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Policy

Special series: Integrated primary health care

Integrated primary health care in Australia

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Abstract

Introduction: To fulfil its role of coordinating health care, primary health care needs to be well integrated, internally and with other health and related services. In Australia, primary health care services are divided between public and private sectors, are responsible to different levels of government and work under a variety of funding arrangements, with no overarching policy to provide a common frame of reference for their activities.

Description of policy: Over the past decade, coordination of service provision has been improved by changes to the funding of private medical and allied health services for chronic conditions, by the development in some states of voluntary networks of services and by local initiatives, although these have had little impact on coordination of planning. Integrated primary health care centres are being established nationally and in some states, but these are too recent for their impact to be assessed. Reforms being considered by the federal government include bringing primary health care under one level of government with a national primary health care policy, establishing regional organisations to coordinate health planning, trialling voluntary registration of patients with general practices and reforming funding systems. If adopted, these could greatly improve integration within primary health care.

Discussion: Careful change management and realistic expectations will be needed. Also other challenges remain, in particular the need for developing a more population and community oriented primary health care.

Keywords

primary health care, health policy, integration, Australia

Introduction

Primary health care links communities to first contact heath care, facilitates access to other health and related services and coordinates care for those with complex and chronic care needs [1]. To perform these tasks well, primary health care itself needs to be well integrated, internally (e.g. between general practice and other primary health care services) and externally (e.g. with hospitals or community care). This paper describes how Australian primary health care is currently integrated, assesses the likely impact of current and proposed reforms and suggests what else may be required for effective and sustainable integration.

Australia and its health system

Australia is a large continent with a relatively small population of 21 million people. Seventy per cent live in

major cities, with small proportions in regional (14%), rural (14%) and remote areas (3%) [2]. The population is diverse: 24% were born overseas, 16% speak a language other than English at home and there is a growing population of refugees. Indigenous Australians, who make up only 2.5% of the population, have a life expectancy 17 years shorter than the rest of the population. The country is generally affluent, but has significant populations with social and economic disadvantage.

This diversity requires a variety of approaches to designing and delivering health care, each with its own challenges for integrating primary health care. Thus, in some places (often urban) the main challenge is to ensure coordination of care across a complex web of generalist and specialist services, many with poor knowledge of each other. In other places (often rural and remote) it is to combine the efforts of scarce services so as to provide adequate coverage for the population, and develop ways of linking in distant specialist services. For minority groups with distinctive needs the issue can be how to coordinate the special programs that have been set up to meet their needs and link them with mainstream services.

The Australian health care system has a number of features that help shape its primary health care services and, in many cases, complicate efforts to integrate health and related services.

Responsibility for health care is divided between Commonwealth (federal), state and local governments. The major elements of the system were set out in the Health Insurance Act 1973 [3]. The Commonwealth funds medical services outside public hospitals, and some associated allied health care, through fee for service rebates under Medicare, the national health insurance scheme [4]. States and territories are responsible for public hospitals and most public health and community health services, using a mix of Commonwealth government funding and their own taxes. These services are usually provided directly, although some are contracted out to non-government organizations. The role of the third tier, local government, varies, with some providing community nursing services, community care, and some public health functions, as well as addressing local health issues.

The private sector plays a significant role in service provision, including 40% of hospital admissions and most medical services outside public hospitals [5]. More than 44% of the population have some level of private health insurance as at March 2009 [6]. While this has traditionally been confined to private hospital, dental and allied health care, the health insurance industry is beginning to develop a role in primary health care through preventive and chronic disease self management programs [7].

Like many countries, Australia has a significant shortage of health professionals. Their distribution does not reflect population need, with particular shortages in outer urban, rural and remote areas [8]. This is exacerbated by the fact that professionals who can access Medicare benefits can set up practice wherever they choose. The shortage of health professionals increases the need for efficiencies in service provision, but this is sometimes hampered by the rigidity of demarcations between professions and between sectors.

