

# The need for a National Primary Health Care Policy

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## Summary

*This paper argues the need for a national primary health care policy to overcome persistent problems in primary health care workforce, in continuity of care, in efficient service delivery, in quality, access, equity and the appropriateness of care. The problems result in part from changes in workforce; the changing needs of an ageing population with increasing levels of complex chronic illness; and changes in technology leading to a greater number of same-day surgery procedures with consequent increase in the need for management in the community. At present there are myriad solutions (and myriad funding streams) to address these problems but the complexity of the health care system and in particular the State–Commonwealth divide leads to some initiatives undermining each other, some duplicating each other while significant gaps in service delivery remain. There is a need for a simple overarching policy and strategy that governs decision-making at all levels of primary health care so that there is some consistency in goals, targets and strategies and so that the structural barriers to continuity of care between general practice and other parts of the health system are removed.*

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## Purpose

This paper argues the need for a national primary health care policy that brings the Commonwealth and States into formal agreement on the key areas that affect primary health care: effectiveness, access, equity, workforce, safety, efficiency, responsiveness. The policy should form the guiding principles of a national primary health care strategy that finally removes the structural barriers between general practice and all the other elements of primary health care.

In Australia, perhaps the best available model for such a policy can be found in the single issue policy and strategy addressed in the seven-point national immunisation plan introduced in 1997. This plan was introduced following intense concerns about continuing outbreaks of vaccine preventable diseases due to inadequate immunisation rates. The plan involved close cooperation between the Australian, State and Territory Governments, local government, immunisation providers and community groups. It targeted childhood immunisation milestones; developed educational strategies and incentives for all involved to achieve targets (including parents and GPs); provided funds for the organisational development required to achieve immunisation targets; developed a national database with regular feedback to providers and was supported with monitoring, evaluation and research that in turn inform policy. All seven parts of the plan have been implemented. Immunisation rates in Australia have steadily increased. For example, for all vaccines due by one year of age, coverage estimates increased steadily from 75 per cent in 1996, to 90 per cent by September 2001. For all vaccines due by two years of age, coverage estimates also increased steadily from 64 per cent in 1996 to 88 per cent by September 2001.<sup>1</sup> For those aware of its success, the immunisation policy and strategy has long been regarded as the model for improving population health. It is also a model of effective organisational cooperation in a very complex system.

It is a substantial leap from a single population health issue to the whole of primary health care but a growing list of health system problems has led to ever more calls for health system reform with a focus on primary care. The emphasis on primary care has been justified by the evidence supplied by Starfield and others correlating better population health outcomes, and greater cost control, with health

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<sup>1</sup> McIntyre P, Gidding H, Gilmour R et al. *Vaccine preventable diseases and vaccination coverage in Australia, 1999 to 2000*: May 2002 Supplement, *Communicable Diseases Intelligence*, Communicable Diseases Network Australia. National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases (NCIRS), Commonwealth of Australia 2002 p.68

systems that have a stronger primary health care orientation.<sup>2,3</sup> The emphasis on national change rather than on ‘letting a thousand flowers bloom’ is driven by the complex interrelationships of the Australian health system, where change in one area will readily undermine change in another unless coherence is provided by a national policy and strategy. The Productivity Commission, while not commenting on primary care per se, argued strongly for a nationally coordinated approach to health reform. The Commission noted that:

*Where an activity is of national significance, where actions in one jurisdiction affect outcomes in others, or where policy and delivery responsibilities are shared, there will often be value in adopting a national approach to reform.<sup>4</sup>*

It noted in particular that the variations in performance for the same service across jurisdictions and inefficiencies associated with the current intergovernmental division of responsibilities for key human services were grounds for change:

*An integrated health services reform program within an agreed national framework would add much needed impetus to addressing structural problems of long standing that are preventing the health care system from performing to its potential. The ageing of our population adds to the urgency of reform in this area.<sup>5</sup>*

While the Commission was focusing on broader solutions such as Managed Competition, these statements are equally as relevant to primary health care. This paper documents the accumulation of problems in Australian primary health care that give rise to the need for a nationally coordinated solution.

## Background

The need to develop a national primary health care policy is being widely advocated and Australian Divisions of General Practice (ADGP) is consulting with divisions in all States at present to form a national view. The Victorian divisions independently identified the need to advocate for a national primary health care policy, having recognised that workforce issues would make the existing model of general practice—small independent practices unsupported by primary health care teams—unsustainable. The purpose of this paper is to further develop the rationale for a national primary health care policy, basing it mainly on the issues facing Victorian general practice and Victorian State-funded primary care.

### The workforce crisis

The GPDV Forum dealing with the general practice workforce crisis (August 15 2004) concluded with the resolution that GPDV should prepare a Policy Issues Paper on *Why we need a national primary health care policy*. The impetus was the recognition that the current workforce crisis will almost certainly threaten the viability of the present model of general practice.

Specific workforce problems recognised in the current model are:

- **ageing GP profile:** the proportion of GPs aged 55 or more increased from 21.4% in 1991 to 31.6% in 2003.<sup>6</sup>

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<sup>2</sup> Starfield B, *Balancing health needs, services and technology*, Revised edition, Oxford University Press, New York, 1998.

