Victorian Healthcare Association

National Primary Health Care Strategy
Secretariat
MDP 94, GPO Box 9848
CANBERRA ACT 2601

"Optimising Health Outcomes through Primary Health Care"

The Victorian Healthcare Association Submission on:

Towards a National Primary Health Care Strategy: A Discussion Paper from the Australian Government

The Victorian Healthcare Association welcomes the opportunity to respond to the "Towards a National Primary Health Care Strategy: A Discussion Paper from the Australian Government" *(the paper).*

The Victorian Healthcare Association

The Victorian Healthcare Association (VHA) is the major peak body representing the interests of the public healthcare sector in Victoria. Our members are public hospitals, rural and regional health services, community health services and aged care facilities. Established since 1938, the VHA promotes the improvement of health outcomes for all Victorians, from the perspective of its members.

In preparing this submission, the VHA has consulted its members and distilled a shared position aimed at improving the health of Australians. This submission remains the position of the VHA and does not supersede any submission or position stated by any member agency.

The VHA stated in 2007 that 'the primary healthcare system is in need of reform to make it simpler, more effective, and to ensure that the system continues to meet the needs of the Australian community'[1,2]. Over the past three years, the VHA has advocated for a reformed health system that prioritises:

- Preventative and population health approaches
- Effectiveness and efficiency
- Quality and safety

Attached are a number of papers the VHA has developed in consultation with the Victorian health sector. The following position statements form the basis of this submission:

- Optimising Primary Healthcare: Refreshing the MBS
- Optimising Primary Healthcare: GP Super Clinics
- Planning for Optimal Health Outcomes: Improving Access to Data

In addition, the VHA has released the following discussion papers, also informing this submission:

- Optimising Primary Healthcare: System Reform
- The Future of Community Health

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Executive Summary

The VHA applauds the promising development of a National Primary Health Care Strategy. This is needed to improve access, reduce the growing burden of chronic disease, meet the demand growth resulting from an ageing population, achieve system efficiencies and move prevention to the centre of healthcare.

This submission recommends a major restructure of all of the tenets of the public healthcare system including funding models and cycles, workforce development and health system planning.

'Tweaking' the system will not deliver the reform needed to sustain the public healthcare system in the face of population ageing, workforce constraints and rising rates of preventable chronic illness. Improving health outcomes is not just about a different service model, but reforming the system as a whole. The VHA hopes Victorian innovation is not jeopardised by federal forays into state jurisdictions. Cooperative approaches, shared learning and integrated reforms based on knowledge are required.

The strategy must not operate in isolation and should intersect with other health reform bodies, including the National Preventative Health Taskforce, the COAG Working Groups and the National Health and Hospitals Reform Commission (NHHRC).

Primary healthcare approaches offer tremendous potential for systemic reform of the healthcare system, providing the definition is correct in the first place. The VHA is concerned that primary healthcare will be mistaken for primary care and as a result governments will continue to focus on and, therefore, fund a disease-based, deficit model of practice that overtly focuses on general practice. A true primary healthcare approach offers pathways for the better use of finite resources. The obstacles to this approach include territory disputes between state and federal governments and between traditional workplace structures and professional boundaries.

The VHA proposes reform through an integrated health system that funds multi-disciplinary teams of health professionals and offers flexible, long-term funding for regional service providers to meet key performance targets. The system should deliver holistic and client-centred services informed by population health approaches, with consideration to the social determinants of health.

This submission recommends:

1. Accessible, clinically and culturally appropriate, timely and affordable

Key Recommendation: The Federal Government must restructure the Medicare Benefit's Schedule to increase the range of professionals and telemedicine options to address critical workforce shortages in rural areas. Local government must contribute to the attainment of National benchmarks through planning and inclusive policy.

2. Patient-centred and supportive of health literacy, self-management and individual preference

Key Recommendation: Governments must invest in better health education in secondary schools to lift "health literacy" particularly among low socio-economic groups. This will enhance personal capacity to make decisions that are less detrimental to health status.

3. More focussed on preventive care, including support of healthy lifestyles

Key Recommendation: Substantial funding increases are required in public health and prevention that go beyond the existing unsustainable 1.8 percent of the national health budget that leads to a paradigm shift towards population health funding measures

4. Well-integrated, coordinated, and providing continuity of care, particularly for those with multiple, ongoing and complex conditions

Key Recommendation: Funding packages must support flexible approaches and provide access to multi-disciplinary teams. There should be further trialling of innovative packages of care that transcend funding boundaries.

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5. Safe, high-quality care which is continually improving through relevant research and innovation

Key Recommendation: To facilitate the systemic changes required there is a need to introduce incentives for health services that are proactive in addressing population health needs and that embed contemporary clinical governance processes within their service model.

6. Better management of health information, underpinned by efficient and effective use of eHealth

Key Recommendation: The VHA believes significant investment is required to create inter-operable eHealth systems that overcome data fragmentation from multiple providers. The cost burden of IT must be borne by governments rather than health service providers in recognising the public benefit from such initiatives. The information must follow the individual, not the provider.

7. Flexibility to best respond to local community needs and circumstances through sustainable and efficient operational models

Key Recommendation: The VHA recommends regional organisations be created to operationalise reform and sustain effective service models. These organisations should be newly formed structures that incorporate community governance models to effectively engage with local communities and service providers.

8. Working environments and conditions which attract, support and retain workforce.

Key Recommendation: The VHA believes that new roles within the primary health workforce and greater flexibility in scope of practice based on worker competence needs to be explored and developed. The funding structures to support such innovation must be created. To meet the challenges of increased demand and declining workforce, demarcation disputes and old funding methodologies must be removed.

9. High-quality education and training arrangements for both new and existing workforce

Key Recommendation: The VHA wants the government to conduct a transparent analysis of training in university health science faculties with a view to shifting to competency based training. A remodeled primary health care system should be staffed by professionals whose roles are based on competency not professional discipline.

10. Fiscally sustainable, efficient and cost-effective

Key Recommendation: The VHA believes that greater accountability is required to ensure that primary health spending is effective and efficient. This requires boards of management to be made accountable for population health indicators in addition to financial and clinical outcomes.

Any federal foray into healthcare reform must retain existing innovations in healthcare delivery. Victoria is a positive example in many areas of health service structure and our submission provides case studies of many positive Victorian projects. In addition, the Boards of Governance structure underpinning Victoria's health services has proven an effective framework for facilitating local solutions for local needs.

The VHA recommends you take the time to read our submission in its entirety and reiterates its commitment to being an active voice on the subject of healthcare reform.

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Context

There is growing evidence of the "health-promoting influence of primary healthcare"[3] in preventing illness and premature mortality and achieving a more equitable distribution of health across population subgroups. The term 'primary healthcare' itself is contentious. The VHA defines primary healthcare as an approach, derived from the social model of health that confronts the determinants of health[4,5]. Within Victoria, this incorporates responsiveness to local population needs through a 'balanced system of wellbeing, health promotion, illness prevention, rehabilitation, treatment and effective management' with allied health practitioners integral to the delivery of services.

A purely disease-based, medical approach to reform will fail to address the social determinants of health. Health services in Victoria operate in close coordination with myriad stakeholders. The paper demonstrates that looking at primary healthcare in isolation is problematic. Therefore, a primary healthcare strategy must complement and interconnect with the work of the National Preventative Health Taskforce, COAG Working Groups and the NHHRC. Clear implementation timelines and strong outcome statements are essential to integrate this into a broader framework.

What are the key elements of an enhanced primary health care system?

Are there aspects of a future Australian primary health care system that are not included in these key elements?

The elements within the paper principally consist of **selective** primary healthcare principles that have not responded adequately to the interrelationship between health and socio-economic development[6] with preventable diseases remaining a major challenge.. **Comprehensive** primary healthcare has thus far not achieved its goals for several reasons, including the refusal of decision makers to accept the principle that communities should plan and implement their own healthcare services[7]. As Keleher notes, "there is much to be lost if primary healthcare is disguised as primary care and not understood for its capacity to make a difference to health inequities; although, of course, in some circumstances, **comprehensive** primary healthcare is interdependent with services provided by primary care"[8].

