Better Outcomes
FOR PEOPLE
with Chronic and Complex Health Conditions
through
PRIMARY HEALTH CARE

Primary health care advisory group

Discussion Paper

August 2015

Contents

Get Involved!

All Australians will be able to contribute to the broad reform process to deliver a healthier Medicare. One of the priority areas under this process is reform of primary health care to better support people with chronic and complex health conditions, including mental health conditions. A Primary Health Care Advisory Group has been established to lead work in this area.

The Advisory Group wants to engage with all groups who have an interest in strengthening primary health care, including patients, carers, health care providers, doctors and other health professionals. Consultation with these groups will help the Advisory Group to develop short, medium and long term options in this area for the Government to consider.

This discussion paper, a consumer supplement, and a companion background paper prepared for the Advisory Group by McKinsey and Company, will support the Advisory Group's consultation process, setting the scene and introducing some possible options to improve primary health care to support people with chronic and complex conditions.

Everyone with an interest in this process will be able to have a say through a public submission process. An online survey will collect responses to this discussion paper. This survey can be accessed from the Healthier Medicare pages on the Department of Health's website **www.health.gov.au/healthiermedicare** from 6 August 2015. Survey responses will be collected until Thursday 3 September 2015, following the release of this discussion paper.

In addition, there will be opportunities to hear from members of the Advisory Group at public information briefings in each state and territory and through a public interactive live broadcast, which will then be available online on demand. This broadcast will also be available from the Healthier Medicare pages on the Department of Health's website.

Advisory Group members will also conduct stakeholder sector briefings with peak bodies, health organisations and targeted consultations with key stakeholders, including state and territory health departments. Consumer focus groups will also be run.

You can further visit the Healthier Medicare pages on the Department of Health's website **www.health.gov.au/healthiermedicare** to find information on dates and locations of public briefings.

Message from the Chair

When the Minister asked me to Chair the Primary Health Care Advisory Group (Advisory Group), I was both excited and humbled.

The establishment of this Advisory Group, alongside the Medicare Benefits Schedule Review Taskforce, through the Government's *Healthier Medicare* Initiative, presents a unique and significant opportunity for health professionals, patients and governments to come together to improve the health care system for people with chronic and complex health conditions.

We are fortunate in Australia to have a high quality health system that performs well by international standards. However, we are facing some significant system challenges that primarily relate to a shift in burden of disease from infectious diseases requiring episodic, or one-off care to chronic illnesses that require more ongoing care with input from multiple health care providers.

Care needs are more complex and require more maintenance and multiple professional interactions across the health system.

This discussion paper presents the outcomes of initial discussions and investigations of the evidence by the Advisory Group, and begins to canvas some potential directions to improve the system. For some there will be few surprises, for others there may be some challenging options. Either way, we need your views to ensure we get this right.

I encourage all of you to engage with the paper and participate in the consultation processes over the following weeks. This is your opportunity to have your say, and to support the Advisory Group in developing short, medium and long term options for improving health outcomes and the experience of care for people with chronic and complex health conditions.

On behalf of the Advisory Group, we look forward to your feedback and meeting with you at briefings.

Steve Hambleton

Dr Steve Hambleton

Introduction

Overall, Australia has a strong health system that is supported by a highly trained and dedicated workforce. However, we face some significant challenges in delivering quality health care to people with complex and chronic health conditions, including mental illness, while ensuring health system sustainability.

Australians are now living an average of 25 years longer than they were a century ago. But we are increasingly living with chronic conditions such as heart disease, diabetes, cancers, respiratory diseases and mental illness. These conditions are the leading causes of illness, disability and death in Australia:

- 35% of Australians, or around 7 million people, have a chronic condition[1];
- many people experience multiple chronic conditions[2];
- people with severe mental illness and Aboriginal and Torres Strait Islander peoples are three times more likely than the general population to also have diabetes and are at increased risk of cardiovascular disease[3,4]; and
- risk factors for chronic conditions, such as obesity, are at high levels and increasing[5].

Our current health system is not set up to effectively manage long-term conditions. Increased and poorly targeted service use is resulting in significant financial impacts across the entire health system.

The average cost of a single hospital admission for heart failure or chronic obstructive pulmonary disease without any other complications is around $5,500 [6], equal to more than 100 general practice consultations. While not all hospital presentations for chronic or other conditions can be prevented through primary health care interventions, it may be possible to prevent many:

- in 2013–14, 48% (285,000) of potentially avoidable hospitalisations were for chronic conditions; and
- nearly a quarter (23%) of people who visited an emergency department in 2012–13 felt their care could have been provided by a general practitioner[7].

