

Forward Thinking For The Primary Care Space

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Outline

- Health reform: Where are we up to?
- The Divisions' space
- The practices' space
- The empty spaces: Lost opportunities?

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Health reform: Where are we up to?



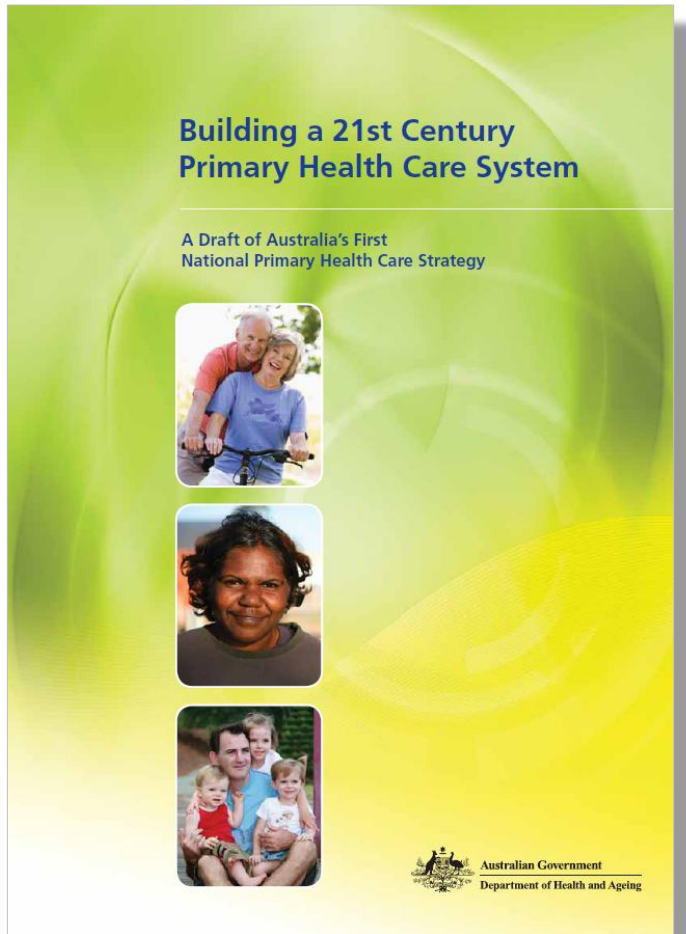
Goals

- Tackle the major access and equity issues that affect people now
- Redesign our health system to meet emerging challenges
- Create an agile and self-improving health system for future generations

Themes

- Taking responsibility
- Connecting care
- Facing inequalities
- Driving quality performance

123 recommendations



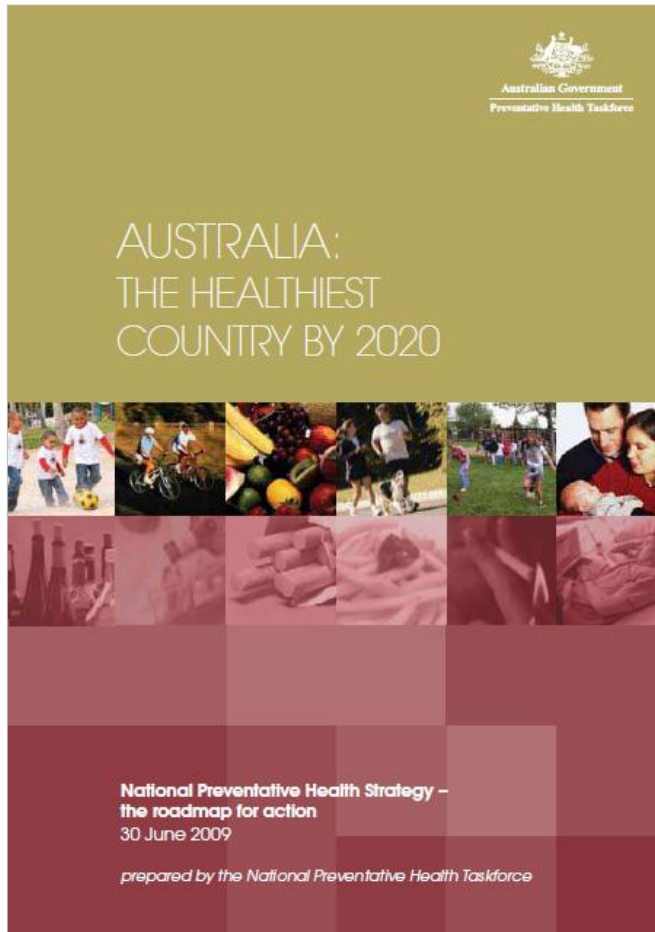
Building blocks for a 21st century primary health care system

- Regional integration
- Information & technology (including e-health)
- Skilled workforce
- Infrastructure
- Financing & system performance

Key priority areas

- Improving access & reducing inequity
- Better management of chronic conditions
- Increasing the focus on prevention
- Improving quality, safety, performance & accountability

Health reform: Where are we up to?