<sup>3</sup> Health Evidence Network, *What are the advantages and disadvantages of restructuring a health care system to be more focused on primary care services?*, World Health Organisation, Europe, January 2004

<sup>4</sup> Productivity Commission, *Review of National Competition Policy Reforms*, Discussion Draft, Canberra, October 2004, p.261

<sup>5</sup> Productivity Commission, *Review of National Competition Policy Reforms*, Discussion Draft, Canberra, October 2004, p.267

<sup>6</sup> Charles J, Britt H and Valenti L, ‘The evolution of the general practice workforce in Australia, 1991–2003’, *MJA* 2004; 181(2) pp.85–90

- **increasing proportion of female GPs** with implications for hours worked (fewer hours and reduced participation in after-hours care). The GP female workforce was 19.3% in 1991 and 35.2% in 2003.<sup>7</sup>
- **male GPs working fewer hours** Between 1999 and 2003 the number of male GPs working 11 or more sessions per week dropped from 23.8% to 17.1%. The number of male GPs working fewer than six sessions a week increased from 6.1% to 11.4%.<sup>8</sup> This trend alone, if it continues, would result in the need for an extra 600 GPs by 2008.<sup>9</sup>
- in the under-40 age-group, **less GP interest in investing in the business of general practice** ('we just want to practise medicine').<sup>10</sup>
- **fewer medical students applying for available GP training places.** While the Government budgeted for 450 more GP trainee places by 2007, the number of applicants has decreased from 764 for 450 places in 2001 to 667 (projected) for 600 places in 2005.<sup>11</sup>
- continued **dependence on overseas trained doctors** for rural practice. In 1991, 81.4% of GPs were graduates of Australian medical schools, but the proportion declined over the next decade, dropping significantly between 1999 (78.3%) and 2003 (72.2%) ... Overseas-trained doctors holding visas for up to 5 years that are conditional on rural placement have been recruited at a rate of about 200 per year since 2000.<sup>12</sup>
- **nursing shortage and shortage of other allied health workers** making simple solutions of workforce substitution unsustainable. Of the non-information and communications technology professions on the Australian Government Department of Employment and Workplace Relations national skill shortage list, 12 are health professions: general nursing (aged care, cardiothoracic, community, critical care, emergency, indigenous, neonatal, neurological, oncology, operating theatre, paediatric, palliative, perioperative, renal); midwifery; mental health; and enrolled nurses. Current allied health workforces on the register are: physiotherapy; pharmacist (hospital/retail); occupational therapist; speech pathologist; diagnostic radiographer; radiation therapist; sonographer; and nuclear medicine technologist.<sup>13</sup>
- **more older patients requiring more frequent visits.** In 1998–99 the rate for GP visits per head ranged from 2.95 for 10–14 year olds to 9.04 for 65–74 years and 12.02 visits for people 75+.<sup>14</sup> Australia's older population, aged 65 years and over, represented 12.7% of the total population in 2002. It is predicted to represent 14.3 % by 2010 and 18.6% by 2020.<sup>15</sup>
- **longer consultations due to changing demographics** Steady and significant increase in the proportion of encounters charged as long consultations from 7% in 1998–99 to 9.8% in 2003–04.<sup>16,17</sup> This increase reflects the increase in the 65+ population and the consequent complex chronic conditions managed in general practice.

In short, the key concerns are the number, the distribution, the availability of GPs and other health professionals around the clock and the vital issue of who will invest in general practices in the

<sup>7</sup> Charles J, Britt H and Valenti L, 'The evolution of the general practice workforce in Australia, 1991–2003', *MJA* 2004; 181(2) pp.85–90

<sup>8</sup> Charles J, Britt H and Valenti L, 'The evolution of the general practice workforce in Australia, 1991–2003', *MJA* 2004; 181(2) pp.85–90

<sup>9</sup> Anastasopoulos C, 'Crisis deepens as men cut hours', *Australian Doctor*, 23 July 2004, p.1

<sup>10</sup> Wilson D, *The new cohort of GPs: Who are they and what are the implications for Divisions?* Presentation: GPDV Forum, 15 August 2004

<sup>11</sup> Carnell K, *General Practice Registrar Numbers and Trends: A national perspective*, Presentation: WA General Practice Education & Training Day 18 September 2004

<sup>12</sup> Charles J, Britt H and Valenti L, 'The evolution of the general practice workforce in Australia, 1991–2003', *MJA* 2004; 181(2) pp.85–90

<sup>13</sup> Cited on the Health Workforce Australia website: <http://www.healthworkforce.health.nsw.gov.au/amwac/info.html> Accessed 24 January 2005

<sup>14</sup> Kosmina, S *Victorian General Practice Workforce*, Presentation: GPDV Forum 15 August 2004

<sup>15</sup> Australian Bureau of Statistics, Catalogue 3222.0, 2003

<sup>16</sup> Britt H, Miller GC, Knox S, Charles J, Valenti L, Henderson J, Pan Y, Bayram C, Harrison, C 2003. *General practice activity in Australia 2002–03*. AIHW Cat.No.GEP 14. Canberra: Australian Institute of Health and Welfare (General Practice Series No 14)

<sup>17</sup> Britt H, Miller GC, Knox S, Charles J, Valenti L, Pan Y, Henderson J, Bayram C, O'Halloran J, Ng A *General practice activity in Australia 2003–04*. AIHW Cat.No.GEP 16. Canberra: Australian Institute of Health and Welfare (General Practice Series No 16), 2004

future—a question that has implications for the model of general practice and primary care that is delivered in Australia. These problems call into question the capacity to maintain current standards of care in the future. They also threaten the capacity of divisions and GPs to deliver on national programs.