More sustainable use of health system resources is critically important, since national health care costs continue to grow at a rate faster than the national economy.

Stronger, more effective, and better integrated and coordinated primary care services are the best way to achieve better outcomes for patients and ensure a sustainable health system into the future. This also includes the most effective use of existing primary health care funding to appropriately target and support people with chronic and complex health conditions.

Primary health care in Australia

Our need for health care varies from person to person and over time, but each year most of us use primary health care services.

Primary health care is typically the first and main contact with the health care system. For most people, going to the doctor when they are unwell means seeing their general practitioner. Primary health care professionals also include nurses, nurse practitioners, allied health professionals, midwives, pharmacists, dentists and Aboriginal health practitioners.

The types of services delivered by primary health care include a continuum of health promotion, prevention and screening, early intervention, clinical treatment and chronic condition management.

The primary health care system can provide community-based, multidisciplinary and patient-centred care. For these reasons, it is the best setting for the prevention and management of chronic and complex health conditions. Unfortunately, this is not everyone's experience.

Medicare reform is yet to meet the chronic condition challenge

Medicare was designed as a public insurance mechanism, to manage episodic, or one-off illnesses and its core features have not changed.

As a result, there are some health system barriers to providing the ongoing, comprehensive and coordinated care that is required to manage chronic and complex health conditions.

Patients often experience:

- a fragmented system, with providers and services working in isolation from each other rather than as a team;
- uncoordinated care;
- difficulty finding services they need;
- at times, service duplication; at other times, absent or delayed services;
- low uptake of eHealth and other health technology to overcome these barriers
- difficulty in accessing services due to lack of mobility, transport, language, financial barriers and remoteness; and
- feelings of disempowerment, frustration and disengagement.

The best possible health care is not always delivered

Patients can experience poor outcomes, for example:

- Every 2–3 hours in Australia there is an amputation that could have been prevented with better management of diabetes.[8,9]
- Nearly 400 Australians die each year from asthma. Some of these deaths could have been prevented through better management of their disease.[10]

Variations exist in the care received – between clinicians, services and geographic locations. This can result in patients experiencing poorer quality care and increased rates of adverse outcomes.

Poor outcomes are more likely for Aboriginal and Torres Strait Islander peoples, people with mental illness, people from culturally and linguistically diverse backgrounds, and those living in rural and remote areas.

Governance of the health system is complex

The Australian health system has divided responsibilities for funding and performance. For example, Commonwealth and State governments provide the most funding, but local governments also contribute, as do non-government organisations, private insurers and people out of their own pockets (figure 1).

People with chronic and complex health conditions will often require health care from a range of providers. Responsibility for funding and delivering these services may be spread across the entities described above. This can result in confusion for patients and poorer health outcomes when continuity of care is lost.

These issues are compounded in primary health care, which often appears to be more a collection of separate services than a coordinated and integrated system.