Strategy principles

- Maximising community wellbeing
- Shared responsibility – working together
- Addressing health equity
- Ensuring quality implementation

Strategic directions

- Develop strategic partnerships
- Act early and across life
- Engage communities
- Influence markets/develop coherent policies
- Reduce inequity
- Refocus health systems towards prevention

Health reform: Where are we up to?



Health reform: Where are we up to?



Outline

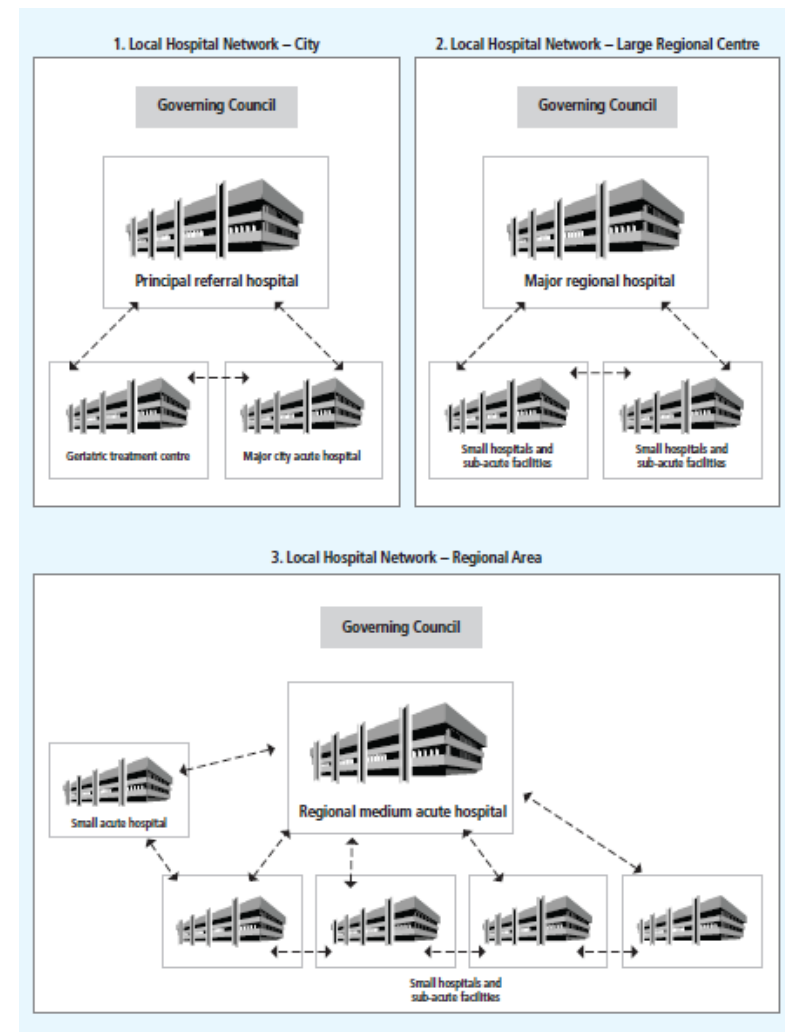
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New roles / new players

- Local Hospital Networks
- Medicare Locals
- National Preventive Health Agency
- Australian Commission on Safety and Quality in Health Care
- National Performance Authority
- Independent Hospital Pricing Authority
- National Funding Authority
- State Funding Authorities

Local Hospital Networks

- Responsible for managing and delivering hospital services:-
 - 120 – 150 nationally
 - Geographical or functional focus
 - Activity-based funding ... in some cases
 - 40% State / 60% Commonwealth funding
 - Governing Council
 - Subject to “clear and transparent performance reporting”



- Governing Council will include local health, management and finance professionals
- Lead Clinicians Groups, comprising doctors, nurses and allied health professionals drawn from within each LHN, will guide Networks on¹:-
 - how national best practice is best delivered locally;
 - how quality and safety can best be improved;
 - service planning and the most efficient allocation of clinical services within the Network; and
 - development of innovative solutions that best address the needs of local communities.

- States will:-
 - negotiate ‘service agreements’ to define “the number and broad mix of services to be provided by the LHN”¹
 - be responsible for “adjusting services between LHNs to meet changes in demand”¹
 - appoint Governing Council members and approve CEO appointments¹
 - “continue to have responsibility for overall industrial relations policy, including the conduct of enterprise bargaining and the setting of broad IR policies such as union consultation.”²
- Clinical expertise on Governing Boards to be “external to the LHN wherever practical”¹

- Independent entities (not government bodies) with strong links to local communities, health professionals and service providers
- Where possible [they] will be drawn from those Divisions of General Practice that have the capacity to take on the roles and functions expected under the new arrangements.
- The first Medicare Locals will commence operations by mid-2011 with the rest to be rolled out by mid-2012

- Functions will include:-
 - facilitating allied health care and other support for people with chronic conditions;
 - working with local health professionals to ensure that patients can access the full range of services they need;
 - identifying people missing out on GP and primary health care, or services that a local area needs, and targeting services to respond to gaps;
 - supporting the delivery of targeted Australian Government programs, such as immunisation, after hours services and mental health;
 - working with Local Hospital Networks to assist with patients' transition out of hospital, and where relevant into aged care; and
 - delivering health promotion and preventive health programs targeted to risk factors in communities.

