

PRIMARY HEALTH CARE REFORM AND THE DEVELOPMENT OF THE NATIONAL PRIMARY HEALTH CARE STRATEGY

Phillip Davies: Thanks, Chris, and thanks for the welcome, and I'm assured that my Victorian colleagues leaving the platform as I arrive is not a sign of a lack of partnership. I'm also sorry I wasn't sitting up here with them. Again, no symbolism; it's merely a reflection of that particularly wicked problem known as Melbourne's rush hour traffic, which meant I got here rather late.

So thanks very much for the opportunity to talk to you this morning and talk in particular about the development of the National Primary Health Care Strategy.

What I'd like to do in the time we've got this morning is outline some of the challenges in primary care that the strategy is seeking to address, to explore the important part that partnerships can play in meeting those challenges and, finally, to explain about how we are going about developing the National Primary Care Health Strategy.

As Chris just intimated, a sizable part of the health sector in Australia is dedicated to the delivery of primary care services. It's actually difficult to quantify precisely the amounts we spend on primary care or to assess the numbers of health professionals and other staff who are involved in delivering primary care health care services. It's difficult to do that, not least since opinions differ as to where the exact boundaries of primary care should be drawn.

Some people, mistakenly, equate primary care with general practice. Obviously I say 'mistakenly', because by doing that they're excluding the important roles that professionals in a variety of settings outside general practice - nurses, allied health professionals and others - play in the delivery of primary care.

Others might argue that primary care services are those first-line health services to which individuals can self-refer or access directly, but that, of course, would exclude vital services such as the dispensing of prescriptions by retail pharmacies because,

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clearly, you do need a referral, in essence, to get a prescription, arguing that first-line, self-referred services would also bring into scope hospital emergency departments, and I think many people here would argue that that was casting the net of primary care a little too widely.

The WHO in Europe, the Health Evidence Network there, suggests that primary care can be conceptualised in a number of ways, as a level of care, as a process of care in terms of specific services or by reference to the personnel involved in its delivery, but I think, as I've just explained, those concepts may be a little restrictive. More generally, primary care has been characterised as being person-centred, as being comprehensive, as offering integrated services, as offering continuity of care and as offering participation for patients, families and communities, and I think those are the sorts of concepts that we would all recognise as underlying what we aspire to in the primary care arena.

Now, obviously we could devote this entire conference and more besides to debating the precise definition of primary care, but I think that would ultimately prove to be somewhat futile. And, what's more, and I think this is important, even if we could arrive at a single definition of primary health care, I suspect that changes in how people seek services and how people obtain services would quickly render such a definition obsolete. But we do know that primary care is the part of our health system that most Australians use most often. We also know that the delivery of effective primary care needs to draw on many different professional skills, and the people who have those skills, as Chris just mentioned, work in the public sector, the private sector and the voluntary or NGO sector. And we know that in Australia the costs of primary care are met by the Commonwealth Government, State and Territory governments as well as out-of-pocket payments by people who use services and, in some cases, private health insurance.

So, clearly, the primary care sector in Australia is very diverse and, hence, very complex, both in terms of funding and delivery. And in an environment like that, partnerships clearly are going to be very

important if primary care services are to be delivered in a comprehensive and coherent manner for all Australians.

So if that's our goal - comprehensive and coherent delivery of primary health care - how are we doing? Well, at the macro level we're doing pretty well. We know we've got a lot of dedicated and devoted health professionals who are working hard to deliver excellent services, and the result is that Australians on average achieve very good health outcomes. We perform well in terms of life expectancy and infant mortality - two measures which are generally acknowledged to provide a good broad indication of countries' health outcomes, and this graph I've plotted here for 190 countries in WHO shows the infant mortality rate and average life expectancy, and Australia is highlighted there in red. So you can see we've got low infant mortality, high life expectancy, and, as you heard yesterday, if you're fortunate enough to live in Victoria, you're even further over in terms of life expectancy.

Another interesting presentation that I came across just the other day - I'm sorry for the rather clumsy slide here; this is actually just taken from the latest edition of *Health Affairs*, but what we've got here is, split into quarters, the difference in actual versus expected life expectancy and actual versus expected health expenditure, and Australia is AU in the top left-hand quadrant, and what that shows is that we've actually got better than expected life expectancy and yet we spend less than might be expected relative to other OECD countries. So that suggests broadly that we're doing something right in the health sector. But, of course, any health system has its shortcomings and has room for improvement, and Australia is, indeed, no different.

