Bilateral Plan for Primary Health Care Services in Queensland

Background Paper

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1. Background and purpose

Reforming and revitalising primary health care (PHC) services in Australia is a central component of the Commonwealth Government’s national health reform agenda. As outlined in the National Health Reform Agreement\(^1\) (NHRA), Clause E1 specifies the Commonwealth Government has lead responsibility for the system management, funding and policy development of general practice (GP) and PHC, with the objective of delivering a GP and PHC system that meets the health care needs of Australians, keeps people healthy, prevents disease, and reduces demand for hospital services.

Initiatives to date implemented by the Commonwealth Government include establishment of GP Super Clinics, implementation of the after-hours GP helpline, and formation of Medicare Locals (ML). In 2010, the Commonwealth Government released Building a 21st century primary health care system: Australia’s first national primary health care strategy\(^2\). Thereafter, the Commonwealth Government prepared a draft National primary health care strategic framework to assist with addressing some of the most pressing challenges identified for PHC services in Australia\(^3\).

The NHRA\(^1\) Clause E2 requires the Commonwealth and the States to work together on system-wide policy and state-wide planning for GP and primary health care given their impact on the efficient use of hospitals and other State funded services, and because of the need for effective integration across Commonwealth and State-funded health care services. A Bilateral Plan for Primary Health Care Services in Queensland needs to be completed by July 2013 (NHRA, Clause E3).\(^1\)

Within the reform environment, the role of the Queensland Department of Health (DoH) moving forward involves system-wide planning and policy for public hospitals and other state funded services.\(^4\) The role of Hospital and Health Services (HHS) is one of providers of public hospital services. However, all jurisdictions are expected to work cooperatively with the Commonwealth in the implementation and ongoing operation of the Commonwealth’s primary health care initiatives (NHRA, Clause E5).\(^1\)

The development of a Bilateral Plan for Primary Health Care Services in Queensland is a collaborative effort between the state of Queensland and the Commonwealth Department of Health and Ageing (DoHA). The Queensland DoH is providing the stewardship of Queensland’s contribution to the plan, with contributions to be sought from both public and private sectors including HHS, ML, other private practitioners, and non-government organisations (NGO).

The expected outcome of this project is a Queensland and Commonwealth Government endorsed bilateral plan that articulates:

- how the Queensland and Commonwealth Governments will work together to ensure gaps in PHC are managed including how ML and HHS are coordinating and integrating care
- key strategies for PHC services, with a particular focus on populations with poor access to services such as people in rural and remote communities and Aboriginal and Torres Strait Islander Queenslanders.

Therefore, the purpose of this background paper is twofold:

- to provide initial identification of the PHC services ‘headline issues’ in Queensland (i.e. key PHC service issues and key health issues which PHC services are well-positioned to address) to ensure stakeholders have a shared understanding
- to pose potential ‘areas of priority’ for action Queensland and the Commonwealth Government may consider addressing.

This background paper is not intended to be an exhaustive analysis of the contributors to PHC service issues, nor is it intended to provide the definitive solutions to address these issues.
2. Defining primary health care

For the purposes of this paper, PHC encompasses a range of services and activities targeted to individuals and small groups, and spanning promotion, protection, prevention, treatment and health maintenance. The functions include:

- health education, health promotion, health protection
- preventive services including screening, early detection and early intervention services
- assessment, treatment and referral at the first contact point in the health system
- community-based management services for persons with (or at risk of) chronic and complex conditions including pre-admission and post-hospital care
- community-based health advisory and maintenance services for consumers with a disability and frail older people with a cognitive or functional impairment
- community capacity building.

Using this definition, PHC encompasses a large range of providers and services across the public, private and non-government sectors.

Services may be targeted to specific population groups such as Aboriginal and Torres Strait Islanders, refugees, culturally and linguistically diverse persons and/or to groups sharing a similar diagnosis / prognosis or identified risk factor(s).

The PHC definition used in this paper has been developed by the Queensland DoH as part of the system manager responsibility for developing statewide policy and plans for public health services. It is acknowledged this definition is one of several used in academic literature and government publications, and reaching a consistent definition for PHC in Australia remains elusive. This lack of consistency in defining PHC can pose a problem for service delivery.

