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The advent of primary healthcare organisations in Australia: why and how?

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Abstract

Over the past decade, Australia, like many developed countries, has seen a shift in its burden of disease from acute illnesses to chronic and complex diseases, with this increase driven by lifestyle risk factors and an ageing population. The comprehensive, effective and sustainable responses to these rely on a connected health care system with an enabled general practice and primary care at its core. However, Australia's complex governance and financing system for health has been a major barrier to this. Over the past two years, Australia has seen a number of health care reforms as structural, financing, systems and quality enablers to address these issues. A central component is the advent of private primary health care organisations, created to develop, enable and embed primary care as the cornerstone of a health care system that is responsive to and meets the health care needs of its population.

Keywords: *primary healthcare organisations, Australia*

1. Introduction

This article discusses the drivers and enablers underlying the recent significant health care reforms in primary care in Australia, of which the creation of primary health care organisations are the most central component.

2. Background

Australia is a wealthy, democratic country of approximately 22.7 million people (1). Although the sixth largest country in the world, it is also one of the most urbanised with approximately 85% living on the Eastern seaboard and 80% living in urban areas. It contains the longest continuous living civilisation in the world, with its indigenous peoples, the Aboriginal and Torres Strait Islanders, having over 40,000 years of continuous culture and comprising 3% of its population (2,

3, 4). It was first colonised in 1798 and has experienced multiple waves of immigration since, leading to a multicultural society, with approximately 25 % of Australians born overseas and 43% of people having at least one parent born overseas (5).

Australia federated in 1901 and now comprises of 6 states and 2 territories. It has three levels of government – federal, state and local. States retain constitutional remit over most internal legislation and planning; including public hospitals, schools, town planning and most infrastructures. The Australian federal government retains the remit over issues that affect the country as the whole; including immigration, defence, trade and most forms of taxation (6).

3. The Health of Australians

In most aspects of health, Australia matches or leads other comparable countries from the Organisation for Economic Co-operation and Development (OECD). It has one of the highest life expectancies in the world, with an expected life expectancy of 84 for females and 80 for males. This has been steadily increasing since the 1970s. However, this life expectancy is not uniform across all groups in Australia. In particular, Aboriginal and Torres Strait Islander peoples have a much lower life expectancy than the general Australian population with indigenous Australians life expectancy approximately 10-12 years less than the overall Australian population (7).

Cancer is the leading cause of disease burden (19% of the total), followed by cardiovascular disease (16%) and mental disorders (13%). Diabetes is responsible for 8% of the burden of disease, with its prevalence having trebled over the past two decades. This increase continues, with diabetes estimated to become Australia's leading cause of disease in burden by 2023. This rise is largely attributed to lifestyle factors of increasing prevalence of obesity (with about 60% of adults either overweight or obese), lack of physical activity and poor diet (8). Within this, there are also groups with a greater burden of disease including indigenous people, those with a disability, those that live in rural and remote areas and prisoners (8).

Between 1987 and 2006 our ranking amongst OECD countries improved markedly for mortality from cardiovascular disease, lung cancer and colon cancer. However it deteriorated for chronic obstructive pulmonary disease, diabetes and infant mortality (9).

Modifiable risk factors contribute over 30% burden of death, disease and disability. The major ones being (10):

- Tobacco smoking. Despite falls from a peak rate of 70% of men and 30% of women smoking in the 1950s to 15% of adults smoking today, it remains the single most preventable cause of ill health and death (9.6 % of the total burden of disease in males and 5.8 % in females)
- High blood pressure (7.6 % of the total burden of disease and injury)
- High body mass (7.5% of the total burden of disease and injury)
- Physical inactivity (6.6% of the total burden of disease and injury)
- High blood cholesterol (6.2% of the total burden of disease and injury)

- Alcohol consumption (2.3 % of the total burden of disease and injury)
- Inadequate fruit and vegetable intake (2.1% of the total disease burden and estimated 11% of the total cancer burden)

4. The development of Australia's health care system

Australia has a relatively long history of at least some parts of its system having cost free access by Australians. Since federation, the States have been responsible for universal access to public hospitals and in 1948, the Pharmaceutical Benefit Scheme (PBS) was established to supply a limited number of lifesaving and disease-preventing drugs to patients for free (11). This was initially introduced as part of wider plans to create a broader universal health British-style National Health Service, but the High Court of Australia at the time stifled this intention.