A disconnect between policy, planning and funding results in a fractured, fragmented system. An approach based on population health-based planning, service delivery and evaluation requires whole-of-government commitment and the accommodation of multiple paradigms, concurrently. One of the major barriers to the application of population health approaches is the fragmented and often conflicting nature of funding methods that significantly influence the way care is structured. Research by Arah and Westert identifies that the contribution of healthcare relies on the systems in place, rather than access alone[9].

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System Structure

Without fundamental reform, the VHA is concerned that current levels of health funding will be unsustainable due to contemporary health challenges coalescing to place unprecedented strain on healthcare capacity.

The VHA and the Victorian healthcare sector have a great appetite for reform to build a health system best suited to meet contemporary needs and plan for future demand. The VHA is concerned the paper takes a myopic view of primary healthcare, with an overtly strong focus on general practice and pharmaceuticals, due to the federal/state funding divide. For too long there has been insufficient supply of funding and infrastructure, due to uncertainty about which level of government is responsible for a particular aspect of the system. A reformed primary health system must overcome this impediment. Systemic structural barriers impede upon optimal primary healthcare in Australia and, subsequently, effective health outcomes.

These barriers are underpinned by conflicting federal and state funding processes. To reform primary healthcare in Australia, it is imperative to change the structure of the health system as a whole. The VHA acknowledges the NHHRC recommendations to align responsibilities and funding for primary health care. This will require clear outcome indicators to ensure primary healthcare does not get pushed aside by the imminent needs of acute care. To resolve this, the VHA recommends the redefinition of the role of GPs, who are already overburdened. Short consultations with GPs often result in re-attendance for people with complex needs. Simply, to achieve a health system that can meet the needs of Australians today, and into the future, we must move from rhetoric to reality.

1. Accessible, clinically and culturally appropriate, timely and affordable

1. **Key Issue:** Governments have failed to enact a "health in all policies" approach and introduce concurrent planning cycles for health services and local government to reduce duplication and develop a shared focus on health.
2. **Key Recommendation:** The Federal Government must restructure the Medicare Benefit's Schedule to increase the range of professionals and telemedicine options to address critical workforce shortages in rural areas. Local government must contribute to the attainment of National benchmarks through planning and inclusive policy.

How can we ensure appropriate services for all geographical areas and population groups?

Victoria recently trialled the *Care in Your Community* project that sets out a framework for a consistent approach to the development of an integrated healthcare system, building on existing strengths in healthcare provision. This framework has potential for health services seeking to achieve a reformed approach. The health sector now requires the resources and impetus to truly realise this change.

The use of telemedicine and linkages with metropolitan emergency staff and resources would greatly improve the provision of emergency and urgent care across rural health services, but this is neither being systematically encouraged nor promoted. Better access to telemedicine and further training in communication of clinical information to on-call doctors could also address some issues.

Refugee Nurses in Victoria

Victoria has instigated Commonwealth and State projects that relocate migrants to fill labour shortages in regional areas by facilitating a welcoming environment and a range of support services. This strategy requires robust health infrastructure to support this.

The Refugee Nurses Program employs nurses with expertise with diverse communities in areas of high migrant populations. This program enables access for migrants to health and social needs assessments, with the nurses crucial to addressing health needs of the newly arrived communities.

Funding follows the provider and providers have the ability to work wherever they wish, resulting in a dearth of practitioners in one area and an overabundance in another. GPs currently perform a "gatekeeper" role within the health system creating additional work for an already overburdened

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workforce. In addition, there are typically fewer GPs in areas of socio-economic disadvantage than in more affluent areas. This skews resources to the wealthy ahead of the poor. If the tinkering at the edges of the MBS continues, the growing burden of disease confronting Australia will be overwhelming.

How could primary health care services/workforce be expanded to improve access to necessary services?

The VHA is pleased the paper acknowledges that team-based models of care are restricted by current program and funding arrangements. Barr et al examine how Wagner's Chronic Care Model (CCM) is geared to clinically-oriented systems and is difficult to use for preventative activities[10]. An enhanced version (the *Expanded* Chronic Care Model) has potential to better integrate aspects of prevention and health promotion into the CCM. This new model includes population health elements to ensure prevention efforts, the recognition of the social determinants of health, and enhanced community participation as part of health teams dealing with chronic disease issues. This strategy requires action on the determinants of health as well as delivering high quality healthcare services.

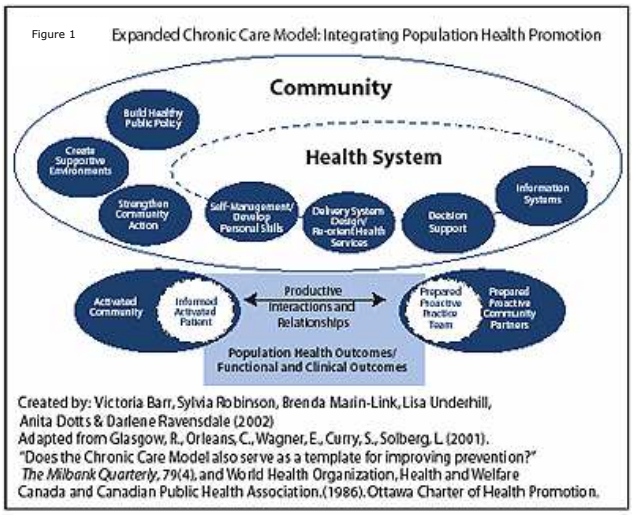

Figure 1 demonstrates clear associations between the healthcare system and the community. Barr et al argues this action-driven model will broaden the focus of practice towards community health outcomes[11].

What more needs to be done for disadvantaged groups to support more equitable access?

The VicLANES study reveals that characteristics of low socio-economic status areas impact on people's ability to engage in activities that promote good health. In other words, place matters for your health[12] with postcodes causing inequity. The existing system is designed to ensure universal coverage, yet the MBS does not meet the needs of the socially disadvantaged or clients requiring longer consultations, due to inconsistency of remuneration to time.

Given demand pressures, major reform is needed to increase the scope of professionals and overcome current system blockages. The extension of the MBS to a broader range of professionals is promising, but does not address workforce shortages. Without a more equitable distribution of providers and reformed structure, extending the MBS to a greater breadth of practitioners will be insufficient.

In every country where it has been studied, the disadvantaged and marginalised are more likely to have a shorter life expectancy and more illnesses than their wealthier counterparts[13]. Policies and programs that aim to strengthen the 'engagement, connectedness and resilience of local communities have increasingly become a core element in public policy responses'[14]. Victoria has had success in Neighbourhood and Community Renewal projects following the release of *A Fairer Victoria*. Wiseman argues this experience suggests that 'engaging and linking local communities can make a useful contribution to local social, environmental and economic outcomes as well as providing a foundation for the democratic renewal of local governance'[15]. To support disadvantaged groups, the VHA encourages

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renewal projects that target the local causes of disadvantage, not just the symptoms. This relies on meaningful engagement of communities.

With limited public health dollars, how could priorities for accessing primary health care services be determined and targeting of public resources improved?
In the current discussions about models and planning, the potential for primary healthcare to improve population health needs to be securely on the agenda[16]. At a time when economic conditions are contracting, it is often tempting to view portfolios that consume large tracts of government outlays such as health as targets for savings. The VHA encourages a bold approach to long-term planning and service development to ensure the health and wellbeing of Australians into the future. While recognising the need for fiscally responsible policy, the VHA wants additional resources invested to enable a transition from the current bed-based focus to primary health approaches.

To address these critical health problems, stakeholders require a cohesive voice "at the table" when decisions are made[17]. Primary Care Partnerships (PCPs), local government and health services currently plan separately as a result of divergent funding and reporting cycles. This results in duplication despite a common focus; structural change is required to remove the barriers to aligned planning cycles. This will facilitate cooperation between services on key health issues and could facilitate funds pooling, effective resourcing and reduce duplication.