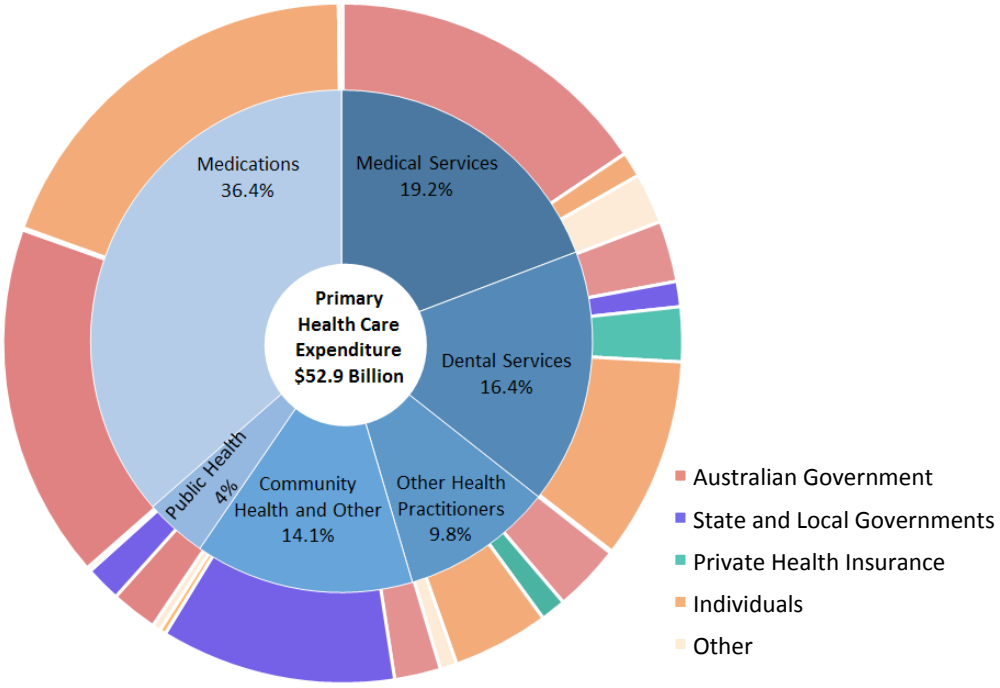

Figure 1 — Proportion of primary health care expenditure (Source: AIHW Health Expenditure Australia: Analysis by sector 2012–13)

Improved information on primary health care outcomes will help meet the challenge

Improving patient outcomes and consistency of evidence-based care can be informed by feeding data on performance back to health care professionals and patients. However, the routine use of primary health care information on patient outcomes to drive improvements in clinical practice and to help shape and reinforce patients' healthier behaviours is not widely used.

Just as primary health care quality varies, so do the resources to record and report on patient outcomes. Improved information on primary health care outcomes can help to:

- facilitate continuous quality improvement processes in the health system; and
- further develop primary health care performance monitoring at a regional and system level.

The reform processes under way

The Primary Health Care Advisory Group has been established to provide the Commonwealth Government with short, medium and long term options to reform the primary health care system. Its focus is better management of chronic and complex health conditions.

The work of the Advisory Group will influence and also be influenced by other reviews of the health system happening at the same time. This includes reviews of the Medicare Benefits Schedule, private health insurance arrangements and mental health services, as well as the development of stronger links between health, disability and aged care services.

The Reform of the Federation White Paper process[11] will be analysing Commonwealth and state roles, with the potential for changes to governments' responsibilities for health services and new collaboration agreements.

This discussion paper sets out the Advisory Group's initial views on opportunities for reform. It has been informed by national and international data, research and experiences.

The Advisory Group has developed a vision and set of guiding principles to frame its work programme.

Vision

A primary health care system that achieves the best possible patient outcomes, health status and community participation; and efficiently targets health system resources.

Guiding Principles

A sustainable primary health care system for patients should:

1. Engage patients and carers as active partners in decisions about their health and wellbeing.
2. Ensure service and payment models are based on best practice to maximise patients' health improvement, service safety and quality, and allow flexibility.
3. Deliver efficient health care, eliminating waste and duplication.
4. Ensure potentially avoidable hospitalisations are minimised.
5. Facilitate integration and coordination of patient care across care settings and support health care professionals to work as multidisciplinary teams.
6. Encourage all primary health care professionals to work to their full scope of practice.
7. Support the collection, reporting and use of primary health care outcome information to promote continuous quality improvement.

Questions — What is the problem?

What aspects of the primary health system work well for people with chronic and complex health conditions?

What is the most serious gap in the primary health care system currently provided to people with chronic and complex health conditions?

Theme 1 — Effective and Appropriate Patient Care

What do we want to achieve?

A primary health care system orientated towards improving patient outcomes and reducing avoidable hospitalisations through targeted and team-based approaches that engage patients with chronic and complex health conditions to achieve their health goals.

Possible Options

A number of primary care systems internationally have moved to build their care models around a single 'health care home,' where people 'enrol' with a single provider, which becomes their first point of care and coordinates other services around the consumer. The specific details of these models vary, but the key elements are holistic and ongoing care with an emphasis on quality and eHealth enhanced management. Possible options relating to the key elements are provided in this theme.

1.1 Identifying Patients

The first step is identifying patients with chronic and complex health conditions that would benefit most from a new model of care.

New tools could be developed to better support health care professionals to identify such patients in routine consultations.

Search tools could also be developed to identify patients within existing health care provider records, for example general practice or hospital records.

1.2 Patient Enrolment

Enrolment means an agreement and a responsibility. For patients with chronic and complex health conditions, enrolment could mean voluntarily agreeing to see, on an ongoing basis, a chosen local primary health care professional or practice. This agreement would establish an ongoing partnership between the patient and provider, each with responsibilities for shared goals and outcomes according to an agreed care plan.