Everything I've spoken about so far has been about averages, and simple averages obviously can hide complex underlying detail. I'm sure I don't need to tell you that some Australians, especially Indigenous Australians and other disadvantaged population groups, face considerable inequities in the health outcomes and face significant barriers in accessing the care they need. I'm still sticking to 17 years life expectancy gap. The 17-year life

expectancy gap between Indigenous and non-Indigenous Australians is perhaps the starkest and most troubling example of inequitable health outcomes in our system as it is today.

Now, one simple way to assess how well our primary care services are performing is to ask the question: Who falls through the gap? How many people end up in hospital for conditions that could in principle have been prevented by earlier access to appropriate care outside the hospital setting? In a sense, it's the fence at the top of the cliff rather than the ambulance at the bottom. Well, the data from the Australian Institute of Health and Welfare tell us that in 2005-6 around 9.3 per cent of all hospitalisations were what they term potentially preventable, and that means they were hospital admissions for conditions where hospitalisation was thought to be avoidable if timely and adequate non-hospital care had been provided. That adds up, as you see there, to just over 700,000 admissions in a year, or about 32 admissions for every thousand population. And if we look at the reasons underlying those avoidable admissions, we can see that more than half - about 400,000 - are attributable to chronic conditions, with almost a third of the total - 31 per cent, in fact - being attributable to complications of diabetes. I have exploded the chronic conditions component of that pie chart there.

So there's a lot of people ending up in hospital because primary care is not working for them, and in particular chronic disease and even more specifically the complications of diabetes are accounting for a large share of those unnecessary hospitalisations. But again, even in these data we see the issue of disparities. The rate of potentially preventable hospitalisations in remote and very remote areas is more than double that in major cities, and the rate in the least advantaged areas of the country, the bottom 20 per cent of statistical areas, is more than 50 per cent higher than in the most advantaged, so we know that it's the people in rural areas, it's the people in poorer communities who are going into hospital more than is necessary, who, by implication, are not getting the primary care they need.

So those data on avoidable admissions suggest that we do need to take a closer look at the issue of access to primary care services, and obviously a key factor there is having enough staff, having enough health professionals on the ground who can deliver the right services on an affordable basis when and where they're required.

If we just focus on GPs for a moment, Australia really is actually quite well served in terms of GP numbers. These are OECD data, and they say that in 2004 we had 1.4 GPs per thousand population. It's one of the highest ratios in the OECD. It's actually twice the proportion in New Zealand, for example. Now, there's a qualifier here, of course: these data refer to head count rather than full-time equivalent GPs and, therefore, they don't fully reflect the growing proportion of GPs who choose to work part time. But this does suggest that while supply of GPs is a recognised problem, there may be issues around distribution that are just as important as the absolute numbers of GPs in our system. And, again, these are averages; they don't tell the whole story. We know that many Australians do, in fact, struggle to access GP services, most notably those who live in rural and remote parts of the country.

You can see here how the ratio of GPs to population has changed over the last six or seven years. There has been an increase in the rural GP numbers, but they still lag behind the rest of the country. So we're managing to move them out but we are coming from behind in that, and a sign of that is the fact that people who live in rural and remote areas don't enjoy the same level of access to Medicare-subsidised services as their urban counterparts. Typically, a rural person in a year will get \$130 worth of Medicare benefits for primary care, whereas someone in the metro area will get \$210, and even if we extend the net beyond primary care we see the same phenomenon occurring.

So in terms of challenges and piecing together the evidence so far, we can see that behind what are some very good headline indicators, such as life expectancy and infant mortality, there is clearly scope for us to do better, especially in terms of equity of

access and equity of health outcomes.

So moving on to solutions and in particular the role of partnerships in solutions, we clearly need a new national approach that places a much greater focus on primary care and preventative care and one that is clearly focused on improving health outcomes, and we know that health systems with strong primary health care deliver benefits for health systems. There's lots of research in this area. We know that those health systems that have more primary care are more efficient, deliver better health outcomes, we know that more primary care means fewer hospitalisations and reduced health inequalities, all issues which I've alluded to in discussing the challenges we face. Indeed, this is a global issue, and the World Health Report 2008, published in the last few weeks, is actually entitled 'Primary Health Care - Now More Than Ever', and it argues for renewal of primary care on a global scale, and clearly Australia is not alone in its desire to move forward and restructure its health system to become more equitable, more inclusive and fairer, but as this quote from the WHO report says, it takes a wide range of interventions to address the social determinants of health and to make health systems contribute to greater health equity, and partnerships, I believe, lie at the heart of much that needs to be done.