Victoria's recent Victorian Public Health and Wellbeing Plan - part of the Public Health and Wellbeing Bill offers scope for cooperation. The plan will include an assessment of the health needs and determinants relating to Victorians. The VHA recommends a "Health in All Policies" approach that introduces "better population health gap as a shared goal across all parts of government and addresses complex health challenges through an integrated policy response across portfolio boundaries"[18].

2. Patient-centred and supportive of health literacy, self-management and individual preference

1. **Key Issue:** There is, unfortunately, very limited or often tokenistic consumer input into how our health system works. Only about half of Australians have sufficient health literacy to fully understand information received from health services.
2. **Key Recommendation:** Governments must invest in better health education in secondary schools to lift "health literacy" particularly among low socio-economic groups. This will enhance personal capacity to make decisions that are less detrimental to health status.

What is needed to improve the patient and family-centred focus of primary health care in Australia for:

- **Individual patient encounters**
- **Health professionals**
- **Health service organisations**
- **The broader primary health care system**

The health sector is responsible for facilitating access to appropriate care at the right time, in the right setting, and with a particular focus on care in the community. Community care should, ideally, be provided (or supervised) by multi-disciplinary teams of professionals. The VHA supports shifting the focus towards the client rather than the client's specific requirement at a static point in time.

A one-size-fits-all approach to service delivery does not suffice. What is required is a multiplicity of approaches to care, supported by principles of equity. A strong primary healthcare system is fundamental to a healthy, productive society. The system must fund packages of care which allow holistic client management. It is ultimately within the system's interest to keep people well. This requires key performance indicators (KPI) of success. However, smaller facilities that transition from an acute-base towards primary health have poor access to funding to aid this process.

Are there specific strategies that are needed to better support consumer engagement and input?
Well organised and empowered communities are highly effective in determining their own health and

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organisations must plan to effectively 'hear the consumer voice'. Media perceptions of the performance of our health system primarily focus on emergency departments, waiting lists and hospital errors. This perception plays a role in shaping funding commitments and political cycles. There is, unfortunately, very limited or often tokenistic consumer input into how our health system works.

Romanow Commission
John Menadue AO has proposed the Federal Government should establish an independent and professional "Romanow-type" commission to engage widely with the Australian community on the design principles for healthcare in Australia. This commission would have an ongoing role to consult with the community and report publicly to the government on whether its health programs are consistent with the agreed principles, and on the effectiveness of health departments in implementing these principles[1].

Three themes emerged from a Health Issues Centre (HIC) review of literature on citizen engagement:

1. Citizens want to be involved in priority setting for health
2. Citizens identify equity and access as issues of significant importance
3. Citizens want greater emphasis placed on prevention

In Victoria, public hospitals are required to conduct consumer advisory committees which provide links with consumers in the service's catchment area, whilst metropolitan hospitals are required to have a Primary Care and Population Health Advisory Committee under the *Health Services Act 1988*. These structures have some potential, but their effectiveness has varied.

North Yarra Community Health (NYCH) Community Liaison Committee (CLC)
The CLC, formed in 1995 engages NYCH with its community and includes board members, staff and community members from diverse social and cultural backgrounds. NYCH provides organisational support including direct communication between board members and the CLC members and representatives. Information sharing from NYCH and the community is mixed with planning, discussion of community health issues, consultation and collaboration on different projects.

A HIC review of the CLC confirmed community commitment to engaging with NYCH. The result is positive relations, a sense of empowerment and a relationship to their health service.

3. More focussed on preventive care, including support of healthy lifestyles

1. **Key Issue:** The VHA believes the discussion paper is too narrowly focussed in defining the role of health services and fails to recognise the potential to incorporate health promotion principles into service provision.
2. **Key Recommendation:** Substantial funding increases are required in public health and prevention that go beyond the existing unsustainable 1.8 percent of the national health budget that leads to a paradigm shift towards population health funding measures.

How could primary health care be enhanced to better support prevention activities?

The VHA and its members are concerned about the narrow role of health services outlined within the paper. The paper aligns health services strongly with the concept of health education and as disseminators of information to assist 'people change their behaviours'. This overlooks the more substantial role played by health services in operationalising the social model of health and integrating health promotion principles into service provision.

People in certain socioeconomic situations do not always have the necessary control over their circumstances to change factors influencing their health or the capacity to make healthy choices. Health services present several clear opportunities for preventative health activities by responding to the needs of populations and promoting health[19]. There is widespread interest across the primary healthcare sector in the prospect of a system that further strengthens this approach. In terms of health service provision and chronic disease, research by Beilby in 2007 identified that 'only about two percent of patient consultations involve health assessments, care plans and chronic disease management items. Less than

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14 percent of patients with a chronic disease are placed on care plans and less than one percent are reviewed to see if patients adhere to these plans'[20].

With rising petrol costs and poor public transport options, particularly in rural towns mean more health and community services are switching to 'external' or 'outreach' services to support the community. In a reformed primary healthcare model, services need to be where people live, work and play. However, this is not considered systemically within the discussion paper in terms of funding.

How could health professionals be better supported to provide lifestyle modification advice and support consumers in behavioural change?

This paper favours a reductionist approach that focuses on the individual, blames the victim, ignores the broader context which determines patterns of behaviour[21] and produces potentially harmful interventions[22]. Individual behaviours are complex and possessing knowledge is no guarantee of change. Baum notes that it is 'probably true that if people were to eat less fat, exercise more, buy safer cars, lead less stressful lives and avoid violence they would be healthier. The beguiling simplicity of the logic, however, ignores many extraneous factors that make change difficult to achieve and ignores the social, cultural and economic context in which decisions are taken'[23].

Watt argues that "people's behaviours are enmeshed within the social, economic and environmental conditions under which they are living" [24]. Whilst behavioural approaches have demonstrated some benefit they must remain one component of an overarching strategy that encompasses social change, empowerment, personal skill development and supportive environments. The challenge is to support these models and invest in programs and structures that work. Reorientation of the healthcare system to a preventative focus through primary healthcare relies on the concerted efforts of practitioners. These practitioners may require guidance to shift to a preventative model they are not formally trained in.

Greg – Beyond Victim Blaming

The potential of Victoria's system can be shown through the example of Greg, who enters the primary healthcare system. In the intake and referral process, it is noted Greg is not managing his medication and continues to smoke. He is then referred to an asthma nurse. During this consultation, it is apparent that Greg cannot afford the cost of his asthma preventer and reliever medications. A financial counsellor identifies a gambling problem, linking Greg to gambling support programs. Effective primary healthcare recognises that asthma may be the last thing Greg will think about when other social issues are apparent.

How can consumers be linked with local primary health care services to support a stronger focus on population-based preventive health care with national reporting?

The VHA support the NHHRC's recommendation to introduce health literacy to the secondary school curriculum. Consumers play a vital role in the health system as partners in the care process, however, they need to be health literate to enable this to happen. Research shows that only about half of Australians have sufficient health literacy to fully understand information received from health services or provided on medications[25]. It is difficult for a consumer to navigate the health system. This is particularly the case for those from CALD backgrounds and marginalised groups. To facilitate the most appropriate access and support, adequate levels of funding for qualified interpreters is imperative. Improving health literacy involves more than the transmission of health information. If we are to achieve health literacy we need to overcome structural barriers within the system[26].

What measures have been, or could be, effective in addressing prevention for specific population groups (eg. Indigenous, rural and remote, low socio-economic status, CALD)?

Indigenous

Australia's biggest failure in health is in regard to Indigenous populations, where life expectancy is 17 years lower than for other Australians. The 2006 Census reports there are over 30,000 Indigenous people living in Victoria and many Indigenous community-controlled organisations operating. There is often

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inappropriate delivery of care to the Indigenous community, despite high levels of poor health and wellbeing. The rigid time structure of consultations with practitioners does not suit the needs of Indigenous people and the inflexibility of the system (as a result of funding arrangements) results in fragmented care. Indigenous health status transcends organisational boundaries.