Nearly two thirds of Australians have had the same doctor for the last 5 years, and almost all people over the age of 65 can nominate a regular doctor or place of care.[12,13] Despite this, a lack of a formal relationship between patients and providers may mean general practitioners are uncertain about their responsibilities for ongoing care.

There are a number of potential benefits of enrolment. In some health systems around the world, enrolment has been linked with improved care coordination. Enrolment can also be a foundation for changing how health funding enables patient-centred care. It can also be a type of service commitment, where the enrolling provider ensures all aspects of the care plan are coordinated, across primary health care, specialist, hospital and aged care services, as required.

Enrolment would not prevent a patient from formally changing health care providers if they need to, for example if they move or are unhappy with their service.

1.3 Team-based Care

The delivery of comprehensive care to patients with one or more chronic and complex health conditions will often require a team of health care professionals working together. However, the current approaches to care planning are inconsistent and not always inclusive of patients' goals or input from other team members.

It is appropriate that care plans and teams are established by a suitably qualified health care professional, usually a general practitioner, who can assess the clinical and medicine requirements of the patient and discuss their goals. Other health care professionals involved in the delivery of care should also contribute to the development of the plan, as well as monitoring and reviewing patient progress.

Agreements between care team members should recognise members' expertise and responsibilities. This is essential for ensuring continuity of care, and easing transitions when care is escalated to specialists and hospitals, or discharged appropriately to primary health care and community-based care coordinators.

New or enhanced tools could be developed to better support patient assessment, and the development of an appropriate care plan.

Private health insurers could be more effectively engaged in the care planning process. Options could be developed to increase collaboration between private health insurers and primary health care providers, including ensuring that any additional services supported through private health insurance are effectively managed by the patient's main primary health care provider and in a way that avoids duplication.

1.4 Care Coordination

People with chronic and complex health conditions often need multiple primary health care services, especially if they have more than one condition, for example depression *and* diabetes.

The different services that a patient might require to stay well and manage even a single condition can be provided by different health professionals and organisations, often with different funding arrangements, responsibilities and information systems.

As such, coordinating providers and services in a way that delivers continuity of care for people with chronic and complex health conditions is a challenge.

Continuity of care is important because effective sharing of information between multiple providers can reduce errors in care, and can make transitions between different types of services more seamless.

In health systems where responsibilities for providing care are spread across governments, non-government organisations, private businesses and private health insurers, identifying a care coordinator role is a common approach to bridging gaps between services.

Care coordinators can proactively assist patients to manage their chronic and complex conditions in many ways:

i) support the patient and the health care team in assessment and developing the care plan, including identifying service options;

ii) assist the patient and their health care providers in implementing and maintaining the care plan;

iii) help patients to better understand their conditions and how to self-manage them; and

iv) work with other sectors also supporting the patient to better align their clinical and community supports.

Currently in Australia, around one in six people see more than three health professionals for the same health condition[14]. More than two thirds (69%) of these people indicated that a health professional helped to coordinate their care — usually a general practitioner or a specialist[15].

Another option, implemented in other health systems internationally, is a dedicated care coordinator role, provided by a practice nurse or another staff member as part of the care team. This may be more sustainable than employing general practitioners and other medical professionals as care coordinators, although they may still be care team leaders. The additional value of this approach is that it frees up doctors and other highly trained health professionals to work to their full scope of practice.

1.5 Patient Pathways

Patient pathways are agreements between GPs and other local clinicians on how to best assess and manage care for specific conditions. They incorporate best practice clinical guidelines as well as information about locally available services.

Partnerships between primary and acute care sectors through the newly established Primary Health Networks and Local Hospital Networks can be increased to help clinicians develop, adapt and embed localised patient pathways in their regions.

Primary Health Networks could also pursue opportunities with private health insurers to ensure that care pathways recognise the need for patients with and without private health insurance in their regions.

1.6 Patient Participation

Patients have different levels of understanding, skills and capacity to self-manage their conditions.

The provision of targeted education, training and motivational support has been shown to enable patients to more effectively self-manage their health and wellbeing and maintain their independence in the community.

There are a range of established supports to enable people living with chronic and complex health conditions to better manage their own health care.

Nationally consistent guidelines, tools, resources and education for both patients and health care providers could be developed or enhanced where they already exist. These resources would need to be culturally and linguistically appropriate and adapted to meet local circumstances. Furthermore, health workforce training — beginning at the undergraduate level — must include the principles of the patient as a partner in care.

Care coordinators could spend time with a patient to gain a better understanding of his or her needs and make an assessment of their skills in self-management and self-advocacy.