Finally, Australia does not have a consistent approach to electronic medical records. Each sector and jurisdiction has its own approach, and the exchange of health information is complicated by the lack of standards for inter-operability and different rules governing privacy in different sectors. This major barrier to health services integration is currently being addressed on behalf of all Australian governments by the National E-Health Transition Authority [9].

Primary health care and its integration

Australian primary health care involves four main types of services and providers: general practice, community health services, private allied health providers, and indigenous community controlled health services. Emergency departments are used as a first point of contact in the health system by many, although their use as a primary health care service is often discouraged and after hours GP clinics have been set up in some areas [10]. Box 1 provides a brief description of each of these types of service. This is followed by a summary of the structural arrangements for each of these types of service, and the resulting state of primary health care integration.

The structural arrangements for each of these types of service are shown in Table 1.

Primary medical care is usually provided and coordinated through general practice, although this also occurs through Aboriginal Community Controlled Health Services and, in some remote areas, through nurse practitioner led clinics. Access to general practice is almost universal, and a recent Commonwealth Fund survey of seven countries found that Australia

Box 1. Main components of Australian primary health care

General practice

Most general practice is organized on a small business or sole practitioner model, although a significant number now work from corporately owned practices. There is no system of patient enrolment. General practitioners usually see themselves as independent professionals who choose when and where to practice, which patients to accept and what fees to charge. Practice nurses have over the past five years become more common in Australian general practice, particularly in rural areas. Fifty-eight percent of general practices now employ one or more practice nurses, with one FTE practice nurse to every 3.4 GPs [11]. A small number of practices also involve private allied health service providers, employed as part of the practice team or as independent co-located practitioners, although the number is not known.

General practices are supported by **Divisions of General Practice**. These are member organisations funded by the Commonwealth government to support quality improvement, integration with other services and address population health issues through general practice within a geographical area [12]. There are 111 Divisions covering the whole of Australia, with peak organisations (Stated Based Organisations) in each state/territory and a national body (Australian General Practice Network [13]). Divisions are also funded by government to support the implementation of specific health care programs. Their activities are reported in a series of annual surveys [14].

Community health

Community health services are the second largest part of primary health care. They are funded by states and territories, with considerable variation in the range of services provided, how decentralized they are and how closely they are linked to hospital management. Community health generally takes a broader approach to primary health care than general practice, with a stronger focus on population health and health promotion. Core community health services include generalist community nursing, allied health, and a wide range of more specialized services including early childhood, alcohol and other drugs, mental health and sexual health [15]. Over recent years there has been an increasing emphasis on hospital avoidance, post acute care and chronic disease management [16], although some services, predominantly non-government, also maintain a strong focus on community development and health promotion. Except in Victoria, very few community health centres have GPs. Some non-government organizations also provide community health services.

Private allied health services

These include pharmacists, physiotherapists, dieticians, podiatrists, optometrists and more recently exercise physiologists. Like general practitioners, private allied health clinicians may offer their services wherever they wish. They operate independently, and lack the local networks and organisation that Divisions provide to general practice.

Aboriginal Community Controlled Health Services

There are more than 140 Aboriginal Community Controlled Health Services. These vary considerably in their structure and the services they provide, and may include general practitioners, allied health workers and Aboriginal health workers. These are community run organisations, and often take a stronger preventive approach to health care than mainstream services. They have state/territory and a national peak body, the National Aboriginal Community Controlled Health Organisation [17].

