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APHCRI DIALOGUE

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Australia's health system faces major challenges in the coming years, including an ageing population, a growing burden of chronic disease and increasing consumer knowledge and expectations.[1] In order to tackle the juggernaut of issues bearing down on primary health care, new approaches to its organisation and financing need to be considered.

The Federal Minister for Health and Ageing Tony Abbott has expressed the government's commitment to "... trying to ensure we get good value for taxpayers as well as good outcomes for patients".[2]

Countries around the world, facing similar challenges, have responded by strengthening the role of primary health care. Some countries have established new primary health care lead structures; others have developed the capabilities of existing structures. The kinds of functions these entities perform are summarised in Table 1. A common thread is effective and efficient management of resources to meet the health care needs of communities.

Professor Nicholas Glasgow
APHCRI Director

TABLE 1
Functions and activities of various primary health care organisations

- Allocation of regional budgets
- After hours care
- Brokering access to services
- Clinical and practice support
- Commissioning services
- Community engagement
- Contracting with providers
- Data management
- Funds pooling
- Local/regional decision making
- Disease management
- Education and training including continuing professional development for health professionals
- General practitioner, practice nurse and allied health professional recruitment and support
- Linkage between micro and macro levels of the system; linkage between "horizontal components of the system, including in some cases, other arms of government (e.g. housing); linkage between acute and community sectors of the system
- Monitoring quality
- Patient enrolment
- Population health activities
- Triage

It is in this context that APHCRI convened a summit of key stakeholders on the 14th and 15th of October. Under discussion were various interlinked themes relating to the organisation and financing of primary health care. The question being addressed was "can the health dollar be used more strategically?" in the sense of achieving Minister Abbott's twin goals of good value and good outcomes for Australians into the future.

Broad agreement was reached on a number of key issues. First, there are significant current and future challenges facing primary health care. These include uneven access; the demands on the system resulting from the chronic disease epidemic, including the need for better health promotion and disease prevention; variations in practice (e.g. a large unexplained variance in prescribing patterns when divisions of general practice are compared), in quality and in health outcomes; waste and inefficiency; poor engagement with and responsiveness to both patients and communities; and mismatch between supply and demand in the health workforce.

Second, there was broad agreement that action was needed to address these challenges. The prevailing view was that inaction was not an option and deferring action would see matters get worse, best summed up as: "we are on the reform page". The pivotal role of general practice was recognised, as was the need for primary health care to become more multidisciplinary. There was consensus that primary health care needs to engage more effectively with both patients and communities. Regional planning and integration were seen as important, but it was noted that there is currently an absence of agencies that are formally tasked with that responsibility. In the complex Australian primary health care environment, new approaches must allow flexibility in local implementation.

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Third, there was broad agreement that major system overhaul was not the best approach for Australia, the preferred approach being problem-based solutions that are 'fit for purpose'. The problems need to be clearly defined and the solutions tailored accordingly, that is financing solutions are 'second order' issues to the prime concerns of system weaknesses both now and in meeting future demand. There was general agreement that mixed approaches are needed. In this context, there was recognition of an ongoing place for fee-for-service in any payment arrangements for GP services, but little support for it as the sole method of financing general practice.

TABLE 2

Summit Participants

The thirty-four participants from Australia and New Zealand were drawn from:

- Consumer organisations;
- New Zealand, Australian Government and State/ Territory Government health departments;
- Community controlled Aboriginal health services.
- Academics with expertise in health systems, primary health care, medical ethics and health economics;
- Medical colleges and organisations including ACCRM, ADGP, AMA, RACGP and RDAA; and
- Pharmaceutical industry.

There was no support for "fund-holding " at the level of general practices. However, there was considerable discussion about the allocation of budgets to appropriate primary health care provider organisations. In establishing such new or enhanced financing arrangements, careful consideration needs to be given to appropriate system levels and structures for holding budgets, the bases for defining catchment populations, normative versus historical approaches to budget setting, what we can afford to pay for using health care dollars, risk, substitution, incentives, perverse incentives, appropriate use of savings, conflicts of interest, management capability, transaction and opportunity costs, and information flows. There was recognition that allocating budgets for particular goods and services potentially allows more strategic deployment of the existing workforce and greater multidisciplinarity.

Fourth, there was support for the notion that a set of values and principles governing primary health care should be articulated. These would act as a transparent basis for interrogating proposed reforms. Suggested values and principles related to: equity, justice, diversity, quality, safety, patient centredness and empowerment, sustainability and accountability.

And finally, there was recognition of the need to embrace experimentation and build up a strong evidence base for understanding the strengths and weaknesses of new and existing approaches.

What happens now?

There was endorsement of the need for action. Some peak organisations will lead in developing proposals for more strategic approaches to resource management in primary health care. This would include, for example, innovative approaches to organising and financing high quality care for patients with diabetes and other chronic health conditions. APHCRI will commission work to identify evidence to tackle problems discussed at the meeting.

[1]http://www.budget.gov.au/2002-03/bp5/html/02_BP5Overview.html#P23_3643

[2]Financial Review Tuesday 11th October 2005 p5

AN EYE ON THE MEDIA

APHCRI COMMENTS

The use of the health dollar remains a pivotal issue when discussing the future of Australia's health system, making the ways and means of achieving better health outcomes for patients newsworthy for daily media.

Issues of fundholding and other tools to distribute the health dollar have 'legs' (a story that will continue to attract readers' attention) in media terms, not least because there are conflicting views on how to deal with the growing problems of an ageing population and increasing chronic disease burden.

Options for coping with increased need and a finite health dollar often raise more questions than they answer in today's media.

A scan of three months worth of news clippings from July to September 2005 produced 18 articles directly related to health funding – either bulk billing rates, the debate on health banks or how much doctors can earn from the system.

Of those, five directly related to the discussion of fundholding or models which resemble it.

The most direct example was a Sydney Morning Herald article in July on AMA President Dr Mukesh Haikerwal's annual press club speech: "*Threat of rationing for chronically ill – doctors warn against limited health funding*".

Other events in the world of general practice politics had, perhaps, prompted Dr Haikerwal mentioning fundholding in this speech and the article was given prominence (page three) and has added to the health spending debate.

In the article Dr Haikerwal's view that fundholding could result in health inequalities for patients was countered by that of Professor Stephen Leeder from Sydney University who suggested the system could act as a good incentive to doctors, while health economist Paul Gross said it was 'worth considering'.

How to improve the effectiveness of health spending remains complex and different models for meeting patient needs in primary health care need to be debated.

The media is an important forum for debating the issues of health spending. It gives voice to public opinion, a voice politicians heed.