Reducing structural problems will improve service provision and access to services, potentially achieving better health outcomes through primary, secondary and tertiary prevention. It is important that this process is culturally appropriate, holistic, inclusive and empowering. There is a need for urgent action from all stakeholders; the National Aboriginal Community Controlled Health Organisation (NACCHO), governments, communities, private industry, human services and individuals contributing to a shared goal. There is an ongoing need for engagement and consultation with Aboriginal people to build successful partnerships that achieve gains in health outcomes.

Inner South Community Health (ISCHS) demonstrate collaborative, participatory approaches to health development with Aboriginal communities as an example of an effective partnership.

Our Rainbow Place

ISCHS facilitates "Our Rainbow Place" (ORP) which recognises the importance of 'place' to the Indigenous community. ORP is supported by all levels of the ISCHS and led by Indigenous Elders. Two part time Indigenous Workers are funded through Home and Community Care (HACC), with additional Local Government and Trust Funding. ORP operates from a dedicated facility at ISCHS, as well as in the local area.

Funding is minimal yet this program offers a sustainable model for increased understanding and respect, service development and partnership between Indigenous community members and a mainstream urban community health service. ORP combines a cultural and social approach along with the delivery of health services including dietetics, counselling, physiotherapy, podiatry and dental services.

Low SES

Low socio-economic groups have less capacity to make "healthy" choices due to social factors accompanying poverty and disadvantage. It is important to ensure that the investment is made where the effect is likely to be greatest. In outer Melbourne, the growth corridors around Whittlesea in the north and Wyndham in the west will require additional infrastructure to maintain current service delivery and to meet increases in demand. This is a case of having inadequate infrastructure in the areas of most need. Therefore, the VHA encourages the Federal Government to make longer-term funding commitments (5–10 years) for such programs[27].

Whilst the highly disadvantaged must be considered a crucial population sub-group to target, chronic illness rates indicate the need for services to focus on middle class populations, who require specific strategies to improve health outcomes.

With limited public health dollars, how could preventive care priorities be determined and public resources subsequently targeted?

A 2008 report by the Australian Institute of Health and Welfare (AIHW) estimates Australia's total investment in "public health" activities is 1.8 percent of recurrent health expenditure[28]. The other 98 percent was spent on "hospitals, medical centres, pharmaceuticals and other treatment for people who were already sick"[29]. This 1.8 percent is inadequate for the creation of a truly contemporary health maintenance system. Unfortunately it has remained unchanged for a decade. To facilitate a significant re-orientation of the health system towards prevention, substantial funding increases are required.

Within Victoria, the Hospital Admissions Risk Program (HARP) was designed to reduce growth in demand for acute services by 'collaboratively developing preventive models of care between acute and community providers, targeting people with manifest health needs who are frequent users of the hospital system'.

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This model coordinates existing services and reduces hospital demand. In general, HARP patients experienced:

- 35 per cent fewer emergency department attendances
- 52 per cent fewer emergency admissions
- 41 per cent fewer days in hospital[30]

An evaluation by Bird reveals HARP has economic advantages and beneficial impacts among patients[31].

There is a need to improve processes to identify population health needs across the health system. This includes ongoing assessment of community needs to ensure the most appropriate response. Whilst public health dollars may be limited, there is ample evidence of gross inefficiency. If we continue to use existing healthcare resources then we need to employ them more efficiently and effectively[32].

A paradigm shift is required towards population health funding measures and away from the frustrating era of "projectism" - short-term project funding that achieves limited outcomes. Baum recommends funding should be for a minimum of five years and be granted only if local agencies are committed to sustaining successful projects[33]. Australia can learn from examples in other jurisdictions in developing long-term flexible funding arrangements to eliminate organisational dependence on short term project funding. Harper and Oldenburg recommend "the 'scaling up' of successful pilots to overcome a common problem where numerous pilot programs are funded by governments but there are rarely the funds available to 'scale up' the promising pilots to a level that they could really make a difference"[34].

4. Well-integrated, coordinated, and providing continuity of care, particularly for those with multiple, ongoing and complex conditions

1. **Key Issue:** Urgent and major investment is needed better coordinate care across all spectrums of the health system, to overcome service gaps and ensure patients are at the centre of care.
2. **Key Recommendation:** Funding packages must support flexible approaches and provide access to multi-disciplinary teams. There should be further trialling of innovative packages of care that transcend funding boundaries.

What target groups would most benefit from active clinical care and/or service coordination?

Service coordination and planning are necessary to ensure resources can be mobilised when required. Victoria's health system is built on strong foundations however gaps exist, restricting many Victorians from accessing appropriate services when they need it, undermining the ideals of universal healthcare. The causal factors contributing to increased demand are changing and co-morbidities are increasing. This requires the system to focus holistically on a person's needs rather than a diagnosis of 'now'. As a result of buck-passing, many client groups slip through the gaps.

For some client groups a 'package of care' would provide more effective health outcomes. To facilitate this approach a designated service provider in partnership with clients would receive adequate funding to develop a suitable package of care that facilitates empowerment. The provider would develop a care plan, purchase services and provide care using an evidence-based model. How this will occur in practice needs further definition and trial, but requires sophisticated outcome measures that go beyond perverse incentives and focus on the health and wellbeing of local populations and outcome-based incentives. Eligible providers would require accreditation to show capacity to deliver desired outcomes.

How could information and accountability for patient handover between settings (eg. hospital and general practice) be improved?

Individuals with continuous, complex care needs often require care in multiple healthcare settings. During transitions of care between settings, this population is "particularly vulnerable to experiencing poor care quality and problems of care fragmentation"[35].

The 2004 Commonwealth Fund International Health Policy Survey[36] of approximately 9,000 people across Australia, Canada, New Zealand, the United Kingdom and the United States identified that primary healthcare shortfalls exist in all countries. Gaps were found in patient-centred care, access, safety and coordination of care. The report identifies that 62 percent of Australian respondents' did not receive

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preventative care reminders, the highest of surveyed countries. Similarly, 62 percent believed their doctor had not provided advice on weight, nutrition or exercise and 67 percent believed their doctor had not asked if any emotional issues may be affecting their health over the past two years. The report summates that these are missed opportunities for prevention, due to issues amenable to policy action.

What changes are needed to improve integration between different primary health care organisations?

Investment is required in services linked across funding programs. This requires a unique patient identifier and a data management system that is capable of meeting the needs of the population and a contemporary health system. The paper highlights the concept of an Individual Electronic Health Record (IHER). This requires a great deal of funding and infrastructure. Recent COAG announcements demonstrated a disconnect between fiscal commitment and policy development. For example, an extra $807 million (totalling $1.2b overall) is designated for the Federal Government's computers in schools vision with the National e-Health Transition Authority (NEHTA) only receiving $218 million to continue its glacially placed operations.

What sorts of advantages would there be if patients had the opportunity to 'enrol' with a key provider?

Service providers must be structured to consider their population before they present with acute needs. The Victorian primary health sector is a model which demonstrates a responsible and proactive health continuum encompassing primary and secondary prevention. The establishment of enrolled populations for primary healthcare services is an iterative step in the shift towards population health approaches.

Enrolled populations would see regional funds holders having a defined population of interest, receiving funding based on a range of community indicators. For this approach to work practically across primary healthcare services, outcome measures are needed to measure service and partnership effectiveness. For example, the development of chronic illness programs for specific populations that target identified needs. The most marginalised often slip through the net of health services due to the pressures of those coming through the door and limits to capacity. Enrolling populations would be underpinned by common data systems with technology to facilitate best practice such as reminders and communication through practices such as SMS and outcome tracking.

5. Safe, high-quality care which is continually improving through relevant research and innovation

1. **Key Issue:** The VHA has identified a need for clinical governance training and indicators in the community health sector and acted to implement a training program as a model for primary care.
2. **Key Recommendation:** To facilitate the systemic changes required there is a need to introduce incentives for health services that are proactive in addressing population health needs and that embed contemporary clinical governance processes within their service model.