In order to avert a crisis the Chairs of Victorian Divisions of General Practice suggested that we consider in more depth the rationale for a national primary health care policy. This suggestion is the most recent of a long series of recommendations that Australia address health system problems by moving to a primary health care model. While the Victorian impetus to change comes from a fear that the current system is unsustainable due to workforce problems, such concerns are not the only problems that have given rise to the view that a primary health care policy is needed.

## Other health system problems

AHMAC (The Australian Health Ministers' Advisory Council) adopted a national health performance framework for assessing the Australian health system.<sup>18</sup> The framework addresses three levels: health status and outcomes, the determinants of health, and health system performance. In the category of health system performance there are nine criteria for assessment. Problems in at least six of these areas have contributed to the justification by a range of advocates for a primary health care policy. Notable on the list of advocates are the Divisions Review Panel, the Senate Select Committee on Medicare (2003), DoHA (1999), PHCRIS (formerly NIS), Bill Glasson, and Hal Swerissen. John Dwyer and John Menadue have both advocated substantial national reform, with reform of the primary care sector as a vital component.<sup>19,20,21,22,23,24,25,26</sup>

The workforce crisis described above is categorised in the national health performance framework under 'sustainability'. We consider below the arguments within the other categories to further illustrate the need for a national primary health care policy.<sup>27</sup>

### Efficiency

Definition: 'Achieving desired results with most cost effective use of resources'

#### *Efficiency in the acute-primary care interface*

In a recent paper Jeff Richardson, Professor of Health Economics at Monash University, asked 'Why does Australia, a relatively young country, use hospitals more intensively than much older countries while, at the same time, believing there is a crisis in the access to hospital services?'<sup>28</sup> Part of the explanation is that 12% of admissions (in Victoria in 2003–04) involve cases that the Department of Human Services (DHS) argues could and should be treated in primary care.<sup>29</sup> These are the

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<sup>18</sup> National Health Performance Committee, *National health performance framework report: A report to the Australian Health Ministers' Conference*, Queensland Health, 2001

<sup>19</sup> Commonwealth of Australia, *The future role of the Divisions Network: Report of the review of the role of divisions of general practice*, Commonwealth of Australia, June 2003

<sup>20</sup> The Senate, Senate Select Committee on Medicare, *Medicare—healthcare or welfare*, Commonwealth of Australia, October 2003

<sup>21</sup> Furler L, First Assistant Secretary, Health Services Division, Commonwealth Department of Health and Aged Care 1999–2000 'The purpose of divisions: The Commonwealth view' in *Divisions Quarterly*, November 1999, pp.18–20

<sup>22</sup> Raupach J, Kalucy L, Magarey A, Catherine Hurley, *Primary care and general practice: the way ahead*, NIS, Department of General Practice, Flinders University, 2001

<sup>23</sup> Glasson, B, President AMA, Australian Doctor, October 2004

<sup>24</sup> Swerissen H, Professor of Public Health, La Trobe University, 'Why cross the boundaries?', conference presentation: *Crossing the Boundaries*, Australian Institute for Primary Care, October 2004

<sup>25</sup> Dwyer J, Chair, Australian Health Care Reform Alliance, *Radical action: Taking a fresh look at the Australian health care system*, Conference Presentation, ADGP, 2004

<sup>26</sup> Menadue J, Chair, *Generational Health Review*, SA, 2003

[www.sa.anf.org.au/pdf/ghr/GHR\\_Main\\_Report\\_WEB.pdf](http://www.sa.anf.org.au/pdf/ghr/GHR_Main_Report_WEB.pdf)

<sup>27</sup> The italics under each sub-heading are the definitions provided in the national framework

<sup>28</sup> Richardson J, *Priorities of health policy: Cost shifting or population health*, Working Paper 147, Centre for Health Economics, Monash University, January 2004

<sup>29</sup> Department of Human Services Victoria, *Background paper*, Healthy Futures Workshop, October 2004

Ambulatory Care Sensitive Conditions (ACSCs) and include diabetes, asthma, dental conditions, COPD, and cardiovascular disease. At the same time we experience seemingly unresolvable problems in gaining access to hospital in a timely way both for emergency and elective cases.

Developments in technology are also reducing the number of medical conditions for which multi-day hospitalisation is necessary so that the system requires the capacity for management of more conditions in the community.

Finally, there is the issue of the high number of patients using emergency departments for relatively minor matters that could be treated in general practice. 'For Victoria, these now constitute 38% of presentations in Melbourne, while in the larger provincial cities they are estimated to average just over half of all emergency department presentations....Statewide primary care presentations increased...29.7% over the five-year period from 1998-99.'<sup>30</sup>

There are many initiatives undertaken by divisions of general practice in Victoria designed to reduce the incidence of ACSCs and the use of emergency departments for problems treatable in general practice. Initiatives include systems for chronic disease management, integrated disease management projects etc. But there are some key problems:

- there is no driver for the hospital system to liaise with general practice or other primary care post hospital treatment
- there is no driver for the hospital system to assess referrals before admission with the option of referring back to primary care instead of admitting
- no aggregated data related to general practice to provide the necessary feedback as a motivator for GPs in relation to chronic disease management
- specialists do not appear to be in the organisational loop for the planning of strategies for management in the community yet they are responsible for the majority of referrals for admission
- a concerted effort to shift the locus of care away from hospitals and specialists to general practice assumes a workforce capacity that may not be available
- addressing workforce issues by establishing primary health care teams is often proposed as a significant component of the solution. In particular, it is suggested that nurses take on many of the tasks currently performed by GPs. Such tasks may include screening, many of the more routine and protocol-driven aspects of chronic disease management as well as the administration of CDM. But workforce projections for nurses and other allied health also predict substantial shortages. Investment in total primary health care workforce planning with adequate training places and retention strategies would seem to be vital.