They could support patient participation, engagement and self-management and build health literacy, either directly or in conjunction with practice nurses, community nurses, and Aboriginal and Torres Strait Islander health practitioners.

1.7 Coordinated Care across the Health System

Care teams and patient pathways for people with chronic and complex health conditions cross many parts of the health system. Transition points between providers are inevitable as people's health needs change, but these are also times of risk and waste when health care is not coordinated effectively.

The Primary Health Networks have been established to deliver improved access to the breadth of primary health care as well as better coordination with local hospitals. These organisations will align with states' Local Hospital Networks, and work cooperatively to better integrate the health system at a regional level.

Commonwealth funding is being provided to Primary Heath Networks to drive effectiveness and efficiency in primary health care. Working together with Local Hospital Networks, other health service providers and also private health insurers, Primary Health Networks will be able to better coordinate services and support new and innovative programmes that deliver better health outcomes.

Outside the health system, community-based services also play an important role in supporting people with chronic conditions with a large range of social supports.

1.8 More Flexible Care

There is no 'one size fits all' model, particularly for rural and remote Australia. Health workforce availability varies across regions, as do the health care needs of population groups such as Aboriginal and Torres Strait Islander peoples.

Publicly funded community and allied health services and Aboriginal and Torres Strait Islander health practitioners and workers provide significant chronic care services in rural communities, often with little or no access to similar private services.

Flexible approaches to implementation of effective and appropriate care models will be essential to ensure local relevance and applicability, including in general practice, rural multipurpose, nurse practitioner and Aboriginal Community Controlled Medical Service models.

Questions — Patient care

Do you support patient enrolment with a health care home for people with chronic and complex health conditions?

What are the key aspects of effective coordinated patient care?

Theme 2 — Increased use of Technology

What do we want to achieve?

An efficient and integrated health system that embraces cost-effective technology to improve patient management across the whole health system, and empowers patients with chronic and complex health conditions to participate in their care and incorporates convenient and accurate monitoring and feedback.

Possible Options

2.1 Patient Participation

Appropriate use of accessible health records and other technologies can have a positive impact on patient outcomes and their need for services.

Through new platforms such as *My Health Record*, patients will be able to access much of their health information, promoting greater involvement in the delivery of their care.

Advances in medical technologies mean that home-based self-testing and self-monitoring options are more readily available and decreasing in price.

Education and ongoing support could be developed for patients and health care professionals in order to maximise the benefits of the technology.

Insurers could also be further encouraged to partner with primary health care providers to support the use of home-based monitoring and health record technologies. Some insurers already include access to health aids and appliances for the management of chronic and complex health conditions that the primary care providers may not be aware of.

Confidence in the security and privacy of health information systems is essential. High levels of security and multiple levels of access control are built into the *My Health Record* and secure messaging is available for data generated between care team members and to patients, but its use is variable.

2.2 Enhanced Team-based Care

Electronic health records, like *My Health Record*, will play a critical role in supporting team-based care by ensuring that health care professionals have ongoing access to up to date information on their patients' conditions and treatments, (subject to patients' consent).

These records complement existing tools used to support team-based care, such as web-based information portals that can also schedule services and allocate responsibilities according to a care plan. Appropriate use of telehealth or video-conference consultations can also be used to effectively address local service gaps.

Greater use of encrypted communication between health care providers is needed to ensure privacy and security of sensitive health information. Existing systems are well placed for further development to support this communication.

Targeted education, training and support for cultural change may be required to accommodate new processes, and link to existing systems across health sectors.

For example, integration of care team and case management technologies with clinical information systems from hospitals will improve discharge planning and support continuity of care for patients with chronic and complex health conditions.

2.3 Emerging Technology

Advances in medical technologies, including software, smart phone applications, self-testing and point of care testing, can improve convenience and efficiency. These technologies may decrease the need for dependence on pathology labs and repeat testing by providing convenient alternatives for patients and health care professionals.

Improving the quality and frequency of information sharing and communications between health care team members will improve condition management and patients' outcomes, as well as better support health care providers to share necessary information consistent with legislated and clinical requirements. Software compatibility across health care providers remains a challenge.

While there are major potential gains to be realised from new technology, education is required to ensure testing and monitoring devices are appropriately used, deliver value for money, and that the storage and communication of health information with new devices is secure and compatible with national standards.

2.4 Cultural Change

Primary Health Networks and Local Hospital Networks could be further supported to progress cultural change within the health care system to facilitate system-wide use of electronic health records and other technologies.

