

AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE

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SIREN PROJECT: SYSTEMS INNOVATION AND REVIEWS OF EVIDENCE IN PRIMARY HEALTH CARE:

NARRATIVE REVIEW OF INNOVATIVE MODELS FOR
COMPREHENSIVE PRIMARY HEALTH CARE DELIVERY

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POLICY CONTEXT

Primary health care (PHC) delivery models can be influenced through mechanisms that affect three different system relationships: General Practitioners (GPs) and patients, GPs and other health professionals and third-party funders of PHC and PHC providers. The aim of this project has been to provide a review of innovative models for comprehensive PHC delivery.

KEY FINDINGS

Relationships framework for synthesising literature

In synthesising a diverse range of literature we found that three fundamental relationships affect PHC performance. Policies aimed at improving PHC will influence these relationships. Three relationship types are useful for developing policy options:

- General practitioner/clinician – patients
- General practitioner – other health professionals
- Third party PHC funders – PHC providers

Flexible GP funding

- Supply-side mechanisms are most effective in achieving PHC reform and change in practice
- Delivering funding to groups of GPs and PHC teams encourages joint decision making, team working and discourages solo practice and there are likely to be efficiency and quality gains when working in groups and teams
- Community Health Services (CHS) in Victoria are an example of State funding being used to offer GPs an alternative type of funding

Quality frameworks at a practice level:

- Despite the existence of quality frameworks for performance measurement and management, coupling indicators with financial incentives lacks strong evidence

Meso-level PHC organisations

- Strong PHC systems are characterised by a degree of devolution of governance. In some cases this has taken the form of “meso” level PHC organisations.
- In Australia a number of meso-level PHC organisations exist (Area Health Services, Community Health Services or the Divisions of General Practice network) and may pave the way for implementing PHC reforms.
- Other organisations exist that integrate regional governance of both primary and secondary care, such as Multi-Purpose Services.

Infrastructure:

- PHC infrastructure is key to improving access and equity, enhancing quality and increasing efficiency
- Investment in PHC infrastructure ought to be based on a notion of optimal size and scope of practices

POLICY OPTIONS

The four key areas for potential policy reform include: [flexible GP funding](#); [quality frameworks at a practice level](#); [meso-level PHC organisations](#); and [infrastructure](#). These are not independent of one another and examples of each exist in the Australian health care system.

Three fundamental relationships affect PHC performance. Policies aimed at improving PHC will influence these relationships.

Three relationship types are useful for developing policy options:

- 1) General practitioner/clinician patients
- 2) General practitioner other health professionals
- 3) Third-party PHC funders PHC providers

Flexible GP funding:

- Fund general practices, rather than GPs. The Practice Incentive Program (PIP) is an example of payments to practices rather than GPs. Expansion of the PIP and its use to deliver funding to practices for a range of quality improvement initiatives should be considered.
- General Practitioners and General Practices should have a choice of funding arrangements with their third-party payers. Different funding arrangements can be offered to accommodate variations in GPs working practices and styles which are likely to have a favourable impact on recruitment and retention and local service provision. [Funding arrangements](#) could be between the General Practice and the regional PHC organisation or health authority, rather than with central government. The Community Health Services model is an example of where GPs hold a fund with the State, rather than the Commonwealth.

Quality frameworks at a practice level:

- A combination of regulatory (i.e. accountability, transparency) and integrated (e.g. joint budgets, planning, indicators) governance arrangements are suggested to connect policy development and implementation, with particular attention to clarity about where the accountability for meeting the goals of reforms rest.
- Performance measurement for quality improvement and accountability should be viewed as separate processes. Given this, oversight of performance management may be served by a body that is separate from any organisation assisting practices with their quality improvement activities.
- In addition to using financial incentives, where performance can be measured and linked to evidence-based guidelines, alternative options include linking performance with non-financial incentives, such as directing funding to improving practice infrastructure, new equipment, facilities, rather than individual financial incentives.
- The National Performance Framework developed for Divisions of General Practice may provide an opportunity for further developing quality performance options at the practice level, given that the framework includes scope for this level of reporting although development in this area is rudimentary.

Meso-level PHC organisations:

- Devolution of governance should address issues of optimal size, balance local ownership with economies of scale and consider integration with secondary health care services.
- Devolution could be achieved by strengthening the role of Area Health Services, Community Health Services or the Divisions of General Practice network to become PHC organisation networks, with legislated community boards and multidisciplinary provider representation.
- These organisations could receive pooled funding for both infrastructure and service delivery at a regional and practice level. Improved governance frameworks for monitoring, auditing and accountability would be required.
- Meso level organisations could make greater efforts to integrate primary and secondary health care.

Infrastructure:

- Information technology investment is crucial for linking providers with resources and services beyond the practice.
- The offer of significant new investment in practice infrastructure could be contingent on a commitment to specified quality and accountability arrangements.

METHOD

A narrative review and synthesis approach was used to analyse evidence from five comparator countries (New Zealand, Canada, UK, USA, and the Netherlands) on issues confronting the PHC system in Australia. Evidence was accessed from published and ongoing systematic reviews, general bibliographic databases and search engines, organisation websites, and grey literature. To ensure that the quality of the evidence review was transparent, an [Evidence Review Form](#) was developed. Overall, 780 references were searched and collated, with 318 documents reviewed.

For more details, go to the [full report](#)

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