In summary, there has been a decline in long-stay hospitalisation, an increase over many years in the number of acute illnesses for which day hospitalisation is suitable and a steady increase in chronic illnesses best managed in primary care. The policy response is lagging so we are still using hospitals and specialists for conditions that the evidence suggests are more cost-effectively managed by primary care teams. But the potential workforce shortages in general practice and in other primary health suggest the need for a primary health care policy that has primary health workforce planning as a central component.

### ***Efficiency in the combined use of State and federal resources***

In general terms, the Australian Government is responsible for funding general practice, specialists, pharmacy, aboriginal health, aged care and rural health. State governments are responsible for providing secondary care, mental health, aboriginal health, alcohol and drug, community health, and aged care.

There are major examples of overlap between State and Commonwealth initiatives. For example, the Commonwealth funds Carelink while the Victorian State Government funds the Statewide Human Services Directory; the Commonwealth funds immunisation through GPs while the Victorian

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<sup>30</sup> Swerissen H, *General practice and Medicare: Options for reform*, Australian Institute of Primary Care, May 2004

Government has historically supported immunisation through local government; the Commonwealth funds Enhanced Primary Care items to improve coordination of care while the State has developed State service coordination tools; and the Commonwealth has funded More Allied Health Services (MAHS) and Better Outcomes in Mental Health while the State funds Primary Mental Health Teams.

Mental health initiatives provide a perfect case study both of the inefficient use of resources and of the potential to improve the efficiency of the existing system.

In 2002–03, the North East Health Wangaratta Area Mental Health Services (State Government funded) and the North East Victoria Division of General Practice (Commonwealth funded) joined forces to combine three funding sources into the provision of one service. As the Integrated Primary Mental Health Service, they used resources from the Primary Mental Health & Early Intervention Initiative (Victorian State Government), the More Allied Health Services (MAHS) (Commonwealth) and Better Outcomes in Mental Health Initiative (Commonwealth) to create an integrated primary mental health service with 12.4 EFT and which provides for co-located clinicians in GP clinics as well as specialist services in dual diagnosis and perinatal mental health provided through the Area Mental Health service. This model of service integration has resulted in a 30% reduction in referrals to Wangaratta Adult Mental Health service sustained over 18 months, and provides a strong argument for the effectiveness of primary care prevention and treatment of mental health disorders and problems.

The inefficiencies that this service has avoided are:

- three separate initiatives attempting to engage primary care
- single workers struggling to operate separate outreach models of service delivery, involving extensive and time-consuming travel
- separate workers visiting primary care services extolling the virtues of their particular initiative
- primary care providers, such as GPs, having to differentiate which initiative best suits the needs of a particular patient, and then grappling with one of the three referral pathways
- each initiative requiring separate infrastructure support, separate governance and clinical support and separate models of service delivery.<sup>31</sup>

But the efficient use of primary mental health resources in NE Victoria is one of the exceptions that prove the rule. Concerns about accountability for separate funding sources and about double-dipping have prevented this efficient solution being repeated elsewhere.

One of the areas with the greatest potential for cooperation but still limited by professional differences in values and by structural barriers is that of community health policy.

The Victorian State Government funds 100 community health services on 250 sites. Its policy is to expand the role of community health services using strategies that include coordinated disease management and ambulatory care, child and family health, and integrated health promotion. The strategy also includes expanded primary medical care.<sup>32</sup> At the same time there are more than 5700 GPs in Victoria on 1995 sites.<sup>33</sup> A national primary health care policy (agreed to by the Commonwealth and the States) might lead to better use of the existing infrastructure as an instrument of policy rather than to the funding of competing services in community health centres. This could mean expanding the provision of other primary health services in community health centres and linking general practices through divisions into a referral network and, where appropriate, primary health care teams. When there is a need to improve access to primary medical care the State Government could negotiate resourcing existing general practices to meet access targets.

It is the State/federal divide in responsibility that prevents State governments automatically looking to the full range of available resources when determining policy and strategy. There is an urgent need to

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<sup>31</sup> Williams R, 'Integrated Primary Mental Health Service—North East Victoria', *PARC update*, Issue 13, Primary Mental Health Care Australian Resource Centre, September 2004

<sup>32</sup> Faulkner P, Victorian Department of Human Services, *The year in review*, Presentation: College of Health Service Executives, September 2004

<sup>33</sup> Kosmina S, *Victorian General Practice Workforce*, Presentation: GPDV Forum 15 August 2004

break down those barriers. A national primary health care policy could ensure the rationalisation of resources to avoid unnecessary and costly duplication of service provision.

## Access

Definition: 'Ability of people to obtain health care at the right place and right time irrespective of income, physical location and cultural background.'

Variations in access to primary health care services are common in Australia. In 2001–02 availability of GPs remained highest in capital cities and lowest in remote areas.<sup>34</sup> Even in the cities access varies, with waiting times for appointments to GPs in Melbourne's Western suburbs as high as four weeks.<sup>35</sup> Financial access is also an issue in some areas although recent changes to Medicare are expected to reduce financial barriers to general practice.