Until 1975, there was also some limited provision of free community health care by general practitioners and allied health care working in a limited number of state funded community health centres, and a well-established and distributed maternal child health services funded by both state and local governments. However the provision of most health care was private, with both general practitioners and specialists working in a free market economy dynamic (12).

In 1973, the then newly elected government introduced universal access to primary health care services by passing legislation to provide financial rebates to general practitioners and specialists to care for their patients in the community. This started on 1 July 1975. Overnight, this made the access to the vast majority of general practitioner and private non hospital based services free for all Australians. It also created a direct financial and ongoing regulatory relationship between the federal government and general practitioners that continues to this day. Currently about 85% of services provided by general practitioner and private non hospital based services are fully subsided by this government rebate (13).

Furthermore, Australia has a private hospital and insurance system that is an integral and important part of the provision of health care, with approximately 45% of Australians having private hospital insurance and a large and sophisticated private hospital system. However, this insurance does not cover care by doctors outside hospital inpatient settings (14).

Therefore, funding is provided by all levels of government, health insurers and individual Australians.

Australia currently spends 9.4% of its gross domestic product (GDP) on health spending, with approximately 70% of this coming from the government (44% federal government and 26% state government), 18% from individuals (out-of-pocket payments) and 8% from health insurance funds. Although this GDP figure is similar to other OECD countries, compares very favourably to the USA (17.4%) and is slightly below the United Kingdom (9.8%), Canada (11.4%) and New Zealand (10.3%), it has increased from 7.9% in past decade (15).

Of this funding, hospitals are by far the biggest area of health spending and spending increase, consuming 40% of health spending. The next largest component was medical services (18%), comprising mainly services provided by GPs and specialists as private practitioners. Medicines made up another 14%, followed by dental services (7%), 4% on research and only 2% for preventive services (15). Although public hospitals were initially funded almost exclusively by state governments, this has also become more complex over the past decade with some direct funding of programs and initiatives by the federal government and hospitals becoming more innovative in accessing federal government funds.

Health services are provided by highly trained and regulated medical practitioners, nurses and allied health professionals and in the context of private and public hospitals, private clinics, public community health, maternal and child health and aboriginal health centres. Approximately 90% of Australians have a general practitioner (also called a family doctor) that service and coordinate the large part of their health care over their life continuum, with the average number of service per person per year over 5 (8). However there are significant problems with workforce shortages in rural and remote areas with more than a million Australians in rural and remote areas lacing access to basic medical care (16).

5. The system effects of these structures

All of this has led to a complex and siloed health care system, with many types of public and private service providers and a variety of funding and regulatory mechanisms: a public hospital system that is publically funded predominantly by the state; a primary health care system that is federally funded; a private hospital system that is funded by personal insurance; and, increasing out of pocket expenses by individuals.

Over the years, these fundamentals have led to health care system that has multiple inefficiencies, is poorly connected between its various parts and where there is cost shifting between funders, a lack of clear responsibility and accountability and difficulty measuring the effect of care and system responses. It has also led to a lack of coordinated planning across health care sectors that is linked to and agile to the needs of the population.

It has also meant that the hospital care system, with its greater political leverage and the acute forces on it, has received an ever increasing proportion of the health care dollar pie, coming at the cost of primary and preventative health care and services (15). This is despite the fact the increasing burden of disease is a result of lifestyle issues (8), which require long term multifaceted and multidisciplinary care and with overwhelming evidence that primary health care provides more efficient, effective and value health care than tertiary services. It also means that primary care has lost some of its capability in caring for those that it can and should. This is supported by recent figures that found almost 10 per cent of all hospital admissions are potentially avoidable (17).