Table 1. Organisation of Australian primary health care

	Sector	Source of funds	Mode of payment	Budget type
General practice	Private	Commonwealth, some co-payments	Fee for service	Uncapped
Community health	Public or non-government	State/territory, no co-payments	Salary/capped budget	Capped
Private allied health	Private	Patient payment, private health insurance/some commonwealth, with co-payments	Fee for service/ uncapped budget	Uncapped
Aboriginal Community Controlled Health Services	Non-government	Commonwealth and states fund specific programs, no co-payments	Salary except FFS for GPs	Salary budget capped, FFS uncapped

had the second highest proportion of adults agreeing that they had a 'medical home'[1] (59%) [18]. GPs are gatekeepers to the broader health care system, especially medical specialties[2] supported through referral systems and medical networks that are often well established [19]. This appears to work well in comparison with other similar countries: in the Commonwealth Fund survey, Australia ranked first in the proportion of patients reporting that their doctor helped them choose

[1]A medical home is defined as a regular doctor or source of primary health care that is very or somewhat easy to contact by phone during office hours, always or often knows the person's medical history and always or often helps coordinate care from other doctors or sources of care.

[2]A referral from general practice is needed to get a Medicare rebate for private medical specialists' fees.

which specialist to see (63% of those referred) and provided information to the specialist on their care (81%). On the other hand, it ranked third of the seven in the proportion of people reporting having had problems of coordination of care relating to medical records or test results in the previous year (18%).

While coordination with specialist services is well established, coordination with other parts of primary care can be more difficult. Unlike some other countries (e.g. the UK), community based nursing or public allied health services are rarely located in general practice. Practices themselves often have limited capacity coordinating care with other services [16], and fee for service payments do not adequately support the 'behind the scenes' work needed to support care coordination, although there is now some provision through fee for service payments under the Enhanced Primary Care Program [20] for coordinating chronic and complex and aged care [21]. The lack of patient registration (unlike the UK) can also leave responsibility for ongoing management and coordination of care unclear in some cases [22].

Relationships between general practice and community health are complex: while there are good arrangements for coordinating care in many areas, particularly through the work of Divisions of General Practice, differences in role and culture remain a barrier. Fixed budgets leave community health unable to expand their capacity to collaborate with general practice. Relationships are often easier between general practice and private allied health providers, who share a culture of private practice and have more similar ways of working. Until recently, the potential of this collaboration has been limited by the absence of public subsidy for private allied health services and a lack of organisation within the private allied health sector. However, the introduction of limited Medicare benefits [23] for private allied health services for people with chronic conditions who have a GP referral has begun to provide both motive and capacity to change this.

The relationship with hospitals varies across primary health care. Community health and public hospitals are both funded through state/territory governments, and in some states from part of the same organisational structure (e.g. Area Health Services in NSW). This facilitates coordination, and community nursing in particular has become increasingly taken up with hospital demand management and post discharge care [24]. General practice is structurally independent of hospitals and the effectiveness of interactions is determined largely by local factors, such as the quality of information systems, organisational and administrative capacity, the activities of the local Division and the relationships between key individuals [25]. In some areas, there are programs addressing shared concerns, such as supplementing or substituting for low acuity Emergency Department care, supporting hospital avoidance strategies, pre-admission assessments and addressing health issues, such as winter flu epidemics. These are often organized locally through Divisions of General Practice, and the coverage and effectiveness of arrangements varies widely. State Health Departments are increasingly attempting to involve primary health care and hospitals in more formal systems of care that address ambulatory sensitive conditions and the needs of those with frail health, with the most comprehensive program being the Victorian Hospital Admission Risk Program (HARP) [26].

The relationship with social care is also complex. Social care is a responsibility of both Commonwealth and state/territory governments, with services being delivered through a mix of government agencies and non-government organisations. In some jurisdictions, they are funded and planned through a single health and human services government agency, whilst elsewhere it is part of a separate government department. Two areas where there have been particular efforts to better coordinate community health and social care services have been home and community care and early intervention in early childhood.

The Home and Community Care (HACC) program [27] is a joint Commonwealth/State and Territory government initiative that provides basic support and maintenance services, such as nursing, personal and domestic care and day care services for particularly the frail aged and younger people with disabilities living at home. These services are delivered through a mixture of local councils, community health services and contracted providers (in both the both private and public sectors). Where this involves community health, coordination and integration occur through co-location of staff and the use of a common patient record and information and communication systems.