- But aren't divisions already doing that?
 - Achievements of Divisions in 1995 included work with:-
 - Area health authorities and local planning;
 - Hospitals;
 - other primary health care providers; and
 - consumers and community groups. ¹
 - More recently, in 2007/08:-
 - 57% of Divisions reported being eligible to receive funding under the Australian Government's More Allied Health Services initiative;
 - 94% reported having contracted almost 2,000 allied health professionals to deliver services to patients;
 - 95% reported involvement in structured shared care programs; and
 - 99% engaged in activities to improve GP collaboration with hospitals or specialists. ²



So why bother setting up new organisations?

- Too many Divisions?
- Poor performance by some Divisions?
- Need to encompass a broader primary health care membership?

All issues addressed by the Phillips Review in 2003¹



An additional function:-

- “as needed in the execution of other functions, undertake population level **planning** and potential **fund-holding** roles in areas of market failure and where patient needs are not being met.”¹

The Divisions' space

Options for Divisions:-

- Transform into Medicare Locals

Can **planning** and **fund-holding** be assigned to a privately-owned company or similar organisation?



Voice



Exit

The Divisions' space

Options for Divisions:-

- Transform into Medicare Locals
- Take an ownership stake in a Medicare Local
- Provide services to a Medicare Local
- Provide Medicare Local services to a community

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plus ça change, plus c'est la même chose

- Medicare Locals, like Divisions before them, will work by indirect power and influence
- Primary/secondary care interfaces will not change

The practices' space

New opportunities

- Additional funding for practice nurses
- Enrolment and capitation funding for patients living with diabetes

The diabetes measure:-

- Government will provide “up to \$1,200 a year on average for every enrolled patient [living with diabetes] – to cover the costs of day to day GP care”
- “around \$10,800 a year for the average general practice, [will be] paid in part on the basis of performance in providing better care and improving health outcomes”

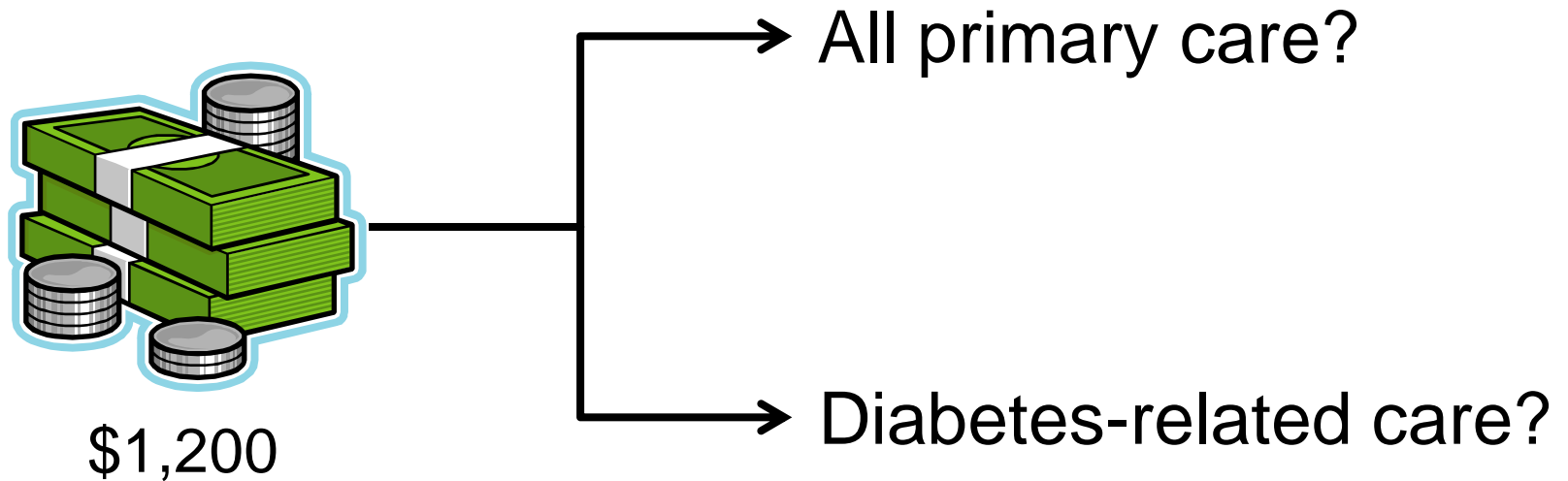
The practices' space



\$1,200

- Encourages delegation and team-based care
- Allows telephone and e-mail consultations and remote monitoring
- Supports 'outsourcing' of protocol-based services

The practices' space



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Lost opportunities

- ‘Top-up’ funding for rural/remote communities
- Voluntary enrolment with a ‘health care home’ for people with complex needs – moving to capitation funding
- Medicare Select