THE AUSTRALIAN NATIONAL UNIVERSITY

Why focus on Primary Health Care in health reform process?

Robert Wells
Director Australian Primary Health Care Research Institute &
Director Menzies Centre for Health Policy

Primary Health Care

Primary health care is socially **appropriate**, universally **accessible**, scientifically sound **first level care** provided by health services and systems with a suitably trained workforce comprised of **multi-disciplinary teams supported by integrated referral systems** in a way that: gives priority to those most in need and **addresses health inequalities**; maximises **community and individual self-reliance, participation and control**; and involves **collaboration and partnership with other sectors to promote public health**. Comprehensive primary health care **includes health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation**

Importance of Primary care

Evidence of the health-promoting influence of primary care has been accumulating ever since researchers have been able to distinguish primary care from other aspects of the health services delivery system. This evidence shows that primary care helps prevent illness and death, regardless of whether the care is characterized by supply of primary care physicians, a relationship with a source of primary care, or the receipt of important features of primary care.

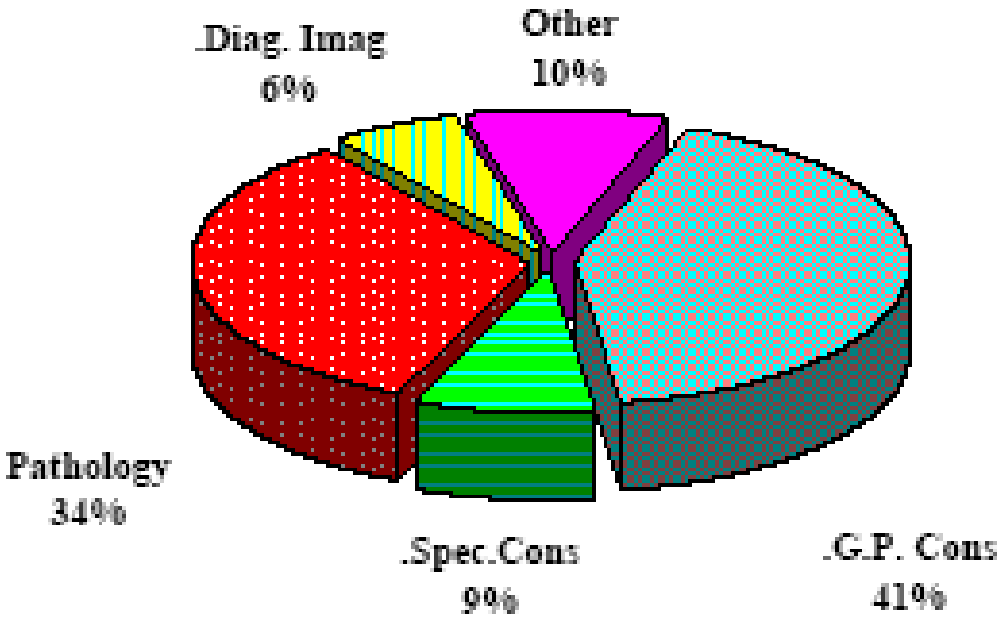
The evidence also shows that primary care (in contrast to specialty care) is associated with a more equitable distribution of health in populations, a finding that holds in both cross-national and within-national studies. The means by which primary care improves health have been identified, thus suggesting ways to improve overall health and reduce differences in health across major population subgroups.

(Starfield et al, *Millbank Quarterly*, 2005)

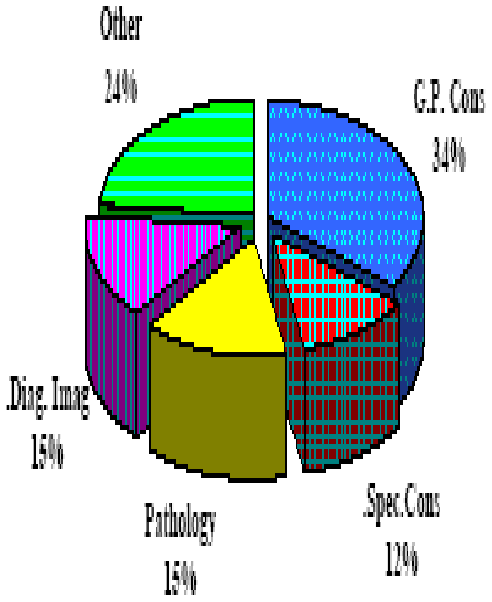
Where does the money go (2006-07)?

