chronic disease.
- Strengthen partnerships between state-funded primary health care services, general practices and private allied health services (for example, pharmacists, allied health practitioners and specialists).
- Facilitate the development and implementation of evidence-based multidisciplinary care models and business rules to support better care management for people with chronic disease and complex care needs and to make the best use of available services, irrespective of funding source.
- Develop satellite multidisciplinary teams to provide outreach care from regional centres to rural and remote communities unable to recruit or justify (based on population needs) the provision of a range of practitioners.[28]
- Improve and streamline access to specialist services for people with chronic conditions to promote proactive management of disease.

Workforce

- Improve workforce capacity to provide self-management support and ability to include consumers in the planning and delivery of care. Models should promote mobility across health roles in line with multi- or inter-disciplinary team-based approaches to care, and may lead to the creation of new health worker roles.

27 Department of Human Services Victoria, 2008 (last updated), Department of Human Services, viewed January 2009 <http://www.health.vic.gov.au/communityhealth/cdm/early_intervention.htm>

28 In some cases this may involve primary health providers linking with other remote access models both within and outside the health sector. The teams could negotiate with local representatives to conduct clinics at times suited to the needs of their community.

- Implement the Chronic Care Model, recognising and rewarding the specific competencies, which include skills for patient self-management as well as the more traditional treatment and monitoring skills.

Sustainability

- Explore financing arrangements to support an integrated Chronic Care Model by allowing for the pooling of funds at a population catchment level/regional level primary health organisation.
- Use incentives[29] to reward compliance with best practice care for an enrolled population.
- Allocate funding on a population basis to address the needs of the hard to reach, high risk groups through the RLPHOs to enable the development of innovative models that improve access and care delivery.
- Explore private insurance as a source of financing in pooled-funds arrangements, especially as the number of people with chronic disease and private insurance cover is likely to increase in the future.

29 A review of the non-FFS incentives, such as the Practice Improvement Payment (PIP) and Service Improvement Payment (SIP), could investigate adapting current models to enhance chronic disease management in primary care settings.

3.3 People with complex or unstable chronic conditions

People within this target group have established complex and/or chronic conditions that are not readily stabilised within the primary health care sector. They are at a greater risk of co-morbidities (such as addiction and mental illness) and may have associated social issues (such as homelessness or domestic violence). This group is also more likely to be over 65 years of age and require specific aged care services.

Consumers with co-morbidities, including mental health conditions, who previously accessed tertiary level services, are increasingly being cared for in community-based primary health settings. The trend of increased acuity and complexity of clients in primary health care has led the sector to develop stronger systems and practices to ensure the quality and safety of services. These efforts have been informed by the Victorian Quality Council *Safety and Quality Improvement Framework*[30].

The sector and the department, together with other stakeholders, have collaborated since 2005 to strengthen clinical governance in agencies. The *Clinical Governance in Community Health* project[31] has produced model policies[32], resources[33] and training[34] to strengthen the sector's governance and operational capacity in quality and safety, clinical risk management and clinical effectiveness.

However, due to the multidisciplinary and interdisciplinary care needs of people with complex and unstable chronic conditions, there needs to be co-ordinated care across health sectors as well as other support sectors. This

30 Victorian Quality Council 2005, *Better Quality, Better Health Care: A Safety and Quality Improvement Framework for Victorian Health Services,* Department of Human Services Victoria, Melbourne.

31 Brown A, Mason V & Lyon A, 2008 'Strengthening clinical governance in community health', *Australian Journal of Primary Health,* Vol 14, No2, August 2008. For more information see www.vha.org.au

32 Board Clinical Governance Policy, Clinical Governance Policy and Procedures, Clinical Risk Management Policy and Procedure, and Clinical Supervision in Community Health Policy and Procedure.

33 Clinical Supervision and Leadership (Literature Review, Practice Guidelines, and other resources), Credentialling and Scope of Practice (Literature Review and Guide), Board of Management Clinical Governance Reporting Guidelines and Checklist, Clinical Risk Management Framework and Resources.