3. Headline issues for primary health care services

There exist a number of health issues, service complexities and inter-sectoral issues impacting on PHC services from both a consumer and system perspective. These issues are summarised in this section.

The headline issues for PHC services have been considered at a statewide level. There may be significant variability in the issues (and indeed the priorities and potential solutions) relevant to metropolitan, regional, rural and remote Queensland. Therefore, not all issues presented here will pertain to each region of Queensland and some local issues may be absent from this analysis.

In the context of the broader health system, PHC services are ideally placed to address many of the health needs of the ageing Queensland population and several of the health issues placing enormous pressure on services at all levels of the system—such as chronic disease prevention/management, and addressing health inequalities between Queenslanders. Additionally, PHC service access, effectiveness, and governance and organisation have been problematic. A brief overview of these issues is outlined below.

- **Burden of disease**: chronic diseases represented 88.1 per cent of the burden of disease for Queenslanders. Cancer was the leading cause of the burden, followed by cardiovascular disease, mental disorders and nervous system/sense organ disorders, accounting for nearly two thirds of the total burden (62 per cent).
- **Health inequalities**: inequalities in health occur across population groups in Queensland. The greatest differences are between non-Indigenous and Aboriginal and Torres Strait Islander people, between those with the greatest socioeconomic advantage and those with less, between

This is a working document and does not represent Department of Health policy at this time.
people living in cities and those living in remote areas, and between people from different cultural and linguistic backgrounds.

- **Service access:** In some areas of Queensland, access to timely and affordable PHC services is limited. Key issues impacting on service access include availability of a local PHC workforce, and issues associated with the provision of health care in rural and remote areas (which may also contribute to service access issues for Aboriginal and Torres Strait Islander Queenslanders).

- **Workforce availability:** As at 30 June 2011, the average number of general practitioners per 100,000 population across Queensland was 88.7 with significant variability across areas (e.g. numbers ranged from 8.9 practitioners per 100,000 in Torres Strait-Northern Peninsula HHS to 108.6 practitioners per 100,000 in Sunshine Coast HHS). 64 per cent of all HHS in Queensland (9 HHS) had less than 76 practitioners per 100,000 population.

- **Rural and remote access:** In rural and remote areas the delivery of PHC is impacted by geographic spread, low population density, limited infrastructure and higher costs. This, combined with housing costs, lack of opportunities for spouse or children and additional administrative costs, means it can be difficult for service providers to deliver a sustainable service in these areas. Residents in rural and remote areas often feel they have to wait longer than reasonable and have to travel further to access PHC.

- **Access for Aboriginal and Torres Strait Islander people:** Indigenous Queenslanders are not accessing the primary and prevention services they need to prevent adverse health outcomes such as premature mortality due to cardiovascular disease and diabetes. This is illustrated by the fact out-of-hospital Medical Benefits Scheme (MBS) and Pharmaceutical Benefits Scheme (PBS) expenditure for Aboriginal and Torres Strait Islander people in Queensland is around two thirds of that for other Queenslanders (0.63 times). Aboriginal and Torres Strait Islander people often do not present for treatment until they are in an advanced state of ill health, by which time they need greater levels of service, at greater cost to both the person and the health system. This dynamic, combined with higher incidence and prevalence of illness in Aboriginal and Torres Strait Islander people, has led to inpatient public hospital costs per capita for Indigenous Queenslanders that are 2.4 times higher than for other Queenslanders.

- **Avoidable deaths:** Of the 10,544 premature deaths in Queensland in 2010, 68 per cent were avoidable—26 per cent of premature deaths were amenable to health care and 43 per cent were preventable. Avoidable death rates were 74 per cent higher in socioeconomically disadvantaged areas than advantaged areas.

- **General practice-type presentations to emergency departments:** In Queensland in 2010–11, presentations to emergency departments that could have otherwise been managed in a general practice setting (and some of which may be managed in other PHC settings) numbered 375,000 compared with the national average of 264,000 presentations per jurisdiction. While this indicates a potential issue for Queensland, when taken as a proportion of all Queensland emergency department presentations, the state had fewer potentially avoidable emergency department presentations than any other jurisdiction (34 per cent compared with the national average of 39 per cent).