Some state/territory governments have invested in inter-sectoral approaches to early intervention in the early years. Programs such as Families NSW in NSW [28] and Best Start in Victoria [29] involve a mixture of universal home visiting services, supported parenting programs and more targeted and specialised services for high risk pregnant women, children and their families. They involve state-funded health and related services, such as early childhood and family services, child protection, education and housing [30]. However, there is little integration or coordination with general practice in home and community care or early intervention programs [31].

Initiatives to improve integration

While Australia fares well in the proportion of people reporting having a 'medical home' and a primary medical care provider who coordinates their care with specialist and other services, this is only part of the picture. It does not take into account the range of services from which the primary care provider can choose, and the structural barriers to referring to them. Nor does it address the coordination of service planning or the ability of the primary health care system to respond in a coordinated way to new health challenges. It is these aspects of primary health care provision which are most compromised by the structural problems in Australian primary health care. The remainder of this paper reviews current and proposed approaches to improving primary health care integration in Australia. These are presented in relation to three main challenges for primary health care integration:

1. **lack of clear and consistent policy directions across the sector**, due in part to split responsibilities for primary health care;
2. **poorly integrated service planning**, due in part to incompatible systems of funding and accountability and a lack of effective regional structures;
3. **difficulties in accessing coordinated multidisciplinary and multisector care**, especially for chronic conditions, reflecting weak linkages between general practice and community health/private allied health.

Primary health care policy

Australia currently has no overall policy for primary health care. Some cross-jurisdictional policies for specific health issues have been developed by the Council of Australian Governments (COAG), the peak intergovernmental forum comprising the Commonwealth and State/Territory heads of government: for example the National Action Plan on Mental Health [32] and the National Chronic Disease Strategy [33]. There are also framework agreements for Aboriginal and Torres Strait Islander health that are tripartite agreements between the Commonwealth, states and territories, and the Aboriginal community controlled health sector [34]. While these both include a strong focus on the role of primary care, there is no policy dealing with primary health care as a whole.

The Commonwealth government has some leverage over the states/territories through the Australian Health Care Agreements, which are bilateral five-year agreements for Commonwealth funding for state services. However, performance reporting has focused chiefly on hospital performance and in future agreements will have fewer specific requirements attached to them. The government has set up three bodies to suggest ways in which the Australian health care system should be reformed: the National Health and Hospitals Reform Commission, the Primary Care Taskforce and the Preventative Care Taskforce. The Commission has proposed in its interim report that "to better integrate and strengthen primary health care, the Commonwealth should assume responsibility for all primary health care policy and funding" [35, recommendation 2.1], leaving it open as to whether hospital care would also become a Commonwealth responsibility. The primary health care taskforce has also recommended a national primary health care policy [36], although it is not entirely clear whether this covers primary health care as a whole or just the parts for which the Commonwealth is responsible. It is also not clear how broad the approach to primary health care would be, or whether it would be anchored in a population health perspective.

Having primary health care under a single level of government and a national policy, would remove very significant barriers to integrating primary health care and open the way for new service configurations. However, their impact would depend on how the opportunity was used, including how comprehensive the approach to primary health care, the degree of decentralisation of service planning and coordination, the flexibility of funding regimes and the willingness of professions to modify their roles.

Service planning and development

Service coordination between the different parts of primary health care is currently voluntary with all the attendant problems of commitment and capacity. Much of this occurs at a local level between Divisions of General Practice and state funded health services, with private allied health services as yet playing little role.

These arrangements are often underpinned by memoranda of understanding. Several states/territory health departments have formal agreements with general practice at a state level, and in NSW this is replicated at Area Health Service level. However, each Area Health Service relates to a number of Divisions and Organisational Boundaries do not always match. Although integrated primary and community health planning and service development have been identified as a priority [15], the lack of a performance and accountability framework leaves these agreements up to the voluntary commitment and good will of the signatories.