34 Training in Clinical Governance for Boards and CEOs, of CHSs, Training in Clinical Risk Management—in collaboration with the Victorian Managed Insurance Authority (VMIA).

includes primary health care (including health promotion), public health, acute and emergency, continuing care/ sub-acute care, specialist mental health, Home and Community Care (HACC), alcohol and other drugs, disability and housing services.

Problems accessing appropriate and timely services, associated with gaps in services and duplication of services, arise because the needs of this group are complex and require intensive case management to draw together the right services across health and community support sectors. Sometimes these people 'by-pass' the primary health care system and present at the acute sector with conditions that could have been managed earlier if the primary health care system had been used.

The service system would work for these people by:

- ensuring the best use of primary, acute and sub-acute health sectors and aged care services
- reducing inappropriate presentations to emergency departments and acute care
- facilitating multi-sectoral approaches to maximise the health and wellbeing of clients in community settings
- reducing prolonged stays in residential care settings.

In Victoria, the Hospital Admission Risk Program—Chronic Disease Management (HARP CDM) focuses on improving the management of people with defined chronic diseases and complex needs who frequently use hospitals or who are at risk of hospitalisation. HARP CDM has successfully reduced the growth rate in demand for acute services, with achievements including improved identification and proactive management of at risk patients; increased health system capacity; and greater collaboration between services.[35] In addition, the specialist clinics reform agenda in Victoria emphasises timely access to care. Wait times for specialist clinics impact on patient outcomes and overall wait times for treatment such as elective surgery. Timely access can be achieved through establishing a patient journey standard; providing patient care in the setting that best matches their condition; and streamlining patient flow.

There are opportunities to better integrate Australian and State Government policy and program initiatives such as HARP CDM, MBS Enhanced Primary Care and the Asthma 3+ Visit Plan.

Action areas

Access

- Implement a client registration (enrolment) scheme for clients identified with chronic and/or complex conditions. Strategic alliances between RLPHOs and acute service providers will determine the appropriate providers to register clients and deliver the care coordination and service provision functions for this target group.
- Provide incentives that promote partnerships between providers at local/regional levels to deliver interdisciplinary service coordination for registered clients.
- Align program eligibility criteria to ensure such barriers to access are removed for complex clients.

Service model

- Provide intensive case management for identified clients that is cognisant of lifestyle or other cultural barriers to access.
- Expand the implementation of the department's clinical governance policy framework in community-based health services. The framework is based on the four domains of consumer participation, clinical effectiveness, effective workforce and risk management.
- Appoint case managers accountable for the planning, monitoring, review and coordination of services for this client group.
- Provide specific 'funding packages of care' for this target group to ensure timely access to appropriate services.
- Increase the effectiveness of appropriate transfers and referrals between primary and acute sectors by including incentive payments for adherence with best practice clinical guidelines.

35 Department of Human Services Victoria, 2009 (last updated), Department of Human Services, viewed January 2009 <http://www.health.vic.gov.au/harp-cdm/>

Workforce

- Provide training in specific competencies for working with people with complex and unstable chronic conditions to support the use of best practice clinical guidelines.
- Develop specific case management roles for this client group within the primary health care system.
- Improve and streamline access to specialist services for people with complex and/or chronic conditions to promote proactive management of disease in the most appropriate care setting.

Sustainability

- Implement payment structures to fund the role of intensive case management and 'care packages' across service sectors and provide incentives for timely access to appropriate health care and support services.
- Develop clear accountability measures for the health outcomes of this group of people at an area or catchment level, linked to funding models.

4. The Victorian context

Victoria has a distinctive, tri-partite primary health care sector, compared to other states in Australia, with the majority of state-funded primary health care services provided by community health services, which are either independent entities (operating as not-for-profit organisations) or components of larger metropolitan or rural health services. Community health services sit alongside general practice and privately funded services and other health and support services to make up the majority of the primary heath sector in Victoria.

State-funded primary health care predominantly refers to primary medical, dental, allied health[36], counselling and nursing services and health promotion action. State-funded primary health care provides significant access to services for the most vulnerable groups in the community, promotes good health, and seeks to intervene early to maximise health outcomes and prevent or slow progression of ill health.