- **Potentially preventable hospitalisations:** In Queensland in 2010–11, eight per cent of hospitalisations were potentially preventable (i.e. could have been avoided through provision of

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a Caution should be exercised in interpreting the data on general practitioners per 100,000 population. The figures only include general practitioners and not other PHC providers delivering a general practice-type service (e.g. medical practitioners with right of private practice working for the HHS and others such as the Royal Flying Doctors Service). The figures also do not represent the actual number of general practitioners in the area (e.g. Torres Strait HHS data indicate there are 9 practitioners per 100,000 population yet in real terms there is only 1 practitioner, as the population of Torres Strait HHS sits below the denominator of 100,000 persons).
appropriate non-hospital services). Of these hospitalisations, chronic health conditions were responsible for 52 per cent, and diabetes complications were responsible for 29 per cent.\(^5\)

- **Defining PHC:** It is difficult to organise and govern a service system effectively without having a clear understanding of the parameters of these services. There is currently no agreed definition of PHC in Australia and therefore no shared understanding of the services being referred to in PHC. Even the definition provided in this paper and the definitions given in other related state and Commonwealth PHC documents differ in focus and scope.

- **Efficiency and effectiveness:** PHC in Australia is provided by a complex mix of Commonwealth, state/territory and privately delivered services each with different policy and services priorities, funding arrangements and eligibility criteria. This is exacerbated by the different policy and funding responsibilities across the boundaries between primary care and other parts of the health system – especially hospitals. The separation of Commonwealth and state policy and funding responsibilities creates what the previous federal Minister of Health described as, “perverse incentives to shunt patients between hospital and non-hospital services…” This mitigates against achieving overall system efficiency and effectiveness, including improving system sustainability.

- **Horizontal and vertical integration:** Partly because there is no combined policy across the boundaries of the PHC and acute sectors, integrated health service planning has been notable by its absence. Additionally, people with complex health issues need to use a range of PHC and specialist services.\(^10\) As general practitioner and other PHC providers work in private practices, non-government organisations and the public health system, they tend to operate in isolation rather than as an integrated service system.\(^2\) Present Commonwealth and State funding distribution tend to reinforce service fragmentation, especially where providers have to compete for funding from the same pool. MLs have been established to help improve service coordination and integration, and HHSs are tasked with cooperating with MLs to address the health needs of people within their catchment areas. However, while coordination at local level may improve some of the symptoms of system fragmentation, it may not address the causes. Robust, long-term solutions require strategic policy and planning decisions at national and state level over which neither MLs nor any another provider have control.

- **Funding arrangements:** The Commonwealth DoHA notes the current funding arrangements in Australia (particularly the MBS) ensure a continued focus on treating the symptoms of ill patients rather than a focus on prevention, promotion, protection and early intervention.\(^11\) Furthermore, the MBS does not encourage PHC providers to work collaboratively with each other or with other health providers to provide integrated and coordinated care for patients.\(^11\)

- **General practice:** PHC in Australia is predominantly provided through private sector general practices operating as small businesses with associated business imperatives. Jackson (2006) has identified these practices are struggling to effectively implement new models of multidisciplinary or team-based care—or any new clinical or organisational approach that differs from the traditional model of general practitioners consulting in isolation.\(^12\)

### 4. Areas for action for primary health care services

The draft *National primary health care strategic framework* identifies four strategic outcomes for PHC services to work towards for the foreseeable future.\(^3\) They are:

- **Strategic Outcome 1:** Build a consumer-focused integrated PHC system.
- **Strategic Outcome 2:** Improve access and reduce inequity.
- **Strategic Outcome 3:** Increase the focus on health promotion and prevention, screening and early intervention.
- **Strategic Outcome 4:** Improve quality, safety, performance and accountability.
The following are some potential priority areas for action for PHC services in Queensland to work towards meeting the draft *National primary health care strategic framework* strategic outcomes. The potential areas for action are organised under each relevant strategic outcome.

As noted in Section 3, PHC service issues may vary considerably between metropolitan, regional, rural and remote areas. When reviewing these potential priority areas for action, please consider whether the action would be a priority for all—or part—of Queensland and how the action may need to be modified to meet the needs of various Queensland communities.

### 4.1 Build a consumer-focused integrated primary health care system

This strategic outcome is about improving **service integration and coordination** in the context of a **patient-or-person–centred care approach** to meet the needs of **specific population subgroups**.