The VHA supports the changes suggested in the paper to promote the safety and quality of primary healthcare services. One of the main challenges for this sector is in accessing the information to assess performance in quality organisationally. The development of a range of quality indicators is needed to facilitate benchmarking and trend analysis.

The VHA Clinical Governance in Community Health project identified the need to develop clinical leadership in this sector to enhance service quality. The community health sector is largely comprised of allied health and welfare professionals and access to skills in clinical/practice data generation, analysis and interpretation will facilitate practice improvement. Health professionals in this sector have limited opportunities for non-management career progression and retention of more experienced staff is challenging. Retention strategies need to develop in order to retain and train more experienced clinical staff to address quality and research in primary health.

The resources available for continuous quality improvement (CQI) initiatives to address service quality in the primary healthcare sector vary according to organisational size and flexibility in funding models. The

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workforce responsible for service quality and CQI is often seconded from embedded clinical work and has little or no exposure to quality theory in undergraduate training. There is a need to dedicate resources to develop the competencies of the quality workforce in primary healthcare.

What aspects of performance of the primary health care sector could be monitored and reported against?

The logic model developed by the Canadian Centre for Health Services and Policy Research describes the use of final outcome indicators, such as quality of life measures in primary healthcare. This is problematic due to the confounding variables affecting the outcomes for an individual in a community based setting. The model emphasises the need to focus on process and impact indicators to evaluate the effectiveness and appropriateness of the primary health sector.

There is a need to develop generic process and impact indicators that are applicable across program streams in primary health. Areas such as care planning and self management are potentially areas for indicator development. Additional indicators to allow uniform evaluation of safety, access, efficiency and acceptability are also required. The VHA has done some initial work in identifying potential indicators to be used in clinical governance reporting in community health. Further development of these indicators is needed so they are applicable across primary healthcare settings. Until the primary health sector can measure and evaluate quality any research and systems development will be limited.

Who should be responsible for developing and maintaining a performance framework?

The approach to quality in primary health is best driven by a quality framework that is articulated in accreditation standards. A review of the evidence is needed to meet the standards around indicators of quality and safety to ensure higher evidence levels in this area.

Would there be advantages in linking patient health outcomes and quality of care provided to incentives for health care professionals?

Currently, there are perverse incentives in the health system, such as the structure of MBS payments which encourage short consultations (7 minute medicine) and procedures over other services[37]. There are currently no incentives for health services to lead with population health approaches and current acute funding models discourage non-bed based solutions.

To facilitate the systemic changes required there is a need to introduce incentives for health services that are proactive in addressing population health needs. Little flexibility exists in a system hamstrung by a focus on fee-for-service and isolated episodes of acute care and workforce shortages[38]. Humphreys and Wakerman undertook a systematic review[39] of rural primary healthcare literature and concluded that funds pooling can be effective in enabling services to better meet community needs. According to the authors, the literature suggests the benefits of moving away from the predominance of a fee-for-service model to a blended payment system.

How can we improve the current research culture and evidence-base in primary health care?

In 2004, one of the recommendations of the national roundtable on primary healthcare was to improve research capacity[40]. Evidence around many primary healthcare interventions is currently minimal and therefore, dedicated research funding needs to be made available in the primary healthcare setting. The Primary Health Care Research, Evaluation and Development (PHCRED) Strategy is a useful model for encouraging clinicians to address issues in service quality.

The PHCRED model develops research capacity while, at the same time, allowing primary healthcare practitioners to combine their work in the sector with study. A model such as this could be used to target priority areas for research in primary health, such as the development of broad quality and clinical indicators. There is a benefit to formally linking the research priorities to state government policy agendas/initiatives to ensure dissemination and implementation of any relevant research findings.

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How can we translate evidence or innovation into practice more systematically?
The use of evidence is imperative to demonstrate the outcomes of primary healthcare and to make use of scarce resources. In the case of general practice, there is a lack of accountability due to their role in the current system. General practice is an expensive component of the health system and without effective evidence, costs will continue to skyrocket.

Translating research evidence into programmatic change has proved challenging and the evidence around how to effectively promote and facilitate this process is still relatively limited[41]. Much of the evidence is not contextualised for the primary healthcare setting, except in the domain of general practitioners. The broader primary health sector would benefit from a national forum for showcasing best practice in primary care and highlighting any relevant evidence-based research.

What options could be used to support health care professionals' involvement in research and innovation?
By providing primary healthcare professionals with the option to engage in part time research as discussed above the capacity for professional to be involved in research is enhanced. The health sector is also interested in pursuing the role of senior research staff in primary health organisations to ensure effective evaluation of programs.

6. Better management of health information, underpinned by efficient and effective use of eHealth

1. **Key Issue:** Significant underinvestment by governments in eHealth has hampered the gains for patient outcomes and health system planning that can be made through effective information management systems.
2. **Key Recommendation:** The VHA believes significant investment is required to create inter-operable eHealth systems that overcome data fragmentation from multiple providers. The cost burden of IT must be borne by governments rather than health service providers in recognising the public benefit from such initiatives. The information must follow the individual, not the provider.

What is the role for eHealth in supporting the provision of quality primary health care?
The health system currently makes extremely poor use of information technology when compared with other public and private sectors. The VHA supports astute investments in eHealth to not only reduce administrative costs but also support continuity of care, better identification of patients at risk, greater safety and more patient control[42].

The eHealth delay
"The introduction of e-Health has been glacial despite the potential benefits in patient satisfaction, reduced costs and fewer mistakes with modern information technology. This is not a political or philosophical issue. It is an operational and administrative matter for which government officials must bear the chief responsibility" – John Menadue AO

Where should the Government prioritise its actions in relation to implementing eHealth reform?
A better system for managing health records is urgently required. This must allow an individual patient's journey to be both coordinated and seamless, facilitating better patient outcomes. With improved technology, the opportunity exists to standardise health records and clinical communications in a way that accommodates all stakeholders, consumers and clinicians. This requires the implementation of systems that allow patients to create Personal Health Records to enhance continuity of care.

In Victoria, individual health agencies are required to pay for their share of implementation expenses and ongoing costs and have subsequently reported mounting budgetary pressures. For some smaller health services, IT costs have doubled recently and form a substantial proportion of their operating budgets. Effective eHealth infrastructure is of public benefit and should be funded by government. A recent Victorian Auditor-General's report *Delivering HealthSMART* found delays in implementation will mean that the HealthSMART shared services arrangement will require an extra $61 million of subsidies until enough

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agencies have implemented HealthSMART. Some agencies are at risk of not fully benefiting from the investments made through the HealthSMART program[43] which hampers service provision.

How can the various information systems be integrated (e.g. state health services and general practice)?

If COAG is willing to initiate systemic change, it must include "measures that deliver tangible improvements along the way as well as lead to structures with better in-built incentives for improved performance"[44]. This includes data collected by the Health Insurance Commission, the biggest source of information on the primary healthcare in Australia. This data is difficult to access and only limited information is provided publicly. Broader access must be facilitated to this database.

7. Flexibility to best respond to local community needs and circumstances through sustainable and efficient operational models

1. **Key Issue:** The existing models for the co-ordination of primary healthcare services lack the accountability frameworks required to meet health needs of the community. The VHA believes smaller health services, in particular, need more funding to transition from acute to primary health care models that focus on patient-centred care.
2. **Key Recommendation:** The VHA recommends regional organisations be created to operationalise reform and sustain effective service. These organisations should be newly formed structures that incorporate community governance models to effectively engage with local communities and service providers

How could planning for primary health care services at the local level be improved?

The VHA endorses governance structures responsible for decision-making behind service delivery. Despite a move internationally to decentralise health system governance, health systems are still governed at the State or Territory level in many Australian jurisdictions. Where Victoria differs is the election and appointment of health service boards of directors under the *Health Services Act 1988*; increasing public involvement while maintaining government accountability.