What I'd like to do now is just highlight three areas where partnerships can contribute to better and more equitable primary health care and, hence, to better health outcomes.

There are partnerships that link health sector agencies with other public and private sector bodies, there are partnerships among primary health care providers, and there are partnerships between those who use and those who deliver primary health care services, so I'm trying to expand here the notion of what we mean by 'a partnership'.

If we start by talking about the first of these - partnerships that link health sector agencies with other public and private sector bodies - the WHO annual report which I've just shown you referred to the crucial role that broader social and economic factors play in

supporting effective primary health care, and that message is reinforced by another recent WHO publication, the report on its Commission on Social Determinants of Health, which highlights the impacts that actions in areas outside the health sector, as conventionally defined, can have on health status, and the quote there is from Margaret Chan, who is the Director-General of WHO, and refers to the need to look beyond the health sector, to partner beyond the health sector.

The complex nature of Australia's health system, with its split of Commonwealth-State, public-private responsibilities, means that we really can't make improvements without taking a partnership approach across the various stakeholders involved. Isolated, unilateral changes that don't take into account the role and interests of other players are, I suggest, doomed to fail, and those partnerships linking health agencies with other bodies need to extend in various directions, and you've heard about some of these from the previous speakers. Within individual governments, State or Commonwealth, we need partnerships across portfolios so that Health is talking to Education, so that Health is talking to Justice, as you've just been hearing. We need partnerships between governments, recognising that in our Federal system achieving positive change typically requires collaboration between different levels of government. As Chris said, we need partnerships between the public and private sectors, acknowledging not only the important part that the private sector plays in delivering health services but also, more generally, the private sector's role beyond the immediate health sector as employer, as wealth creator, as supplier of goods and services. And, finally, we need partnerships between the health sector and what is commonly known as civil society - voluntary non-government organisations and community groups that represent shared interests.

So there's potential for partnerships in all those levels of all those types. And this message is reinforced by the National Preventative Health Taskforce, chaired by Professor Moody. In their initial discussion paper, 'Australia: The Healthiest Country by 2020', they

highlight some of the different players - industry, unions, the media, philanthropy, academia - that all have a part to play in improving health status. And, locally, primary care partnerships using a collaborative approach have made significant headway, and it's great to see that PCPs here are starting to establish those intersectoral partnerships with non-health agencies to provide a more comprehensive response to local needs.

My second category of partnerships was partnerships among primary care providers, and I think there are two types of partnerships that are important here. Firstly, there are partnerships among different health care professionals to deliver multidisciplinary care, and, secondly, there are knows important networks and partnerships amongst organisations that are working in or influencing the delivery of primary care services.

The case for multidisciplinary care teams is very strong. Nurses and allied health professionals can play a key role in delivering services, especially in providing support to the growing numbers of people living with chronic conditions. They can often provide services that are of no less quality but of lower cost, more accessible and sometimes even more appropriate than equivalent services delivered by a doctor, and their potential contribution, I would argue, may be particularly relevant in those rural and remote communities, where we saw access to MBS-funded services can be very difficult due to medical staff shortages.

Now, Medicare as it stands struggles to facilitate access to health professionals other than doctors, and while recent years have seen the introduction of several Medicare items for services delivered by practice nurses and allied health professionals, their role in chronic disease management is still limited and there's clearly great potential to expand it. But the challenge we now face in doing so is to develop financial, organisational and, indeed, legislative arrangements that are more accommodating of partnerships among health professionals and, hence, support the appropriate use of multidisciplinary care.

As I said in terms of partnerships among primary care providers,

there's also a need to foster partnerships among the various organisations that are involved in delivering primary care. Whether or not they're working together in a formally constituted multidisciplinary team as you see here, health professionals need to be able to share information across boundaries on their patients and their programs of care, and partnerships among primary health care provider organisations can also help to overcome many of the diseconomies of scale faced by small practices, especially those based in rural and remote locations.

The changing nature of primary care means that primary care will increasingly come to rely on sophisticated IT and telecommunication systems. It means that providers will need to become adept at combining and coordinating inputs from diverse professional teams, and it means that premises will need to be better equipped, designed to support teamwork, to accommodate multidisciplinary teams and to provide facilities for training and continuing professional education of current and future practitioners.