Other health and aged care services that can also be considered part of the primary health care or community-based health care service sector include HACC, aged care assessment, child and youth health services, drug and alcohol, community mental health and, in some cases, secondary care services. These services are delivered by a range of community organisations, local governments, and primary health care providers such as community health services.

Victoria has undertaken significant development in the primary health care sector over the last 8–10 years. Key achievements include:

- establishment and implementation of the PCP strategy
- implementation of the *Community Health Services—creating a healthier Victoria* and *Improving Victoria's oral health* policies and working with general practice resources
- successful population health programs such as the early intervention in chronic disease management, refugee health nurse, child health and the Aboriginal health promotion and chronic care partnership programs
- organisational development supported by the primary health funding reform, demand management framework, clinical governance initiative and implementation of service coordination
- implementation of an evidence-based and integrated approach to the planning, implementation and evaluation of health promotion through the Integrated Health Promotion Framework
- successful implementation of Commonwealth initiatives such as the Australian Better Health Initiative and the Innovative Health Services for Homeless Youth program
- implementation of dental health service integration and reform.

The sector has a tradition of working in partnership with communities, each other and other sectors to promote good health. Partnerships with hospitals, population health services, specialist health and other human service sectors are an important part of the primary health care system, which cannot operate in isolation of these other sectors. Importantly, partnership approaches enable seamless care pathways, effective population health action and better use of available resources.

PCPs are the core component of the primary health care sector in terms of creating a partnership platform for integrated care and health promotion. PCPs have enabled coordination of planning and care pathways for many population groups at risk of poor health, such as refugee and Indigenous groups, people facing difficulty due to severe drought, and people with chronic and complex conditions to prevent unnecessary use of hospital services.

Victoria's progress in evolving PCPs is acknowledged by other states and the Commonwealth, with Queensland now pursuing the initiative based on the Victorian model of collaborative integration of the primary health sector.

36 Allied health refers to audiology, dietetics, occupational therapy, physiotherapy, podiatry and speech therapy.

A definition of primary health care for Victoria

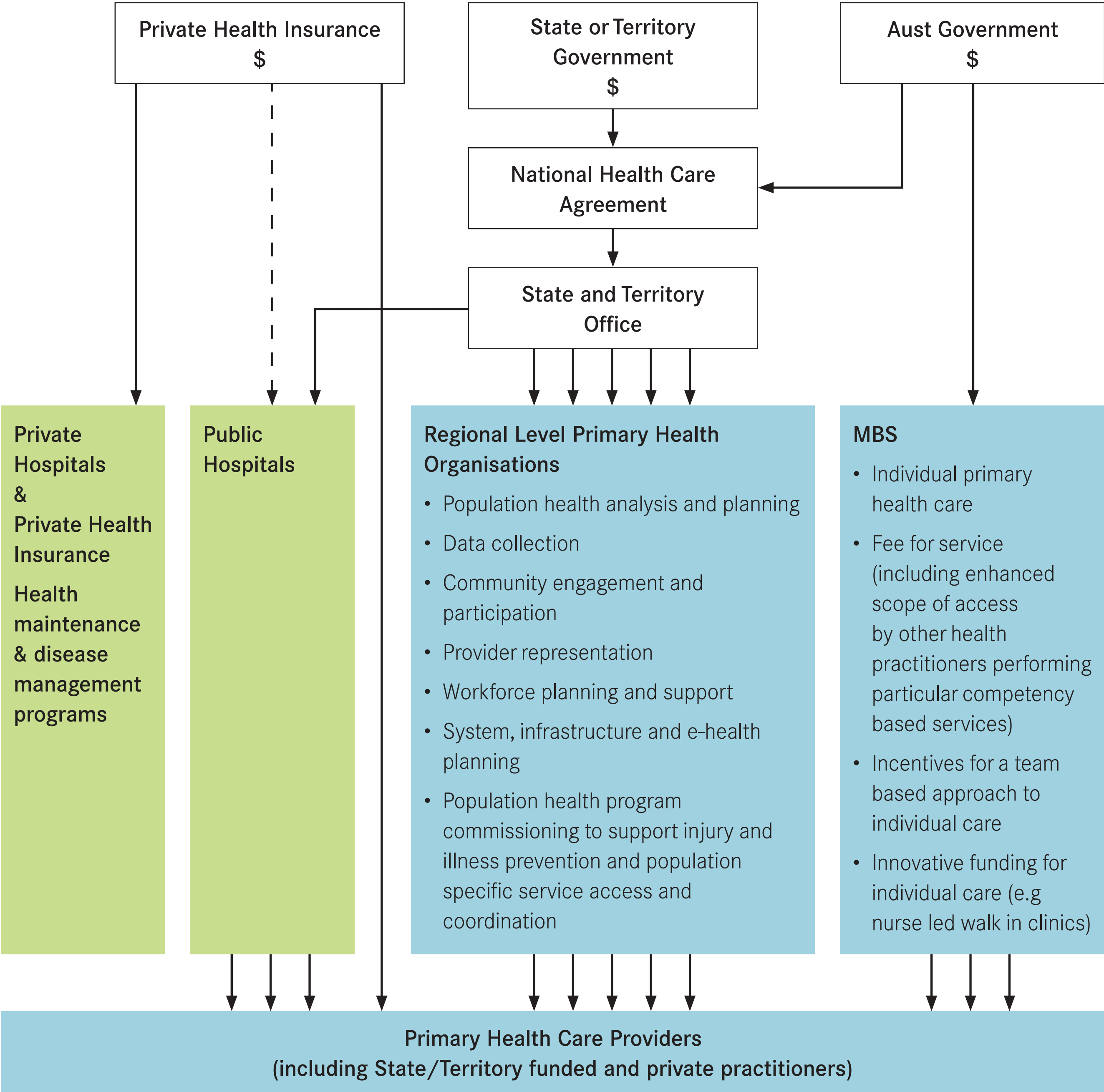
The internationally understood definition of primary health care by the World Health Organisation (WHO), known as the Alma Ata Declaration, was developed in 1978 and still stands today. Most other prominent definitions of primary health care are variants of this definition. The WHO definition has been adapted for the Victorian context.