Some states and territories have set up regional networks to improve primary health care integration. Best established are the 31 Primary Care Partnerships [37] set-up by the Victorian government in 2000

and covering the whole state. Membership includes community health, local government, general practice (through the divisions of general practice), non-government organisations and hospitals. The partnerships have a particular focus on improving service coordination across the community health care system and so reducing hospitalisations. The state government has provided small but consistent funding to the program and has supported their work by developing tools, such as standard referral and assessment forms and an electronic referral system. Primary care partnerships are increasingly used to implement health service innovations, including drought relief and problem gambling and most recently swine flu initiatives. The model is now being implemented across Queensland. South Australia is also developing primary health care networks as part of its GP Plus strategy [38].

This voluntary approach suits the Australian health care system well: it accommodates services from different jurisdictions, does not require services to change their accountabilities or relinquish control of their resources. It also tends to focus on care coordination, which directly addresses the concerns of clinicians. Evaluations of the Victorian Primary Care Partnerships show that they have succeeded in improving coordination of care, especially across state-health funded services [38, 40]. However, they have had variable success in engaging general practice, and they have had little impact on integrating service planning and development except in the area of health promotion [41].

Both the National Health and Hospitals Reform Commission and the Primary Health Care Taskforce have proposed regional primary health care organisations to plan and coordinate primary health care services, with the commission suggesting that Divisions of General Practice might be redeveloped as Divisions of Primary Care and take on these responsibilities [35, recommendation 2.6]. The Primary Health Care Strategy Taskforce suggests a "more comprehensive model" with "regional level organisations that are responsible for activities ranging from planning, coordinating, to delivering health programs, and potentially allocating some elements of funding at the local level" [36, p. 34].

If primary health care is brought under a single level of government, this could overcome the weakness of the current networks and support genuinely integrated planning, particularly if they have devolved responsibility for funding. However, this will require significant changes in culture, particularly in the private sector, and considerable capacity building for the organisations and the individuals who will manage them.

Accessing coordinated multidisciplinary and multisector care

There is little information about who receives multidisciplinary care in Australia, or how appropriate this is to their needs. Two main factors have contributed to limiting access: lack of public funding for allied health care, and difficulties in coordinating care between providers.

In 1999, the Commonwealth government introduced the Enhanced primary care program[3] to support access to multidisciplinary care for people with chronic conditions. This involved Medicare Benefit Schedule (MBS) fee for service items for GP involvement in aged care assessments, care planning, case conferences and Practice Incentive Payments to support general practice infrastructure. These were later supplemented by Service Incentive Payments for reaching certain targets in the use of the MBS items: for example completing an annual cycle of diabetes care. There was, however, no provision for paying community health or private allied health practitioners for collaborating with GPs, and no subsidy for private allied health care. In 2005, MBS fee for service payments were made available for private allied health professional care: up to five treatment sessions a year for patients with chronic disease, on referral from a GP. In 2007, group programs were added to the schedule. These changes have led to increases in referrals [42].

Divisions of General Practice have also received funding to improve GP access to allied health care services through a mixture of employment, brokerage or funding arrangements. The more Allied Health Services program [43] is restricted to outer urban, rural and remote areas with small populations, and the Access to Allied Psychology Services Program [44] provides access to a limited number of focused psychological services. The range and mix of more Allied Health Services funded allied health services depend on the needs of the local population, and Access to Allied Psychological Services targets people with common mental health conditions, including depression and anxiety. Allied health providers are sometimes located in the Division, may share patient records with GPs and use formal referral and feedback processes [45]. However, there is still no consistent approach to linking general practice with community health.