Planning at a community level is an effective way to determine the most pressing local needs. It also ensures a long-term view (to facilitate prevention) and ensures health services are proactive rather than reactive in service planning. Health problems need to be addressed at the causal level, with coordinated policy approaches. Community management, supported by appropriate funding mechanisms, ensures local planning processes meet local needs.

What advantages/disadvantages would there be in having a regional organisational structure with responsibilities (ranging from local planning through to service delivery) for primary health care services?

At a local level, there is the need to plan and coordinate service delivery to best meet the health needs of communities and ensure services are 'in touch' with their local areas. A regional structure could be mandated to take a lead role in facilitating local primary healthcare reform – and have authority to do so.

The VHA proposes the concept of Primary Health Care Consortiums (PHCC) in the discussion paper *Optimising Primary Health Care: System Reform*. Whilst partnerships in Victoria have demonstrated benefits to the community, the VHA believes regional governance structures need to be put in place that emphasise accountabilities for population health. This must not become another troublesome layer of bureaucracy, but rather act in a way that operationalises national priorities for regional areas, based on local area agreements. This provides a structure aligned to health planning, with the capacity to make decisions yet appropriately removed from "turf protection".

The creation of PHCC, as a vehicle for service integration and change, provides a local direction for service modelling. PHCCs would undertake a local strategic needs analysis to determine any additional health priorities within the local area. The PHCCs would then direct the development of the service structures required locally, through local service providers.

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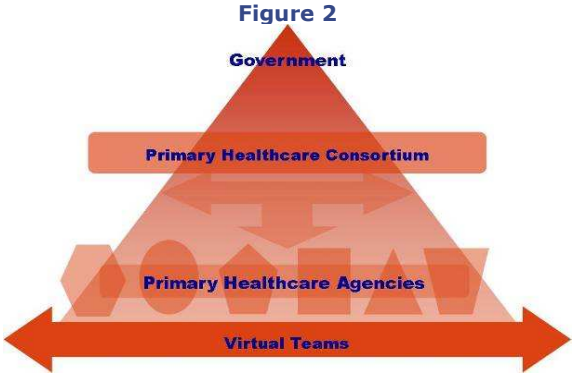
Priorities would be set at both a government and PHCC level. **Figure 2** provides an illustration of how this may operate in practice.

Figure 2



Who could undertake this role? – What changes would be need to existing organisations (eg. Divisions of General Practice, Area Health Services) to undertake this?
To prevent 'turf protection' that limits reform, PHCCs need to be independent from service providers to ensure system change can occur. However, service providers need to be heavily engaged and empowered in the process. The PCP strategy aims to improve health outcomes and better manage service demand by functionally integrating health and community support services[45]. The VHA believe this model forms a basis for the next iterative step in structural change.

Over the past decade, Victoria's Divisions of General Practice have become embedded as geographically-based planning and development organisations[46]. The VHA believes the Divisions are based on boundaries that do not meet the requirements of sensible planning frameworks and do not take a social determinants framework. In the current pluralistic health sector of Victoria, the Divisions would not meet the criteria of community governance, as demonstrated by the Victorian governance model.

What advantages/disadvantages would there be if regional organisations were responsible for purchasing some primary health care services for their communities - that is, should they 'hold funding' for health services?
International experience demonstrates that primary health reform necessitates new, flexible structures. The success of reforms in other jurisdictions has relied on time and stability to build capability, trust, culture and systems in sustainable ways that will impact on quality of care and improve health outcomes[47]. As such, short and long term goals are required that go beyond political or budgetary cycles.

Short-Term Goals
In the short-term, PHCCs would be responsible for planning, monitoring, instigating performance indicators and identifing areas of the structure that require change.

Long-Term Goals
Ultimately, PHCCs would be responsible for establishing required health outcomes from providers. The PHCCs would have responsibility for directing new primary healthcare resources. Where appropriate PHCCs would be a vehicle for "cashing out" of MBS funding, as described in the VHA Position Statement, *Optimising Primary Healthcare – Refreshing the MBS.* It would be a funds holder and funds pooler; initially with funds to restructure the system followed by funding delivered through PHCCs, on the basis of population health need. PHCCs could be a vehicle for directing disparate primary healthcare dollars and a platform for service delivery across the primary healthcare and early intervention spectrum.

What mechanisms could be used to improve the accountability of primary health care services being delivered in a locality (in respect to quality of care, reach and equity)?
There is need for coherent health policy at all levels of government that articulates priority directions at a

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regional and local level. Policies must include clear accountabilities and outcome requirements for funding, being strategic but not too directive. International experience shows that a balance between centralisation and decentralisation is needed to achieve flexible funding.

The inability of integrated community health services to access MBS funding in Victoria limits the reach of service delivery. Many rural providers cannot claim private health insurance from providers or claim Medicare or MBS items. This leads to service gaps and under-provision of services in regional and rural locations where the workforce is limited. This results in a lack of regional/rural workforce available to provide MBS services and reduced service delivery in regional areas.

A strong primary health system requires strategic restructuring that links disparate programs. This necessitates clinical, financial and service governance based on the principle of enabling local people to have their voice heard. An alternative governance model such as PHCC could achieve this.

Whitehorse Community Health Service (WCHS)
In 2004, WCHS surveyed the health of its community, modelled on the Victorian Population Health Survey, examining the general Whitehorse population, the Chinese sub-population, and the low SES sub-population for cardiovascular risk factors and community connectedness. This study provided WCHS with an evidence-base to direct its service planning informed by a better understanding of the key characteristics of priority groups in the local community.

This data provided local stakeholders more precise planning with risks identified amongst sub-populations and was integrated into the 2006 – 2009 WCHS Health Promotion Plan. However, the process was costly, time-consuming and relied on support from external stakeholders. If this approach is to be replicated, services must be assisted with costs and resources. This model was the first of its kind in Victoria and has the potential to succeed on a broader basis.

How can greater community engagement be supported in primary health care?
Community participation in the services being delivered through PHCC is important to ensure services reflect local needs. Partnership between the community and the provider – working ***with*** the community rather than ***on*** them has proven successful. Achieving this at a broad level would better identify the needs of those who do not necessarily walk through the door of a service.

What other approaches could improve planning and service integration at the local level?
To understand the intricacies of communities, population health data must be available to services in a way that supports effective service planning. Mortality and morbidity are the minimum requirements in terms of data. Measuring the overall health and wellbeing of the community requires a much broader approach. Information about the geographical, cultural and socio-economic status of groups is pivotal to the development and success of primary health programs.

Fitzgerald advocates that "by giving the long-term, continuing responsibility for the health of all residents within a region to a single authority, there would be greater emphasis on improving the health status of that community, and increased capacity and incentives for continuity of quality care and service integration"[48].

8. Working environments and conditions which attract, support and retain workforce.

1. **Key Issue:** The existing primary health workforce is struggling to meet the needs of the community and will not be able to meet future needs unless significant changes are made to existing structures.
2. **Key Recommendation:** The VHA believes that new roles within the primary health workforce and greater flexibility in scope of practice based on worker competence needs to be explored and developed. The funding structures to support such innovation must be created. To meet the challenges of increased demand and declining workforce, demarcation disputes and old funding methodologies must be removed.

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What changes in working arrangements and conditions will better support primary health care professionals?

A skilled workforce is vital to meet the emerging health needs of communities. The solution to the workforce dilemma has two elements:

- The creation of roles that complement trained professionals by relieving them of time consuming elements of their job
- Increased numbers of trained professionals

A radical transformation of the health workforce is looming due to pressures on the public healthcare system caused by an ageing population and workforce. There is a need to create multi-disciplinary teams of health professionals to transcend traditional workplace structures. Health roles and new professions are expanding and empirical evidence supports the use of teams in healthcare to improve both the quantity and quality of healthcare services[49]. PHCCs provide the organisational structure to drive systemic change required to embed multi-disciplinary approaches across the primary health system.