Areas of priority for action in Queensland may include:

- Establishing a bilateral governance mechanism involving senior officials from the Commonwealth and Queensland DoH to:
  - agree on policy, planning and funding priorities (e.g. aligning Commonwealth and State investments)
  - oversee/monitor implementation of the Bilateral Plan for PHC in Queensland
  - review results over time and revise the Bilateral Plan accordingly.

- Defining the service provision responsibilities for all PHC service providers/agencies in Queensland (e.g. scope, parameters, funding sources).

- Building relationships between local PHC providers and—in doing so—eliminating duplication of local services.

- Integrating services in each region of Queensland (defined by HHS and ML boundaries) in collaboration with local providers and consumer input (beginning with horizontal integration of PHC services then vertical integration of PHC services with other levels of health care).

- Undertaking collaborative population health planning and evidence-based needs assessment in each region of Queensland (defined by HHS and ML boundaries) to identify important local population groups and related health needs within the community.

- Working with consumers, communities and local providers in each region of Queensland (defined by HHS and ML boundaries) to identify and implement innovative and improved ways of reducing preventable hospitalisations, improving care coordination and/or case management arrangements, and improving outcomes for people with chronic conditions – with a particular focus on Aboriginal and Torres Strait Islander people.

### 4.2 Improve access and reduce inequity

This strategic outcome is about investing in **relationships** between **consumers and health professionals** and ensuring **high quality care** is available to **actively address service gaps**.

Areas of priority for action in Queensland may include:

- Building PHC service accessibility (such as creating a local service or improving the acceptance and use of an existing service) for Queensland communities/populations with poorest access and poorest health gains—particularly rural and remote communities and Aboriginal and Torres Strait Islander Queenslanders.

- Increasing opportunities for Aboriginal and Torres Strait Islander people to have a greater say and influence over their health services. This includes providing policy and support for
transitioning selected health services from HHSs to community controlled health organisations, where HHS Boards consider it appropriate to do so.

- Building the PHC workforce—and workforce availability—in Queensland regions (defined by HHS and ML boundaries) with the lowest numbers of general practitioners and other PHC providers per 100,000 population.
- Working with PHC providers and other organisations to promote development of multidisciplinary teams in which all team members are supported to fully develop their clinical skills and potential.
- Exploring a consistent funding model/mechanism to support PHC service investment in prevention, promotion, protection and early intervention efforts of Queensland PHC service providers.

4.3 Increase the focus on health promotion and prevention

This strategic outcome is about leveraging existing initiatives to support a systematic approach on all factors impacting on health status and better health outcomes such as education, transport, technology and housing.

Areas of priority for action in Queensland may include:

- Developing a cross-sector action plan in each region of Queensland (defined by HHS and ML boundaries) for how PHC services will address preventable/modifiable chronic diseases that contribute significantly to the burden of disease (e.g. coronary heart disease, type 2 diabetes, stroke and selected cancers and respiratory conditions).
- Developing a cross-sector action plan in each region of Queensland (defined by HHS and ML boundaries) for how PHC services will address social determinants of health that lead to poor health outcomes (e.g. targeting areas of social disadvantage, health literacy, access to health services and healthy home/school/work environments).

4.4 Improve quality, safety, performance and accountability

This strategic outcome is about consumers and providers working together on a continuous cycle to enhance the safety and quality of primary health care services.

Areas of priority for action in Queensland may include:

- Collaborating with the Commonwealth Government to develop funding models that incentivise efforts to improve safety and quality in PHC service delivery.
- Collaborating with the Commonwealth Government to ensure effective and appropriate collection and exchange of information and data to support performance improvement in PHC service delivery.

5. Questions for Consultation

A series of questions have been posed for consideration by stakeholders. These questions are available at http://qheps.health.qld.gov.au/planning/html/sw_clinic_serv_plan.htm Responses must be received by COB Thursday 28 March 2013 and should be emailed to Policy and Planning Branch via the Statewide Planning email account at Statewide_Planning@health.qld.gov.au

If you have any concerns regarding these questions, the Background Paper or the project, please contact Cathy Hindmarsh, A/Manager, Strategy and Planning Unit on 07 3234 1684.
6. References

1 National Health Reform Agreement 2011, Council of Australian Governments.