Area of expenditure	Amount ($billion)	Proportion (%)
Hospitals	34	39
Medical services	17	19
Medications	12	14
Other (incl dental, community health & patient transport)	24	28
Total	87	100

GRAPH 5 - MEDICARE: Services by Broad Type of Service, 2005/06



GRAPH 6 - MEDICARE: Benefits by Broad Type of Service, 2005/06



Primary care services in Australia

- GP services (100m+ services per annum through Medicare) [Commonwealth funded]
- Community health services (states)
- Drug and alcohol, sexual health and similar services [states]
- Aboriginal Medical Services (including Community Controlled Services) [Commonwealth & states]
- Community support, eg HACC [Commonwealth & states jointly]

Key aspects of reform agenda

- Governance: Commonwealth responsible for all PHC
- Regional PHC structures
- More integrated primary care services
- Increase blended payments in PHC
- Limited patient enrolment (eg chronic disease)
- Electronic health record
- Funding equity entitlement for rural areas
- Single purchasing authority for indigenous health services
- National Primary Health Care Strategy
- Denticare scheme

Potential benefits from reform package

- More patient-focused care
- ➢ Practices able to deal with patient needs more flexibly
- ➢ Wider range of services available under Medicare
- ➢ More capacity to coordinate & support those patients with greatest needs, eg elderly, multiple chronic diseases
- ➢ Practices dealing with a known patient population & able to plan and utilise their resources accordingly
- ➢ Practices able to have up to date information re patients in hospital through electronic health record

Advantages of reform package

A more efficient system

- Inclusion of all PHC services under one funder allows better use & targeting of resources across community
- Hopefully community support services (eg housing & social supports) could be included in the model
- More flexible funding to practices should be accompanied by reductions in ‘red tape’
- More flexible use of available workforce should allow GPs to focus more on diagnosis, complex management and oversight of patient care

Reform package- the downside

- High cost- several $ billions (up to $7bn pa)
- Is there system capacity or is it just an expensive rearrangement of the deck chairs, eg workforce shortages, electronic health record an expensive dream?
- Complexity of unraveling Commonwealth/states financial arrangements
- Primary health care organisations could be another layer of unnecessary bureaucracy
- Professional concerns: inherent risks in any change; reshaping professional roles; extra burden on already hard pressed front line providers of care

Consequences of doing nothing

- PHC system is under immense pressure, with adverse consequences for patients, spillover pressure on public hospitals & increasing demorilisation workforce
- Perhaps we have gone as far as we can with incremental reform
- USA a salutary lesson: PHC eroded over past 30 years; emphasis on high cost specialist interventions; little care coordination, even for the rich; most expensive system

A way forward on some key barriers

- Commonwealth/states: issues predominantly financial; Henry Tax review might be able to resolve.
- Cost: might well be manageable over time; more detailed cost/benefit analysis needed - 20-30 year perspective.
- Professional concerns: many proposed changes already happening on the ground.
- Primary Health Care Organisations: could replace some existing bureaucratic structures; some models to build on.
- More robust accountability measures focusing on population level outcomes should allow reduced red tape

Tougher knots to untangle

- Workforce: training; roles; numbers
- Electronic health record
- PHC/acute sector divide

Conclusion

- Case for a reformed PHC sector very strong
- We know key elements of what needs to be done
- Some of major perceived barriers can be overcome
- So what are we waiting for?