Access to dental services, counselling services and other allied health services is limited for those who are unable to pay privately. In Victoria, these services are targeted and budget-capped. Dental services in some areas have a waiting time of two years. Swerissen also notes that 'access to community-based continuing care services varies significantly across people with very similar needs, depending on the historical evolution of programs and eligibility criteria.'<sup>36</sup>

### *Minimum standards for access*

The problems defined above can occur because there is no standard for access to care in Australia. The presence of Medicare theoretically means that all Australians have unrestricted access to general practice, which is the gateway to the rest of the health system. In reality, access depends on where you live (Western suburbs and rural areas being clearly disadvantaged); on capacity to pay in those areas where low income and low levels of bulkbilling coincide; and on whether the primary need is for general practice or for some other form of care such as physiotherapy, psychology or dental care.

Finland has recently introduced a policy that prescribes a baseline of access to the health care system starting on 1 March 2005.<sup>37</sup> The policy focuses on ensuring access to the most commonly sought types of treatment. Under the new legislation patients would be guaranteed immediate access by phone to a health centre and receive an assessment of their treatment needs at a health centre within three days. Minimum time standards for further treatment (e.g. hospital, mental health) are prescribed in the legislation.

Rural Workforce Agency Victoria (RWAV) has argued convincingly for the need to develop a national index of access to health services in Australia.<sup>38</sup> RWAV proposes to devise an index based on the complexities of time to travel to key services (given mode of travel, road type and condition; and mobility); socio-economic barriers including ability to communicate, access to transport, affordability and personal mobility; degrees of access to services including equitable access, waiting times, range and quality of services and perceptions of accessibility. The submission notes that use of the population-to-GP ratio is an inadequate almost meaningless measure.

In short, the well-off and well-located are better able to access primary health care although the incidence of ill-health is higher in populations and locations of social disadvantage. An accurate measure of access to health care combined with agreed minimum standards for access to a defined set of services would be a very important component of a national primary health care policy. A primary health care policy could address minimum standards for access not only to general practice but to the range of services that are part of a broader primary health care system.

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<sup>34</sup> National Health Performance Committee 2004, *National report on health sector performance indicators 2003: A report to the Australian Health Ministers' Conference*, AIHW cat. No HWI 78

<sup>35</sup> Wilson, D *The new cohort of GPs: Who are they and what are the implications for Divisions?* Presentation: GPDV Forum, 15 August 2004

<sup>36</sup> Swerissen, H, *General practice and Medicare: Options for reform*, Australian Institute for Primary Care, 2004

<sup>37</sup> <http://www.stm.fi/Resource.phx/eng/subjt/health/hserv/access.htx>

<sup>38</sup> Rural workforce Agency Victoria, *National index of access to health care*, Rural Workforce Agency Victoria, 2004

## Continuity

Definition: 'Ability to provide uninterrupted, coordinated care or service across programs, practitioners, organisation and levels over time.'

Changing demographics mean that the burden of disease is predominantly due to chronic conditions. The BEACH Report for 2004 shows that 50.8% of GP consultations involved management of chronic illness with hypertension, depression, diabetes, lipid disorders and osteoarthritis treated most often.<sup>39</sup> Most chronic conditions require a team of health care providers and supporting systems: GPs, educators, nurses, psychologists, and other allied health; resources for guided self-management, recall and reminder systems, referral to specialists and hospital admission for acute episodes. Fragmented service provision and information flow create major problems within the existing system. For example, when a person leaves hospital the GP should have access to all the details about diagnosis, treatment, medication, and post-hospital issues such as next scheduled appointment with the specialist. With such information the GP can provide high-quality primary care. At present, the availability of such information is a function of local circumstance rather than a basic requirement of the system everywhere. In Victoria in 2004 an estimated 70% of hospitals automatically referred information to GPs but there are no repercussions for those that failed to do so. There is no national policy that requires appropriate communication between hospitals and GPs although, through their divisions, GPs work at change with some very good results in some instances.

### *Vertical continuity*

One of the challenges in the push to manage chronic conditions in primary care is that the connection between GPs and hospital admissions is indirect. The BEACH Report for 2003–04 notes that the patient was given at least one referral at 11.0% of all encounters and for 7.5% of all problems managed. 'Very few patients were referred to hospital for admission (0.6 per 100 encounters) or to the hospital emergency department (0.2 per 100).' The most frequent referrals were to specialists (7.9 per 100 encounters).<sup>40</sup>

### *Horizontal continuity*

Referral rates are low. More than 50% of consultations in general practice relate to chronic conditions, many of which are recognised as requiring teamwork. GPs referred to allied health in 2.6 per 100 encounters. In the BEACH analysis, allied health did not include nurses and did include dentists. Approximately 40% of allied health referrals were to physiotherapists. Others in the top 10 referral categories in descending order were psychology, dietician, dentist, podiatrist, acoustic testing, drug and alcohol, optometrist, counsellor, mental health team.<sup>41</sup> It may be that referrals to allied health are informal because there is no legal requirement or it may be that they are not happening. (There is no agreement in the primary health care system about the GP role as medical care coordinator and, in general, communication and coordination mechanisms with state-funded primary care services are not in place). This is an important area for research and an important issue in the formation of primary health care policy.