> Primary health care is integral to the Victorian health system. Community-based, it seeks to protect, promote and develop the health of defined communities; and by addressing and managing individual and population health problems at an early stage reduces the need for more complex care. At the other end of the health care continuum, primary health care services can support rehabilitation and care at home.
>
> Primary health care in Victoria should be provided by a range of suitably trained health practitioners, working collaboratively and in partnership with other sectors, to provide timely, appropriate, integrated and person-centred services and population health actions.
>
> Primary health care services give priority to those most in need and address health inequalities; maximise community and individual self-reliance, participation and control, and use appropriate technologies. Primary health care in Victoria is underpinned by an understanding of the social, economic, cultural and political determinants of health.

Guiding principles for primary health care in Victoria

1. **People and family centred:** services are shaped around the health needs and reflect the determinants of health of individuals, their families and communities.
2. **Equitable and accessible:** primary health care provision should be timely, appropriate, and affordable. Access should be based on health needs and not related to geographic location, socioeconomic status, language, culture or Indigenous status.
3. **Promotes shared responsibility:** services are able to support people of all ages become more self-reliant and better able to manage their own health care needs by providing assistance for managing complex health needs.
4. **Underpinned by consumer engagement and participation:** consumers, carers and communities inform the planning, organisation, operation and control of primary health care. Services should support and encourage individual and community capacity to participate fully.
5. **Considerate of the determinants of health:** recognises the importance of inter-sectoral partnerships in addressing the broader needs of people.
6. **Focuses on prevention and wellness:** planned integrated health promotion action, prevention, early detection and intervention to prevent disease and injury in order to maximise each individual's health potential and the health of communities.
7. **Shared commitment to partnerships:** all parts of the system need to work in partnership to maximise access and enable person-centred streamlined care.
8. **Based on best practice evidence:** the primary health care workforce uses and contributes to the best practice evidence base, including using innovative technologies and developing flexible ways of working.

Attachment 1
Example primary health care funding and financing model incorporating regional level primary health organisations



State Government Victoria

Department of Human Services