Now, many small, isolated practices may struggle to marshal the financial and organisational resources needed to respond to these pressures for change in the primary care environment. Among GPs we can see that there's already been a steady growth in practice size over recent years, and the growth of major corporates in the primary care sector can also be seen as a response to these pressures of economy of scale. But for many smaller GP practices and for those of you in rural and remote areas, I dare say most of your GP practices are small, expansion is unfeasible and sale to a corporate is often unacceptable. So in such cases, I expect we will see the emergence of new forms of partnerships or loose alliances that bring together a number of smaller practices to share support services and infrastructure, a model which has variously been described as hub and spoke or even a benign corporate.

Then my third group of partnerships is partnerships between those who use and those who deliver primary care services. The key factor here is the increased prevalence of chronic disease, which

is now reckoned to account for as much as 80 per cent of the country's total burden of disease. Chronic diseases are diseases that people live with, often for extended periods. They're not diseases that can be cured by means of a simple one-off intervention or course of treatment. And the growth in chronic disease means that patients will increasingly need to call upon the services of a range of different health professionals to help them manage their condition, hence the need for multidisciplinary care and partnerships amongst health professionals that I mentioned earlier. But, over and above that, patients with chronic disease will need to build and maintain a relationship with the prime health care team that extends over time, and that relationship will enable the person living with a chronic disease to become skilled at monitoring and managing their own condition, and it will allow the primary care team to adjust and adapt the support they provide to reflect the evolution of the patient's condition.

Traditionally, much of primary care was based on transactions. The patient would visit his or her GP with a specific complaint, the GP would diagnose the patient's condition, issue a prescription or make a referral, and then the interaction would end and the patient would either get better, tolerate the condition or, I guess, deteriorate. The transactional approach was adequate in an era when most conditions seen in primary care settings were of an acute nature - infections or minor trauma. Now we need to develop an approach to primary care that's based more on relationships and partnerships extending over time between the patient and those who deliver services for them.

So just quickly to recap before I move on to where we're heading, we've got a health system that delivers good results for most Australians but struggles to meet the needs of some. We know that primary care holds the key to better and more equitable health outcomes. There is evidence that poor access to primary care for some Australians is leading to increased hospitalisations, and partnerships involving governments, the private sector, civil society and patients as well as health professionals and the organisations in which they work, can clearly contribute much to improve primary

care. Those factors really do underlie most of the work that is taking place towards developing the National Primary Health Care Strategy.

The strategy will provide us with an opportunity to address many of the challenges I've outlined and, in doing so, will reflect the important role that these various forms of partnership can play as we go forward in shaping the primary care sector of the future. Specifically, the strategy will look at a number of important issues, and I think you can see there the resonance with a lot of the challenges that I've already mentioned.

The strategies are being developed by the Commonwealth Department of Health and Ageing with the involvement and support of an external reference group. The reference group comprises 13 health experts from various professional backgrounds and is chaired by Dr Tony Hobbs, who is a rural GP from Cootamundra and a former chair of the Australian General Practice Network, and we've also just last week had our first consultation meeting with colleagues from State and Territory health departments who are involved in primary care.

Minister Roxon recently launched a discussion paper at the AGPN Forum up in Darwin at the end of October to facilitate and to seek public comment and input, and the discussion paper is structured around 10 proposed key elements of an enhanced primary care system and canvasses a wide range of important issues. For each of those 10 elements the paper describes the current situation and what it means for consumers and health care practitioners, with a focus on identifying major issues that will need to be addressed in the development of the strategy. The paper also sets out a series of questions to assist individuals and groups to structure their input and invites comment through written submissions by the end of February next year.

Now, obviously at this stage it's too early to anticipate what the final strategy will look like, and to those of who maybe came here expecting some great revelation, I apologise. I can't predict what specific recommendations the strategy will contain. Indeed, it

would be wholly inappropriate to speculate on that until the results of the current submission process are known. But with that in mind I encourage you all to read the discussion paper, consider what it says and contribute your ideas and suggestions to the strategy development process.

So, to conclude, reform of the Australian health care system is clearly overdue, but reform must be well planned and well informed by those who use and those who deliver services. So now is the time for us all to contribute to finding solutions and to be involved in improving the system for generations to come.

The preparation of the National Primary Health Care Strategy will provide us with an opportunity to take stock, to consider the strengths of our system that we can build on, and identify the major pressure points and canvass approaches to meeting future needs, and I am confident that effective partnerships will be a theme that we see occurring as a key element in many, if not all, of those new approaches. So I encourage you all to engage in the discussion and debate about the future of our system and to ensure that your insights and experiences and those of the organisations you represent are fed into developing the first National Primary Health Care Strategy. Thanks very much.

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