The need for improved continuity was the basis of a recent recommendation from the RACGP/GPDV Primary Mental Health Forum (2004) to establish a national primary mental health policy: 'there are pressing issues related to integration and coordination of mental health services across primary care and specialist sectors for all patients in Victoria.' The Forum recommended

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<sup>39</sup> Britt H, Miller GC, Knox S, Charles J, Valenti L, Pan Y, Henderson J, Bayram C, O'Halloran J, Ng A *General practice activity in Australia 2003–04*. AIHW Cat.No.GEP 16. Canberra: Australian Institute of Health and Welfare (General Practice Series No 16), 2004, p.24

<sup>40</sup> Britt H, Miller GC, Knox S, Charles J, Valenti L, Pan Y, Henderson J, Bayram C, O'Halloran J, Ng A *General practice activity in Australia 2003–04*. AIHW Cat.No.GEP 16. Canberra: Australian Institute of Health and Welfare (General Practice Series No 16), 2004, p.79

<sup>41</sup> Britt H, Miller GC, Knox S, Charles J, Valenti L, Pan Y, Henderson J, Bayram C, O'Halloran J, Ng A *General practice activity in Australia 2003–04*. AIHW Cat.No.GEP 16. Canberra: Australian Institute of Health and Welfare (General Practice Series No 16), 2004, p.79

*That the Commonwealth Government, in consultation with States and Territories, develop a Primary Mental Health Care Policy to:*

- articulate the directions of the Third National Mental Health Plan, and*
- identify the areas where joint funding, identified patient health outcomes and agreed performance measures can be applied.<sup>42</sup>*

The mental health recommendation reflects the concerns across all of primary health care and underscores the need for a general primary health care policy of which a primary mental health care policy would be a component.

In short, current service systems are geared to one-off episodic care. These systems do not meet the growing needs of those with chronic conditions who use multiple services over time.

## **Appropriate**

Definition: 'Care/intervention/action provided is relevant to the client's needs and based on established standards'

### ***Care relevant to needs***

Care relevant to peoples' needs requires the capacity to identify needs through data and to allocate funds to address true needs. An excellent illustration of such capacity is cited by Jeff Richardson:

*A Seattle based 'pure' Managed Care company, Ethix, was asked to establish a health scheme for a small town close to Seattle. Routine surveillance of the medical claims over the first two years of the new scheme highlighted an anomaly. There were excessively large numbers of youths receiving surgery for spinal injuries. Further investigation found that the problem was attributable to a toboggan run on the outskirts of the town which had a tree stump half way down the slope. Youths were crashing into the stump and damaging their spines. The health scheme paid for a bulldozer to remove the stump.<sup>43</sup>*

Richardson suggests that this highlights two aspects of an ideal health system—routine data surveillance to locate problems and the flexibility of funding to adopt the most cost effective solution. Both features could be addressed in a national primary health care policy. The Seattle example comes to mind when one considers that nursing homes are trying to provide primary care in English to people who in their old age can only recall Greek, or Italian or Vietnamese<sup>44</sup>; or when pensioners are taking repeated doses of antibiotics for mouth infections when they really need a dentist.

A useful primary health care policy would address the issue of the type of funding required to ensure the flexibility to meet true needs and the type of data collection required to properly identify needs.

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<sup>42</sup> RACGP & GPDV Primary Mental Health Care Forum, *Report and draft recommendations: Consultation document*, GPDV, December 2004

<sup>43</sup> Richardson, J *Priorities of health policy: Cost shifting or population health?*, Working Paper 147, Monash University, Centre for Health Economics 2004 P.14

<sup>44</sup> Monash Newline, *Speaking their language aids dementia patients*, Monash University June 2004  
[http://www.monash.edu/news/newline/story.php?story\\_id=177](http://www.monash.edu/news/newline/story.php?story_id=177)

## *Care based on established standards*

We know that best practice management of chronic diseases usually requires longer consultations and already the BEACH statistics show that on average GP consultations are longer than in previous years. But the evidence suggests that true adherence to standards would logjam the system unless there is a routine shift to primary care teams. In August 2004 Kevin Grumbach, Professor of Family Medicine and Health Policy at the University of California, told the GPET conference in Brisbane that GPs around the world will need to reorganise their practices into primary care teams if they are to cope with their increasing workloads. Grumbach's assessment was based in part on the impact of evidence-based standards applied in protocols. 'It had been estimated in the US that it would take GPs 7.4 hours per day if they were to deliver all of the recommended protocols for conditions such as diabetes.'<sup>45</sup> While the need for appropriate care of a high standard based on evidence is not disputed, the implications for service delivery are also clear.

The development of evidence-based protocols leads to the expectation of the consistent application of evidence-based standards of care. Compliance with such standards requires the provision of teams and a higher level of resourcing than is available at present.

## **Safety**

Definition: The avoidance or reduction to acceptable limits of actual or potential harm from health care management or the environment in which health care is delivered.

More than 90% of general practices are accredited but there is evidence that many are struggling to meet the standards for reaccreditation. In particular, practices have difficulty with after-hours care, sterilisation, medical records, recalling patients with abnormal results, continuing education and cold chain management.<sup>46</sup> There is no similar uniform standard for other parts of primary care. Instead there is 'a proliferation of standards and models for primary health and community care service often with variations across jurisdictions.'<sup>47</sup> Swerissen also argues that there is little information on the safety of primary health and community support services and cites a United States study that 'indicates this may be a significant issue.'

On the positive side, the National Health Performance Committee notes that 'the increase in the rate of practices using electronic prescribing software or data connectivity suggests an improvement in access to safe practice protocols.'<sup>48</sup>

Shared national standards on quality and safety as well as a national monitoring system are fundamental to a national primary health care policy.

## **Equity**

One of the overall questions that the national performance framework applies to the health system is "Is it the same for everyone?"

