

AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE

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SYSTEMATIC REVIEW OF COMPREHENSIVE PRIMARY HEALTH CARE MODELS

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POLICY CONTEXT

Primary health care (PHC) improves population health and reduces health inequalities. As a result many countries have embarked on significant PHC reforms that include the introduction of models that operate across the system as a whole and demonstrate a significant political commitment.

This review brings together evidence from a range of national and international initiatives, with a focus on models that promote comprehensive PHC through PHC collaboration. It reviews three main approaches: reform through organisational change, through funding reform and through developments in workforce.

KEY FINDINGS

- **Environment for reform:**
The rapidly changing health system environment in the selected countries makes it difficult to attribute the achievements solely to the interventions, rather than other contributing factors. New waves of reform have often been introduced before previous interventions could be evaluated, leaving different layers of interventions interacting with one another.
- **Organisational models:**
Organisational models achieve change in the organisation and delivery of PHC, but there is less evidence for their impact on quality or health outcomes. The capacity to implement change depends on the levers that are available, especially through funding or commissioning PHC service delivery. Increased funding and devolution of responsibility have been accompanied by increased accountability and changes to governance. New organisations need time and stability to build capability, trust, culture and systems to be sustainable.

- **Funding models:**

Incentive payments are used in all countries and have been demonstrated to influence provider behaviour, except where there is patient resistance or logistical barriers to uptake. However their impact on quality and outcomes is less clear. Particular payments for specific activities may increase provider activity. However, as the number of these incentive payments increases, the complexity of the payment system increases - unless they are part of an integrated performance framework (as in the UK). Devolution of incentive payments to the primary care organisation level may offer increased flexibility but requires increased accountability. This may be difficult without an effective system of patient enrolment. Similarly, capitated payments for a practice population (real or virtual) may provide greater opportunities for delegation of roles within practices.

- **Workforce models:**

The workforce models are designed to enhance access to PHC providers. There are two main types of model – the first involving introduction of new categories of health worker such as mental health workers. However, in the UK recruitment for some categories of new workers has been slower than anticipated. The second approach is to redeploy existing workers in primary care (such as for allied health) or in new roles. Enhancing access to existing workers (often in private practice) relies on the capacity of 'labour market' to bring about shifts in the training and distribution of the workforce. This is increasingly difficult within the context of existing workforce shortages. Introducing new categories of workers can be slowed by recruitment problems and may create strains as existing teams struggle to adapt to a new culture.

Most models include clinical and practice capacity building roles; the exception being allied health provider roles in Australia where the focus is on the clinical role of (predominantly) private practice professionals. There is more emphasis on defining roles than on other aspects of team work. The development of team-based approaches also requires culture change processes as well as support and education for other team members, patients and the broader community, and this aspect of change often receives little attention.

POLICY OPTIONS

Divisions and other PHC organisations

Organisational structures are more effective in changing local service delivery where they control the funds for PHC through some form of commissioning or contracting. This provides the opportunity and flexibility to develop the range and mix of services, multi-disciplinary team approaches and community-oriented models to meet local population health needs that are appropriate and responsive and for which they are held accountable.

Funding models

Funding PHC providers through contracts could be applied more broadly as a strategy to address areas of need and an alternative to rural incentives and the recruitment of overseas doctors for areas of need. Comparable models in Australia are: Aboriginal Community Controlled Health Services and the employment of GPs in some Victorian community health services.

Australia is close to reaching the limits of using specific financial incentives to reward quality and there is potential for a cost blow-out in an uncapped system.

An alternative approach to incentives could be based on a comprehensive performance framework for quality and access similar to that developed in the UK.

Workforce models

Workforce models may be used to meet unmet community needs or involve a substitution of roles of other providers thus freeing up their time and extending the capacity of the team. While developing new categories of health workers is challenging, the capacity of existing health workforce to respond to new needs is so limited that there may be little choice. Evaluation of the impact of these models on both Commonwealth and State-funded PHC sector workloads and work practices is needed.

METHOD

A two stage approach was used:

- Stage one involved identifying relevant initiatives from a selected literature search and consultations with 'in country' key informants. Saturation point was reached through reviewing a relatively small number of key papers.
- Stage two involved a more systematic review process based on electronic database searches, supplemented by web page searches and personal contacts to identify especially government commissioned studies which may not have been published; a method highlighted as being important in systematic reviews of complex interventions. Searches were limited to papers published from 1995 and in selected countries (Australia, Canada, United Kingdom and New Zealand). Strict quality criteria were not used as most studies involved level III or IV evidence. However studies were excluded if there was insufficient evidence of design and methods.

[Seventeen initiatives](#) (table 3) were identified across Australia, United Kingdom and New Zealand that met the inclusion criteria of being system-wide reforms that had a focus on improving access to more comprehensive PHC through collaboration across the range of PHC providers. Thirteen initiatives had publications providing evaluation data on their implementation. Canadian papers all described time-limited demonstration or pilot projects or regional initiatives that had not been applied across the system (i.e. a Province) as a whole and hence did not meet the inclusion criteria.

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

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