Fundamental workforce innovation is necessary, including changes to scope of practice and job redesign[50] that will ultimately disrupt historical hierarchies. However, the end result, a more efficient, effective and sustainable health system will be undeniably beneficial for all. Existing government funding models continue to stymie innovation in healthcare delivery which is a significant barrier to workforce transformation. Many attempts have been made to better meet communities' health needs only to be blocked by archaic funding systems and union pressure. These barriers must be removed.

A universal electronic health record would allow for true multidisciplinary coordinated care. The VHA acknowledges that the debate surrounding privacy and confidentiality slows this process and needs to be resolved. In addition, improving telemedicine facilities would allow practitioners to achieve joint consultations through sound and video links, without having to leave their workplace. This relies on the success of improving broadband infrastructure nation wide, particularly in rural areas[51] where isolation, lack of communication and lack of access to specialists[52] remains difficult.

How is teamwork facilitated in primary health care services and between them?

Current siloed project-driven funding cycles do not encourage teams working together at a local level. This limits progress, longevity, continuity and long-term examination of success. To make significant gains, long term-systemic funding is required that transcends political or planning cycles, especially when targeting the complex causes of poor health. The health system is over-politicised with short electoral cycles and the demand for instant solutions not compatible with reforming a large and complex system[53].

Chronic disease must be managed over a lifetime using the skills of a wide spectrum of professions. Evidence also suggests that organised systems of care, not just individual healthcare workers, are essential in producing positive outcomes'[54]. It is becoming increasingly recognised that "funding arrangements need to recognise the benefits of a coordinated approach to patient care and should fund all healthcare providers accordingly"[55] and that multidisciplinary team interventions do "improve outcomes for patients within the primary health setting"[56].

The intake and referral model within primary health services in Victoria drives service delivery through multi-disciplinary teams. The intake assessment is undertaken using robust tools and can be undertaken by a range of professionals trained in the intake system. This model has been standardised across much of Victoria, which has lead to improved referral and standardised access to services. These intake systems also identify broader health needs such as housing, social neglect and mental illness. The VHA believes this approach makes better use of available resources and encourages investigation of how intake systems could undertake a 'gatekeeper' role within the MBS.

How could the general practice nurse role be developed and enhanced?

Almost 60 percent of general practices now employ at least one practice nurse however Keleher et al argue that "Australian Government initiatives to support the expansion of practice nursing are not consistently based on strong evidence about effectiveness, outcomes or efficiencies"[57]. Similarly, practice nursing in Australia is under the "spotlight as a means to improve access to primary care services.

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However, the current funding model of general practice relies on task allocation, which limits and controls the type of care nurses are able to provide"[58]. A strengthened practice-nurse workforce has the potential to drive change and improve the delivery of many aspects of primary care[59].

How can newer models of care or newer workforce roles (such as nurse practitioners and physician assistants) better support health professionals to meet demands created by a changing primary health care environment?

Of particular concern to rural areas is the difficulty of maintaining a medical workforce and the capacity to attract myriad professionals, including nursing, allied health and management. Numerous research studies alert us to the fact that with an ageing population, the number of people entering the workforce will become less than the number of people leaving the workforce. As a result, the health industry will need to compete with other industries for a shrinking labour force. The demand for health professionals will increase due to the chronic-care needs of an ageing population. The challenge is convincing a dwindling labour market to make health a career of choice, and to find new methods for providing care.

Changing the dynamics of the health workforce will assist in overcoming service inequity. An overburdened system requires the investigation of how nurse practitioners, physician assistants, allied health assistants and other 'new roles' can be better utilised to develop an integrated skills mix within a service. The VHA encourages the 'Nurse Practitioner model' to develop at a faster rate than is currently occurring, particularly in areas of practice that:

1. Assist isolated rural communities to maintain important 'first-response' services
2. Complement the role of the medical practitioner in a way that reduces their time commitment to the direct delivery of care

Bendigo Community Health Service (BCHS) – Nurse Practitioner

Nurse Practitioners are allowed to diagnose and treat certain ailments, order some tests and can perform minor procedures. In 2003, the Rural Men's Health Nurse Practitioner Project was established at BCHS. The project is designed to assist men to access health services in a regional centre, to ensure that services are delivered in a responsive manner. This includes a Men's Health and Wellbeing Clinic, open one evening per week, providing after hours services to working men.

A trial in the Netherlands[60] was conducted recently to evaluate outcomes of care provided to patients by general practitioners or nurse practitioners as first point of contact. A total of 1501 randomised patients in 15 general practices were consulted by either a general practitioner or a nurse practitioner. When comparing overall care, there were no statistically significant differences found between groups. However, patients in the nurse practitioner intervention group were more often invited to re-attend, receiving more follow-up consultations and experienced significantly longer consultations.

The authors concluded that nurse practitioners and general practitioners provide comparable care, arguing for an increased involvement of specially trained nurse practitioners in the Dutch primary healthcare system. Of concern to the VHA is that the criteria to attain registration as a nurse practitioner is set at a very high level (Masters) in Victoria. As the role is not research based, the VHA encourages the examination of models applied successfully in other jurisdictions that do not require study to this level and must be considered when defining the future application of skilled nurses. The VHA believes that with the right systems in place, these models can be utilised without jeopardising quality and safety.

Are there specific changes needed in those regions or populations where there is difficulty attracting and retaining staff?

Compared with areas of high socio-economic status, the least advantaged areas of Australia have higher levels of smoking, physical inactivity, obesity, higher prevalence of diabetes, heart disease and arthritis and higher mortality across most chronic diseases[61]. Despite this, funding follows the provider and the provider has the ability to work wherever they wish. Therefore, there are typically fewer practitioners in areas of socioeconomic disadvantage than in affluent areas. As an example, there are over 170 counsellors billing Medicare in Booroondara, one of the more affluent areas of inner Melbourne.

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This skews resources to the wealthy ahead of the poor and results in poorer health outcomes for the most disadvantaged. Without a more equitable distribution of providers, extending the MBS to a greater breadth of service providers within the current structure will be insufficient to tackle disadvantage. It is therefore necessary that the review of MBS addresses the core issue of access to ensure that the less affluent have equitable, proportionate access. Extending the MBS has thus far only perpetuated the maldistribution of MBS funding. In reforming the MBS system, the VHA wants to see population-based funding approaches to address the health needs of populations and subsequently, reduce rates of chronic disease, reduce hospital admissions and improve health and wellbeing. Pooled funding and "cashing out" of MBS funds would provide a better distribution of funding and improve access to services.

Goulburn Valley Health (GVH) Dental Initiative
Goulburn Valley Health (GVH) has a 12-chair clinic with a full range of specialists, with the exception of a dental hygienist. Rather than rely on traditional methods of recruitment, GVH offers dental graduates 12 month training placements in a dental clinic that includes a dental laboratory. To broaden its horizons, the service developed links with a private dental practice at nearby Cobram Hospital to expose graduates to private dental work. Links with other dental services include the Rumbalara Aboriginal Co-Operative and Seymour Hospital.

GVH has strong links with Melbourne University which provides final year dental and oral health students a four week rural placement that has resulted in increased competition for the 12 month dental positions. This demonstrates the potential of models that go beyond the current approach to health placements.

What funding arrangement could best support team-based care?
Rural areas are particularly in need of team-based care. Due to the tyranny of distance, many health services are required to deliver primary healthcare in the community, requiring intensive travel by clinicians. This is currently unfunded through State funding arrangements, resulting in rural people being disadvantaged and rural health services being financially impeded.

How is it determined who is best placed to lead in multi-disciplinary team arrangements?
A one-size-fits-all approach is not adequate in this circumstance. The most appropriate person to lead multi-disciplinary team arrangements should ultimately depend on the needs of the client, to ensure client-centred care rather than clinician-led care. The needs of the individual will reflect what is most appropriate to the person at the time.