There is strong evidence that the Australian health system is not the same for everyone. The National Health Performance Committee's own assessment is that 'those living in disadvantaged areas have avoidable mortality rates 54% higher than those living in the least disadvantaged areas... Aboriginal and Torres Strait Islander persons face life expectancies about 20 years lower than other Australians... For Aboriginal and Torres Strait Islander males and females aged between 35 and 64 the rate of death from diabetes was 20 times and 33 times as high, respectively.'<sup>49</sup> Dwyer et al argue that

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<sup>45</sup> Medical Observer, August 20, 2004

<sup>46</sup> Pinski N, *Accreditation & quality*, Presentation: Victorian Advisory Committee General Practice, August 2004

<sup>47</sup> Swerissen H, *General practice and Medicare: Options for reform*, Australian Institute of Primary Care, May 2004

<sup>48</sup> National Health Performance Committee, *National report on health sector performance indicators 2003*. AIHW cat.no. HWI 78. Australian Institute of Health and Welfare, 2004 p.xv

<sup>49</sup> National Health Performance Committee, *National report on health sector performance indicators 2003*. AIHW cat.no. HWI 78. Australian Institute of Health and Welfare, 2004 p.xvi

‘while lack of access to a responsive health system, particularly primary health care, is not the only cause of indigenous health disadvantage, there is good evidence that primary health care can make a significant contribution to redressing it.’<sup>50</sup>

Furler and Harris highlight the fact that people on low incomes have higher death rates from preventable illnesses. They are also less likely to receive longer consultations in general practice.<sup>51</sup>

In summary, there is evidence that our current health system offers inequitable access and delivers inequitable treatment and outcomes. A national primary health care policy could, among other things, define the goals and indicators for different service providers to ensure more equitable access, treatment and health outcomes.

## Implications for policy

The above problems have been recognised for some years, although the non-rural workforce and GP infrastructure issues have reached a degree of urgency (or recognition) only in the last year or two. If the above problems provide the key rationale for systems change of some sort, why should it be assumed that a move to a broader primary care model is the right way to go? There are two key issues here: what do the commentators mean by primary health care? And what would having a national policy achieve?

### The meaning of primary health care

In *Primary Health Care—a scoping report*, Rogers and Veale illustrate competing models of primary health care. The comprehensive model is often seen as the ideal and more likely to occur in a unified system. Selective primary care is reported as the present model in Australia.<sup>52</sup>

#### *Differences between comprehensive and selective primary health care*

	<b>Comprehensive PC</b>	<b>Selective PC</b>	<b>Medical Model</b>
<b>View of health</b>	Positive wellbeing	Absence of disease	Absence of disease
<b>Locus of control over health</b>	Communities and individuals	Health professionals	Medical practitioners
<b>Major focus</b>	Health through equity and community empowerment	Health through medical interventions	Disease eradication through medical interventions
<b>Health care providers</b>	Multidisciplinary teams	Doctors plus other health professionals	Doctors
<b>Strategies for health</b>	Multi-sectoral collaboration	Medical interventions	Medical interventions

Each of the models represents a point on a continuum. When the Divisions Review Panel recommended that the Commonwealth adopt a national primary health care policy and that divisions become divisions of primary care, they were suggesting that Australia should move towards the comprehensive primary health care model.<sup>53</sup>

<sup>50</sup> Dwyer J, Silburn K & Wilson G, *National strategies for improving Indigenous health and health care*, Aboriginal and Torres Strait Islander Primary Health Care Review: Consultant Report No 1, Commonwealth of Australia 2004, p.xiii

<sup>51</sup> Furler J & Harris M, ‘Health inequalities in general practice’, *Australian Family Physician*, Vol 32, Jan–Feb 2003

<sup>52</sup> Rogers W & Veale B *Primary health care and general practice: a scoping report*, National Information Service of the General Practice Evaluation Program, Dept of General Practice, Flinders University, 2000, p.18

<sup>53</sup> Commonwealth of Australia, *The future role of the Divisions Network: Report of the review of the role of divisions of general practice*, Commonwealth of Australia, June 2003

## What is the evidence of the effectiveness of a primary-care-focussed system?

In January 2004, the Health Evidence Network (HEN) completed a worldwide review of the evidence of the impact of health systems dominated by primary care.<sup>54</sup> The research from developed countries included UK, Europe, NZ and USA. The evidence reviewed by the HEN report demonstrates advantages for health systems that rely relatively more on primary health care and general practice in comparison with systems more based on specialist care in terms of better population health outcomes, improved equity, access and continuity and lower cost.

There is also ‘compelling international evidence from the work of Starfield and her colleagues that primary care has an independent effect on improving health status and reducing health inequalities and countries with well developed primary care systems have healthier populations and reduced health care costs.’<sup>55</sup>

## Rationale for a national primary health care policy

The problems discussed in this paper have persisted despite many years of investment at State and national level in general practice and primary care reform. It has been the persistence of problems in efficiency, workforce, access, equity and so on that has led all the advocates listed above to propose a national primary health care policy as a potential solution. In a system famously dominated by ‘a strife of interests’ this is a significant coincidence of viewpoint.<sup>56</sup> The opportunity to move from idea to practice came with the Divisions Review when the Divisions Review Panel recommended the development of ‘a national primary health care policy and implementation framework and that the Divisions Network be centrally involved in its development’. The review noted the importance of articulating ‘the role of divisions in the broader primary health care system’.<sup>57</sup>

The Australian Government’s response disappointed many but also left us to speculate as to why it would reject an opportunity that is being widely and consistently advocated. In effect, the Australian Government has, over a period of many years, gradually implemented a ‘primary care strategy in action’ that shifts the emphasis from the traditional general practice model of the solo GP engaged in episodic treatment of whoever turns up, to a model of group practices in which the GP is increasingly ‘crossing the boundaries’ to work with others in the health system and using systems for improving population health. The Government has also funded State Based Organisations (SBOs) and divisions in large part to function as the link between GPs and other parts of the health system. The support from the Divisions Network has led to important changes, but they are incremental and not universal.