Questions — Use of technology

How might the technology described in Theme 2 improve the way patients engage in and manage their own health care?

What enablers are needed to support an increased use of the technology described in Theme 2 of the Discussion Paper to improve team based care for people with chronic and complex health conditions?

Theme 3 — How do we know we are Achieving Outcomes?

What do we want to achieve?

A continually improving primary health care system that provides feedback on the efficiency and quality of services and publicly reports on system performance.

Possible Options

3.1 Continuous Quality Improvement

Continuous quality improvement processes use outcome information, or data, to understand performance, identify potential areas for improvement and create plans to achieve improvement. Data, including patient health outcomes data, need to be collected and used to continually improve primary health care.

The Australian Primary Care Collaboratives Programme (APCCP)[16] has demonstrated the value of data in continuous quality improvement.

Expanding the use of clinician-led quality registries such as the APCCP and other quality improvement programmes could contribute to improvements in clinical practice and health outcomes. This sort of data collection could be built into new care models for patients to maximise efficiency.

These approaches could be complemented by consistent use of patient experience and outcome measures. Patient measures are important performance indicators.

Patient safety is another key dimension of quality of care. Efforts to improve quality, efficiency and effectiveness must ensure patient safety.

Any new quality improvement efforts must also support the principles of deregulation and reducing avoidable red tape.

3.2 National Minimum Data Set for Chronic and Complex Conditions

A national minimum data set of population, care processes and health outcome indicators for patients with chronic and complex conditions could be developed. This would provide primary health care system information similar to what is available for other parts of the health system, particularly in relation to specific conditions.

This information should be drawn from general practice, community and Aboriginal health services, allied health, and hospitals data. The provision of data could be supported by funding and payment mechanisms.

This may require additional initial investment in data collection and reporting, but has the potential to reduce the costs in the longer term.

3.3 Improved System Performance

Primary health care data from the Medicare Benefits Schedule mostly comprises information on the volume and cost of services. As a result, it is difficult to effectively measure primary health care system performance at the macro level and monitor the success of policies.

Improved primary health care data and its analysis would provide opportunities to further enhance Australia's primary health care performance at local service, regional and system levels.

Questions — Evaluating system performance

Reflecting on Theme 3, is it important to measure and report patient health outcomes?

To what extent should patients be responsible for their own health outcomes?

Theme 4 — How do we establish suitable payment mechanisms to support a better Primary Health Care System?

What do we want to achieve?

A primary health care system that is supported by suitable payment mechanisms to: drive safe, high quality care; support regional flexibility; and improved patient outcomes and value, not just volume of services.

Possible Options

The way health care is paid for can influence how health care is provided, and to whom.

This Discussion Paper identifies elements and options that could make the primary health care system work better for people with chronic and complex health conditions. To implement these changes and support them into the future, the current health payment models may also need to change to best support new models of service delivery.

This section explores different payment models, and opportunities for innovative funding partnerships, across different service providers and private health insurers.

4.1 Fee-for-service payments

Under a fee-for-service model, health care professionals receive a payment for a defined service.

This is the most common method used to pay for primary care services in Australia and it works well for the majority of Australians' primary health care needs. While this type of payment is a practical way of reimbursing service providers for isolated episodes of care, it does not provide incentives for the efficient management of care delivered to patients requiring ongoing health care.

Changes to existing payment models or alternate models could be explored to assess their ability to better support the delivery of care to people with chronic and complex health conditions. Consideration of any changes to payment arrangements will take account of the review of the Medicare Benefits Schedule.

4.2 Capitated payments

Under a capitated model, health care providers are paid a set amount to provide a defined package of care for a patient over a specified period of time.

The set payment amount encourages providers to focus on effective and appropriate patient engagement to deliver that care. For this reason, it may be applicable to the delivery of ongoing care to people with chronic and complex health conditions.

Capitation models can be implemented as payments to individual professionals, care teams or organisations such as general practices and Primary Health Networks.

4.3 Salaried health care professionals

Under a salaried model, health care professionals are employed to provide defined services and receive a salary for the provision of those services.

Salaries may represent a practical approach to payments to coordinate team-based care for a group of patients.

4.4 Pay-for-performance

Under pay-for-performance, health care providers are reimbursed based on the achievement of a specific outcome associated with the provision of care.

The Practice Incentives Programme currently provides payments to general practices for activities that encourage continuing improvements and quality care, enhance capacity and improve access and health outcomes for patients.

This programme could be enhanced to link health outcomes for patients to a pay-for-performance model. New performance payments could be introduced to support a new model of care.