Are other changes needed to current roles and responsibilities (eg. for prescribing and referral rights to be extended to non-GPs and specialists)?
Significant reform is required to support the implementation of complementary workforces that will address the skills shortage. This requires a review of existing funding systems focussed on role specific funding, and for funding models to become more flexible to support innovation and to enable services to trial new initiatives.

9. High-quality education and training arrangements for both new and existing workforce

1. **Key Issue:** Increasing the number of healthcare professionals is only one answer to the problem of unmet demand, particularly in rural areas.
2. **Key Recommendation:** The VHA wants the government to conduct a transparent analysis of training in university health science faculties with a view to shifting to competency based training. A remodeled primary health care system should be staffed by professionals whose roles are based on competency not professional discipline.

Current Department of Human Services analysis of workforce shortages suggests that by 2016 demand for health services will increase by 54 percent, but that the health workforce will only increase by 37 percent. This implies that Victoria will face significant health workforce shortages over the next decade.

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A report by Allen Consulting[62] argues that further productivity gains are unlikely in the community services sector without jeopardising service delivery outcomes as these organisations are inadequately funded to enable them to invest in innovation, impeding their ability to improve service delivery and increase their productivity. The report states that community services have 'absorbed' additional costs to date by requiring staff to manage larger case loads and work longer with no additional pay and have found it necessary to augment core Government funding with other types of funding sources. This is problematic for the future of the health and community services' workforce.

What improvements are needed to primary health care education and training?
One solution is to increase the number of allied health assistants and other certificate qualified staff in rural areas. Some Victorian health services are trialling school-based apprenticeship programs to act as a pathway for students who have completed the allied health certificate IV through to degree programs. This is particularly relevant for rural students who may have difficulty gaining high ENTER scores but often have the practical ability to complement health practitioners. Some rural health services may not be able to provide full time EFT but a complementary role across a region may have a full time load.

How could inter-disciplinary learning be better supported and provided in a more sustainable way?
The training of staff is intense and costly; however there has been some success in roles. There are increasing examples of workforce enhancement through community development.

Is there a greater role for competency-based education?
Research has shown that healthcare organisations can increase their efficiency and effectiveness through competency-based education[63,64]. However, the focus of our health workforce centres on professional discipline rather than professional competence. The VHA seeks a commitment to a transparent analysis of training within health science faculties, with a view to identifying skill stratification that may be applied to competency based care. This will require the full definition of competencies for health professionals.

Rather than individual workers, a modified primary healthcare system would comprise professionals whose roles are based on levels of competence rather than traditional professional responsibilities. This reflects a growing recognition of the interrelatedness of factors and functions within systems and the related need for holistic approaches to working in such systems.

What incentives could be offered to trainees to make settling in high needs/workforce shortage communities more attractive?
The VHA seeks to highlight the Victorian reforms for Vocational Education and Training (VET) in which there will be an uncapped number of places to allow industries to drive the workforce structure and overcome a skills shortage.

10. Fiscally sustainable, efficient and cost-effective

1. **Key Issue:** The current system does not ensure that expenditure creates improved health outcomes for the community.
2. **Key Recommendation:** The VHA believes that greater accountability is required to ensure that primary health spending is effective and efficient. This requires boards of management to be made accountable for population health indicators in addition to financial and clinical outcomes.

Are there other funding models for primary health care that need to be considered?
The organisation of health services across Australia is heterogeneous and duplicative. In reorganising the system, it is important to build on the positive structures currently in place. Victorian primary healthcare services are provided through over 100 community health services across the state. These services provide access to primary health to all Victorians, particularly those from lower SES backgrounds.

Funding for primary healthcare services by two levels of government, without a cohesive national primary healthcare policy, has caused systemic duplication. In order to achieve the vital reorganisation required in Australia, the models developed internationally, particularly in New Zealand, Scandinavia and the United

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Kingdom warrant investigation. Relationships between state, federal, local government and local communities must be clearly articulated and refined. The service delineations between primary and secondary prevention must also be better clarified and understood.

How can we ensure that primary health care expenditure is sustainable?

Primary healthcare has the potential to have a profound impact on reduced demand for acute inpatient services. The objective should be to realign funding models to fully reflect cost and productivity capacity, with the improvement of population health outcomes at the centre of each activity and process.

In Victoria many rural health services are well placed to provide primary healthcare services to their local communities. However, as public hospitals they are not easily able to access Federal funding for primary care services. This delineation of service structure hampers the ability of many rural communities to access needed services. This is particularly applicable when the local health service may be the only local provider. Victoria's Small Rural Health Services (SRHSs) have been shifting their focus to primary health for the past five years. The ability to realise the potential of this model is stymied by funding.

In reforming primary healthcare in Australia it is important not to overlook the role of small rural health services and their capacity to draw together local services to create a critical mass required to enable safe, efficient and effective services. This can also address the professional isolation associated with rural practice that acts as a disincentive to practitioners moving to rural areas. The drawing together of services under one umbrella also creates the environment in which a training and development framework can be created for workforce development from within the local community.

Should a new mechanism(s) be implemented to consider whether proposed new primary health care interventions should be subsidised?

Around 60-70 percent of all primary healthcare visits in developed countries are for preventable diseases. The VHA recommends further investigation of the effectiveness of 'lifestyle interventions'[65] and innovative strategies that transcend current funding formulas. Egger discusses the application of "environmental, behavioural, medical and motivational principles to the management of lifestyle-related health problems in a clinical setting".

As an example, Cai and Kalb argue that poor health is likely to have an adverse effect on work performance and leads to lower productivity. As a result, "poor health decreases individuals' earning potential, the opportunity costs of leisure and therefore their willingness to participate in the labour force."[66] The VHA recommends further investigation of the public health system subsidising beneficial health programs such as gym memberships and access to leisure centres with the view of cost-savings in the future. These efforts are in their infancy in the private health sector.

Furthermore, the current capital planning process lacks clarity and transparency which hampers efforts for co-location of health services and other community services. MonashLink Community Health and Inner East Community Health have health facilities co-located with leisure facilities, which can make the continuity of care process more streamlined and open access to lifestyle change strategies.

What should be an appropriate mix of public and private funding for primary health care?

Australia has always had a health system that relies on public and private financing and service delivery. The private health insurance surcharge can be seen as unfair by those who live in rural areas, where access to private health facilities is limited. About 57 percent of Australians who are without private health insurance must wait, often for months, for elective surgery in the public system. This creates an equity challenge where access to care is based on ability to pay rather than need. Specialist surgical training remains concentrated in the public sector, where the caseload is diminishing.

Consumers do not see healthcare in terms of funding structures and political jurisdictions despite the current funding mechanisms resulting in health services that are uncoordinated, inaccessible and that represent poor value for money. The VHA endorses a funding structure that enables a balance of technical efficiency and allocative efficiency.

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Conclusion

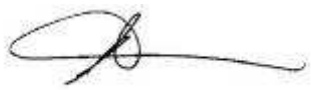
Improving population health requires far more than just excellent health services. For the sake of sustainability, Australian governments need to consider the health of their population and the health impacts of all aspects of government policy. In addition, governments must be willing to invest in a primary health system that meets the needs of the population now, and into the future.

Setting a model health system is no easy challenge. To achieve the broader reforms necessary, the Australian Government and the Primary Health Care reference group needs to broaden their focus. Reforming the primary health system is necessary to achieve efficiency, reduce hospital admissions and ensure a healthier population. Similarly, we require a broader vision and health paradigm that encompasses health determinants in addition to health outcomes.

Unfortunately, the discussion paper, whilst being described as a reform agenda appears to be more focused on improving what already exists rather than **reforming** primary healthcare to meet contemporary and future population health needs. The VHA calls for a transformational view of primary healthcare to ensure Australia's health system can meet future demand and ensure optimal health outcomes for all. Optimum health and wellbeing is fundamental to a productive and sustainable society.

The VHA welcomes the opportunity to meet with The Hon Nicola Roxon MP and members of the External Reference Group regarding this response. We welcome the opportunity to represent the Victorian public healthcare sector throughout this or future inquiries.

Yours sincerely



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