The primary care strategy in action has achieved a great deal. Its achievements include:

- (a) cultural shift in general practice including collegiate relationships within general practice and recognition of the need to work with others
- (b) population health targets in immunisation, diabetes and cervical screening
- (c) accreditation of general practices
- (d) GP research
- (e) adjustment of Medicare to recognise other health professionals as part of the PHC team.

These achievements have been enhanced in Victoria by the range of strategies developed by DHS, in particular the General Practice Registry, General Practice Liaison Officer (GPLO) positions, Regional Data Quality Officers (RDQOs) and the Primary Care Partnerships. GPDV and divisions have also worked to bridge the gap between Commonwealth and State services.

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<sup>54</sup> Health Evidence Network, *What are the advantages and disadvantages of restructuring a health care system to be more focused on primary care services?*, World Health Organisation, Europe, January 2004

<sup>55</sup> Cited in Julie McDonald & Lesley Hare, *Literature review: the contribution of primary and community health services*, The Centre for Health Equity, Training, Research & Evaluation Centres for Primary Health Care Equity, UNSW September 2004, p.3

<sup>56</sup> Sax S, *A strife of interests: Politics and policies in Australian health services*, Allen & Unwin, 1984.

<sup>57</sup> Commonwealth of Australia, *The future role of the Divisions Network: Report of the review of the role of divisions of general practice*, Commonwealth of Australia, June 2003, p.23

If the 'strategy in action' has achieved some important goals then what is missing? On the missing list are:

- the drivers for the hospital system to engage with primary care.
- systematic drivers for specialists to review their own roles and systems in relation to primary care.
- elimination of structural barriers to real continuity of care. Despite all of the developments designed to ensure GPs' closer involvement with other health professionals, they remain structurally disconnected from most of the health system.
- accountability (through data). There is no accountability at present for the substantial variations across the country in access, sustainability, continuity, quality and equity.
- effective strategies to avert the anticipated workforce crisis and to plan primary health workforce needs with reference to changing needs of the population and changing evidence about the most effective practices.
- investment in adequate infrastructure: Information Technology, practice ownership.
- coherence— at present the lack of policy enables federal and State health and sections within each to duplicate each other's efforts in some instances, to leave gaps in others, to work against each other and to shift costs to each other whenever possible.

It is the 'what is missing' list that gives rise to the need for a national policy. The advocates of a national policy have variously argued that a policy would provide an organising principle for the health system, a basis for allocating resources and a set of principles that enable all the key players to hold each other to account.

In practice, primary health care policies in Australia do not work that way because they are state-based and so retain the disjunction between general practice and the rest of the primary care system. Only a national primary health care policy could address that fundamental problem.

In concluding her report on a national consultation on primary care, Julie McDonald stated that:

*Several factors have created a climate conducive to the development of a national primary health care policy. Firstly, there is an overall sense of progress and willingness for all stakeholders to work together. Secondly, a number of States/Territories have initiated forums to achieve consensus on primary health care goals and values. Thirdly, the layered introduction of many, often overlapping, initiatives over the past 2-3 years has led to the sense of a loss of direction at all levels, and subsequent 'change fatigue', particularly in practitioners. A significant concern identified was the need to ensure that a national primary health care policy would be 'owned' by all the jurisdictions.<sup>58</sup>*

Finally, at a GPDV Forum to discuss the need for a policy (November 2004) the Chairs of Victorian divisions of general practice considered a set of questions relevant to the formation of a primary care policy. There was not universal agreement but there were some common themes. The dominant views were that general practice should retain its professional identity in the context of a much greater involvement with primary health care teams and that while fee-for-service should be maintained for acute care, capitation/salary could be introduced for general chronic disease management with patient enrolment.

These views represent a significant cultural shift in general practice and reinforce the perception that the time is right to bridge the gap between Commonwealth and State jurisdictions in primary health care by forming a national policy.

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<sup>58</sup> McDonald J, *Reviewing the contribution of general practice to a well functioning and comprehensive primary health care system: Final report*, Centre for General Practice Integration Studies, UNSW, April 2003, p.32

## Conclusion

The Commonwealth Government has received advice for some years that Australia needs a national primary health care policy. Why should it listen now? It is not exactly a case of the Titanic heading for the iceberg<sup>59</sup> but there are major predictable problems ahead that could be averted. There is an available model in the seven-point immunisation plan for bringing Commonwealth and State objectives and resources together in a concerted effort for change. And there is a growing conviction among health policy analysts and health professionals that a national primary health care policy would provide the organising principles to address many of the health system's most intractable problems.

Thinking issue by issue—workforce, efficiency, access, quality—results in the proliferation of simultaneous actions that pull in opposite directions. So funds spent on outer metropolitan workforce undermine funds spent on rural workforce; developments to improve the quality of rural birthing services undermine access to rural birthing services; and initiatives in general practice to promote continuity of care are undermined by the absence of incentives for hospital CEOs to contribute to seamless health care. A national primary health care policy should provide the guiding principles and the incentives at all tiers of the health system to ensure that high-quality health service is universally accessible at the least expensive appropriate level of care.

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<sup>59</sup>Lomas J, *Macchiavelli meets Ivan Illich: A commentary on Milton Lewis and Stephen Leeder's call for a comprehensive national health policy*, Australian Health Policy Institute, February 2001



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