4.5 Blended payments

Combinations of these payment models are increasingly used in primary health care systems internationally. This approach is generally referred to as blended funding.

For example, it may be desirable to use fee-for-service payments in combination with capitation models to best support more ongoing team-based care.

Blended payment models could also be useful in accommodating different local contexts such as rural and remote health care.

4.6 Innovative Health Care Partnerships

Innovative models of health care delivery have been trialled in several local health districts in Australia. At their core, many of these models harness partnerships between funders and health care professionals to integrate services provided by general practitioners, allied health and community health professionals along with secondary and tertiary care services to deliver regionally-focused, care coordination.

A number of these programs also explore innovations in funding to drive efficiency in the delivery of care such as the patient-focused service procurement model championed in the NSW Integrated Care Programmes.[17]

4.7 Private Health Insurance

Private health insurers have a strong interest in programmes that reduce preventable hospital admissions

These programmes are important to ensure the long-term affordability, value and competiveness of their products.

Private health insurers are increasingly investing in new models of management of chronic and complex health conditions including team-based care.

Better coordination between public and private funding of health care innovation can also improve the effectiveness of this investment for all patients. This can also include pooling of funds to share risk.

The Carepoint Integrated Care Trial[18] is an example of public and private health insurer collaboration and illustrates the potential of public-private partnerships to foster innovation in the management of chronic conditions. This trial in both Victoria and Western Australia is jointly funded by the respective state governments, Medibank Private Limited in Victoria and HBF in Western Australia.

4.8 Funding Flexibility

Different payment models may better support care in different contexts, particularly in rural and remote areas with workforce challenges. Different approaches may also be needed to better support people experiencing social disadvantage and local demographics that impact on service provision.

Under any of the funding options outlined above, funders could bundle or pool their funding to achieve better health outcomes for these areas.

Questions — Payment Models

How should primary health care payment models support a connected care system?

What role could Private Health Insurance have in managing people with chronic and complex health conditions in primary health care?

Appendix A — Glossary

Acute care: Health services provided to patients for a condition requiring immediate care or intervention, often within or aligned with hospitals.

Aged care: The management and care of the health of the elderly, considered to be 65 year or older in the general population, or 50 years and older in the Indigenous Australian population.

Allied health professional (AHP): AHPs are qualified to apply their skills to retain, restore, or gain optimal physical, sensory, psychological, cognitive, social and cultural function of clients, groups and populations. AHPs hold national accredited tertiary qualifications, enabling eligibility for membership of their national self-regulating professional association or national board. AHPs include, but are not limited to, pharmacists, psychologists, physiotherapists and dieticians.

Australian Primary Care Collaboratives Programme (APCCP:) Programme established to provide a generic quality improvement model for use in the primary health care setting.

Burden of disease: The quantified impact of a disease or injury on an individual or population, using the disability adjusted life year measure (DALY) which calculates a year of health life lost, through premature death or through living with disability due to illness or injury.

Care Coordinator: A role or specific person responsible for organising patient care activities and sharing information among participants concerned with a patient's care to achieve safer and more effective care.

Care plan: Care arrangements between patients, general practitioners, allied health, non-government organisations and other relevant agencies to facilitate patient care.

Chronic and complex health conditions: Diseases that tend to be long-lasting and persistent in their symptoms or development, usually confined to non-communicable disease such as cancer, arthritis and mental illness.

Chronic obstructive pulmonary disease (COPD): COPD is a serious, progressive and disabling condition that limits airflow in the lungs. It includes emphysema and chronic bronchitis. People with COPD are prone to severe episodes of shortness of breath, with fits of coughing. The condition mainly affects older people.

Community health: Non-residential health services offered to patients in an integrated and coordinated manner in a community setting, generally provided by, or on behalf of, state and territory governments.

Continuous quality improvement processes: A systematic approach to collecting and reviewing data for purposes of feedback that promotes better services.

eHealth: A system of health care supported by a secure platform of national eHealth infrastructure including: individual identifiers for health care organisations, health care providers and patients, a systematic nomenclature of medicines and diseases and communication protocols.

Health care team: Professionals from a range of disciplines working together as a team to deliver comprehensive care that addresses the patient's needs.

Health literacy: The ability of individuals to gain access to, understand, and use information in ways which promote and maintain good health.

Local Hospital Networks (LHN): State government health organisation comprising groups of local hospitals, or an individual hospital, that links services within a region or through specialist networks.