More recently, the Commonwealth, NSW and South Australian governments have established (separate) programs to develop integrated primary health care services. The national program [46] involves setting up 31

[3] For details of the current Enhanced Primary Care Program see http://www.health.gov.au/internet/main/publishing.nsf/Content/Enhanced+Primary+Care+Program-1.

'GP Super Clinics' over four years, chiefly in regional and rural areas. These will bring together general practitioners, nurses, visiting medical specialists, allied health professionals and other health care providers to provide primary health care, either through stand alone services or through 'hubs' of support and referral services that will support existing general practice 'spokes'.

The NSW government is setting up 26 HealthOne NSW services [47] and the South Australian government up to 14 GP Plus Centres in the metropolitan area [48]. These will combine general practice with state funded community health services, and in some cases private allied health services and community care services. They vary from small rural health centres to a network model, providing allied health and other support for more than 70 GPs in a disadvantaged urban area.

The development of these centres has been slow, partly because of the difficulties of collaborating across different sectors. While some centres have begun operating, it is proving difficult to develop governance systems and models of care that can accommodate all the different players, and in the absence of any further structural reform these centres will still have to deal with varied funding systems and inconsistent accountability mechanisms.

The National Health and Hospitals Reform Commission [35] and Primary Health Care Taskforce [36] both propose continuing to develop integrated primary health care services, with active care coordination for some patients and individual electronic health records. Other changes that are signalled include establishing clearer responsibility for patient handover/transitions and associated sharing of information, and a trial of voluntary enrolment with a key provider for patients with complex needs [36, p. 26].

Much less attention has been paid to collaboration with services outside the health system, although the COAG mental health strategy [32] has provision for care coordination between health housing and education for those with complex metal health needs. It is recognised that multidisciplinary and multisectoral care places heavy demands on the information infrastructure and there are proposals to address this.

Discussion

Structurally, primary health care in Australia remains highly fragmented. It involves a mixture of public and private services, funded through different jurisdictions and with varied funding arrangements. As elsewhere, service providers and their support organisations have developed their own ways of working around the discontinuities in primary health care, for the benefit of their individual patients. The data from the Commonwealth Fund quoted earlier suggest that they are probably quite successful at this. However, this is not an efficient or equitable way of arranging health care. It also provides no base for integrated service development, or for a focus on the needs of populations.

Structures are needed that will enable the disparate parts of primary health care to function as a system. The current reform process suggests that these may be politically achievable for the first time in many years. Taken as a whole, the recommendations from the interim report from the National Health and Hospitals Reform Commission [35] and the Primary Care Task Force [36] contain all the main elements that will be required: management through a single level of government, guidance from a national primary health care strategy, regional organisations to coordinate service planning and voluntary patient registration with general practice to strengthen the relationship between patients and their general practitioners. The reports also point to other elements that will contribute to more coordinated primary health care: more flexible approaches to program funding, payments to service providers that relate to prevailing chronic and complex conditions rather than single episodes of care and better infrastructure for supporting care coordination, such as shared information systems could then facilitate the adoption of more integrated models of care.

As usual, any reforms will be influenced by the political realities and professional interests, and will undoubtedly be modified by workforce shortages and the current global recession, although it remains to be seen whether these will restrict opportunities and change or create a greater acceptance of the need for change. Careful change management will be needed and realistic expectations: at best the proposed reforms may create the conditions under which service funders, developers and providers can design more integrated models of health care at regional and local levels.

Other challenges remain, and in particular developing more population and community oriented primary health care. Australian primary health care is, in Lamarche's term [49], predominantly a professionally oriented system. This type of system focuses on providing responsive and accessible care for presenting individuals. It is less good than community oriented systems at providing comprehensive health care for populations, or addressing equity issues. The reform documents also tend to have a professional rather than a community orientation, and yet Australia will need both types to achieve comprehensive primary health care, and will have to work out how these two different approaches can best be linked. But the reform proposals as set out in the interim reports will be a very satisfactory beginning.

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