6. The birth of primary health care organisations

In 2007, the then new Labor government commissioned a number of pivotal reports on the health situation in Australia (18, 19). These reports told the story of a siloed health system that was at tipping point and on the verge of collapse and without the structural building blocks to plan for and meet the health needs of the Australian population moving forward. Health care costs outstripping inflation; rising out of pocket expenses for individuals; hospital admissions rising by 37% in the last decade; ambulances ramped up at hospital emergency departments; long and increasing hospital waiting lists; a lack of systems and drivers for cross health sector patient care planning and coordination; a lack of transparent quality, efficiency and performance measures; poor cross health sector clinical communication and care coordination leading to inefficiencies, mishap and suboptimal patient care; an almost complete lack of cross sector planning leading to duplication and gaps in services; and a fragmented and difficult to negotiate health care system where those at the most disadvantage were facing increasing inequities.

These reports supported the experience of both primary care and hospital sectors with resultant broad health sector support for significant system wide reforms. The Australian government wanted this nationwide reform and it brought the state governments to the table. On 2nd August 2011, the Council of Australian Governments (COAG), comprising the heads of the States and Federal government, ratified the *National Health Reform Agreement.* "The objective of this Agreement is to improve health outcomes for all Australians and the sustainability of the Australian health system. This agreement sets out the architecture of the National Health Reform, which will deliver major structural reforms to establish the foundations of Australia's future health system. In particular, this Agreement provides for more sustainable funding arrangements for Australia's health system." The reform themes were: taking responsibility; connecting care; facing inequities; and, driving quality performance and they led to a number of structural reforms in quality, performance and accountability, funding and preventative health.

The core part of this was the National Primary Health Care Strategy, which represented the first comprehensive national policy statement for primary health care in Australia (20), designed as a *platform to build a strong and efficient primary health care stem into the future (20).* The most central element of this strategy was the development of independent Primary Health Care Organisations (PHCO), called Medicare Locals *to provide better services, improve access to care and drive integration across GP and primary health care services (21).* The government defined the boundaries of these 61 Medicare Locals geographically according to criteria including resident population, local government areas, general practitioners and primary care services and hospitals and their catchment areas. Invitations were then made to create these *Medicare Locals*. By and large, the Boards of approximately 100 Divisions of General Practice, started some 20 years earlier as a means to connect general practitioners in a region together and provide professional development and peer and practice support, rose to the challenge and successfully transformed into these larger and more enabled Medicare Locals whose aims went far beyond those of the Divisions of General Practice. These Medicare Locals developed from mid-2010

onwards and although they are incorporated companies with independent Boards, they have five key strategic objectives in common (22). These are to:

1. Improve the patient journey through developing integrated and co-ordinated services
2. Provide support to clinicians to improve patient care
3. Identify the health needs of local areas and develop locally focussed and responsive services
4. Facilitate successful primary health care initiatives and programs
5. Be efficient and accountable with strong governance and effective management

Medicare Locals are the new kids on the block, and still yet to prove themselves, yet they have already created a much needed authorising voice and body for general practice and primary care to improve the development of pathways and systems for their patients across health care sectors. They have also created a local health needs population planning arm that aims to identify the burden of disease, changing patterns, inequities and needs of its local population and respond to these by: supporting and developing the capacity of primary care to respond to these needs; planning with the tertiary sector to develop whole system responses; and, developing innovative initiatives to respond to local needs, inequities and areas of market failure. In doing so, they have already forged partnerships and innovative models of local health care system development not previously seen in Australia. Since their development the government has changed, and a review of their effectiveness over the past two years is currently underway, with findings due early 2014.

7. Conclusion

Primary health care organisations are the central tenet of much needed recent health system reform in Australia. Their task is to improve the health care outcomes of Australians by rebalancing the health care system towards primary health care. To achieve this they will need to both identify the health care needs of their population and have the authority, relationships and capability to ensure there are sustainable, coordinated and effective responses to these needs, in both the general practice and primary care settings and across care sectors.

Australians have much invested in this current health care reform, as it is only if its goals are achieved that Australia will be able to deal with the important health care challenges that lie ahead in an effective, equitable and sustainable way.

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