Medicare: A national, government-funded scheme that subsidises the cost of personal medical services for all Australians and aims to help them afford medical care. The Medicare Benefits Schedule (MBS) is the listing of the Medicare services subsidised by the Australian Government.

My Health Record: An electronic record that allows patients, doctors, hospitals and other health care providers to view and share the patient's health information, if the person has given prior consent. (Formerly known as the Personally Controlled Electronic Health Record).

Patient enrolment: Individuals registering with a primary care provider or practice to provide a 'home base' for medical services to optimise delivery of health care services and management of chronic diseases.

Patient pathways: Nationally or regionally standardised, evidence-based multidisciplinary management plans which identify an appropriate sequence of clinical interventions, timeframes, milestones and expected outcomes for a patient group.

Primary health care: Typically the first and main contact with the health care system accessed directly by consumers and including general practice, nursing, allied health providers and other services by recognised health practitioners in the community.

Primary Health Networks (PHNs): Federally funded primary health care organisations that coordinate and commission primary health care services within regional boundaries, intended to increase efficiency and effectiveness of medical services.

Private Health Insurers: Insurers that fully or partly cover the cost of being admitted to hospital as a private patient and/or the cost of other ancillary health services and a range of other items or services not covered by Medicare.

Self-management: Patient's ability to be proactive in managing their condition, and the ability to acquire the needed skills.

Team-based care: The provision of comprehensive health services to individuals, families, and/or their communities by at least two health professionals who work collaboratively along with patients, family care givers, and community service providers on shared goals within and across settings to achieve care that is safe, effective, patient-centred, timely, efficient, and equitable.

Appendix B — The Primary Health Care Advisory Group

PHCAG Membership

- Dr Steve Hambleton – Chair
- Dr Brian Morton
- Professor Bruce Robinson
- Dr Eleanor Chew
- Dr Ewen McPhee
- Ms Karen Booth
- Mr Marcus Dripps
- Ms Leanne Wells
- Dr Mary Foley
- Dr Malcolm Parmenter
- Mr Rob Bransby
- Dr Michael Wright
- Professor Claire Jackson
- Professor Geoff Riley
- Dr Catherine Engelke
- Mr Bruce Elliot
- Mr Mark Booth (Ex Officio)

PHCAG Terms of Reference

Australia's health system is under increasing pressure to provide better quality, affordable and accessible health care, built on universal access to Medicare. A long term strategy for the health system is needed, including providing better management of patients with complex and chronic conditions, eliminating waste and improving efficiency. To support this endeavour, a Primary Health Care Advisory Group (PHCAG) is being established to develop advice to Government on short, medium and long term opportunities to reform the primary health care system.

Role and deliverables

The role of the PHCAG will be to examine opportunities for reform and to develop them into a series of proposals for consultation, prior to reporting to Government.

The PCHAG will be supported by the Department of Health to identify opportunities for health system reform, with a particular focus on:

- Primary/acute care interface, including the proposed and potential roles of PHNs;
- Innovative care models for target groups such as those with complex, chronic disease;
- Funding models that best support proposed service improvements;
- Potential revised roles for existing players in the health system that support proposed service improvements; and
- Better recognition and treatment of mental illness.

In conjunction with the Department, the PHCAG will:

- Assess the current system and review national and international literature;
- Consider learnings from innovative service model trials and other service models innovations within Australia, and where appropriate, internationally;
- Analyse and model potential impacts across the system, key target groups and individuals;
- Undertake targeted consultations; and
- Develop concrete proposals for short, medium to long term reform options for consideration by Government.

Membership

External Members are appointed as individual experts, but will be expected to drive interest with their respective sectors to support the PHCAG work programme.

Governance and Engagement

A targeted but comprehensive stakeholder engagement process will be essential to the development of achievable and pragmatic proposals for reform. The process will include a range of consultation mechanisms including forums, issues papers, public submissions and targeted clinician, industry, and consumer consultations.

State and territory governments are key stakeholders and will be fully engaged. They have specific expertise as systems managers and have access to unique data sets and a range of analytical and planning tools and are also trialling a number of innovative service delivery approaches which the PHCAG should consider in formulating their advice.

Endnotes

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8 AIHW Lower limb amputations [internet] available from: http://www.aihw.gov.au/diabetes-indicators/lower-limb-amputations/

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14 ABS Patient Experiences in Australia: Summary of findings 2013–14. Cat. No. 4839.0

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Better Outcomes

FOR PEOPLE

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PRIMARY HEALTH CARE