

## 2. Creating strong primary health care services for everyone

Key messages
<ul style="list-style-type: none"><li>• Primary health care is the gateway for people to health services. Almost everyone uses a primary health care service at least once a year.</li></ul>
<ul style="list-style-type: none"><li>• There is compelling international evidence that demonstrates the benefits of strong primary health care services in improving health outcomes for people. Transformed primary health care services – comprehensive, visible and accessible – should be acknowledged as the preferred primary source of care.</li></ul>
<ul style="list-style-type: none"><li>• Primary health care services must be able to respond to the changing health needs of people throughout their lives, ranging from child and family health services to promote early childhood development and wellbeing, to coordinated care for people with chronic diseases, and to support for frail older people to remain living in their own homes.</li></ul>
<ul style="list-style-type: none"><li>• A strong primary health care foundation is vital to driving quality performance through ensuring the 'right care in the right setting'. This includes reducing avoidable hospital visits and admissions through a focus in primary health care on early intervention and self-management.</li></ul>
<ul style="list-style-type: none"><li>• Rebates for fee-for-service medical care provided by general practitioners work well for most people who require episodic care and should be retained.</li></ul>
<ul style="list-style-type: none"><li>• Across our life journey, we have different health needs at different times. A major stage of the life cycle is the birth of our children. Another occurs with the development of chronic diseases as we age. Care for the chronically ill can require a broader range of health services than medical care, provided in a connected way over time. To address these major life cycle challenges, Medicare needs to be further expanded beyond medical care to support access to a wider range of health professionals in primary health care, using funding approaches that are better suited to care over an extended time.</li></ul>
<ul style="list-style-type: none"><li>• We currently do not have an Australia-wide network of large primary health care organisations that meet people's needs through a wide range of services and extended hours. Larger centres can support a larger and more diverse team of primary health care professionals and can be more convenient for people needing care because they can access more of the services they need in one place.</li></ul>

## Our reform directions

- 2.1 We propose that to better integrate and strengthen primary health care, the Commonwealth should assume responsibility for all primary health care policy and funding.
- 2.2 We propose that, in its expanded role, the Commonwealth should encourage and actively foster the widespread establishment of Comprehensive Primary Health Care Centres.
- 2.3 We want young families and people with chronic and complex conditions (including people with a disability or a long-term mental illness) to have the option of enrolling with a single primary health care service to improve care. To support this, we propose that:
- There will be grant funding to support multidisciplinary clinical services and care coordination for that service tied to levels of enrolment of young families and people with chronic and complex conditions.
  - There will be payments to reward good performance in outcomes including quality and timeliness of care for the enrolled population.
  - Over the longer term, payments will be developed that bundle the total cost of care of enrolled individuals over a course of care or period of time, in preference to existing fee-based payments.
- 2.4 We support embedding a strong focus on quality and health outcomes across all primary health care services. This requires the development of sound patient outcomes data for primary health care. We also want to see the development of performance payments for prevention and quality care.
- 2.5 We support improving the way in which primary health care professionals and specialists manage the care of people with chronic and complex conditions through shared care arrangements in a community setting. These arrangements should promote the vital role of primary health care professionals in the ongoing management and support of people with chronic and complex conditions.
- 2.6 We believe that service coordination and population health planning priorities could be enhanced at the local level through the establishment of Divisions of Primary Health Care, evolving from or replacing the existing Divisions of General Practice. These divisions will need to be of an appropriate size to provide efficient and effective coordination.
- 2.7 We propose facilitating access to care where doctors are scarce. Commencing in remote and some rural areas:
- Medicare rebates should apply to relevant diagnostic services and specialist medical services ordered or referred by nurse practitioners and other registered health professionals according to defined scopes of practice determined by health professional registration bodies.
  - Pharmaceutical Benefits Scheme subsidies (or, where more appropriate, support for access to subsidised pharmaceuticals under section 100 of the *National Health Act 1953*) should apply to pharmaceuticals prescribed from approved formularies by nurse practitioners and other registered health professionals according to defined scopes of practice.
  - Where there is appropriate evidence, specified procedural items on the Medicare Benefits Schedule should be able to be billed by a medical practitioner for work performed by a competent health professional, credentialed for defined scopes of practice.
- 2.8 In accordance with our later proposal for the establishment of a National Aboriginal and Torres Strait Islander Health Authority, we would expect that this Authority should be responsible for the purchasing of services that encourage and promote best practice and quality outcomes in primary health care for Aboriginal and Torres Strait Islander peoples wherever they elect to seek their health care.
- 2.9 We support the development of a person-controlled electronic personal health record. We will explore the prerequisites and incentives to allow us to reach this goal in our final report.

*Primary health care reform is the single most important strategy for improving our health, and making the system sustainable. Community-level prevention and primary health care is essential to restoring universalism and efficiency in Australian health care.<sup>1</sup>*

Primary health care must be the foundation of our future health system.

Primary health care is the cornerstone of our 'connecting care' theme. This is why we begin our examination of the health service system with primary health care. When we think about 'connecting care', we need primary health care to be the connecting link as people move back and forth between using other health services, such as hospitals, specialists and sub-acute services. While we consider issues related to improving other parts of the health service continuum in Chapters 3 to 7, we want to emphasise that all these other health services depend upon, and must connect people back to, strong primary health care services.

Primary health care should also provide the 'connection' across our lifetime. While we may have needs for different specialised health services as we age, primary health care should be our 'home base'.

Strong primary health care, as the front line of Australia's health system, is integral to our vision of people- and family-centred care. It is central to keeping people well, not just looking after them when they are sick.

■ Primary health care is the cornerstone of our 'connecting care' theme

## 2.1 Defining and scoping primary health care

There are many definitions of primary health care, including from the World Health Organization.<sup>2</sup> Others have suggested that there is 'no absolute or consistent view about whether particular settings and services are part of primary health care or not'.<sup>3</sup> At the same time, primary health care as the point of first contact appears to be a consistent theme.

### For the purposes of this report:

**Primary health care** means services in the community accessed directly by consumers. It includes primary medical care (general practice), nursing and other services such as community health services, pharmacists, Aboriginal health workers, physiotherapists, podiatrists, dental care and all other registered practitioners. It includes community mental health, domiciliary nursing, maternity and early childhood, sexual and reproductive health, alcohol and drug treatment services, young people's services, school health and other services.

International evidence shows that the strength of primary health care is associated with better health outcomes for the population and the containment of growth in overall health system costs.<sup>4</sup> Health systems that include strong primary medical care are more efficient and have lower rates of hospitalisation.<sup>5</sup> This has also been demonstrated at the local level in Australia.<sup>6</sup> At the same time, lower use of hospitals and greater patient satisfaction with all care is associated with continuity of care with the same primary care provider or service.<sup>7</sup>

1 J Doggett (2007), A new approach to primary health care for Australia (Centre for Policy Development: Sydney)

2 World Health Organization (1978), Declaration of Alma-Ata, at: [http://www.euro.who.int/AboutWHO/Policy/20010827\\_1](http://www.euro.who.int/AboutWHO/Policy/20010827_1)

3 Department of Health and Ageing (2008), Towards a National Primary Health Care Strategy: A discussion paper from the Australian Government (Commonwealth of Australia: Canberra).

4 B Starfield (1995), Is strong primary care good for health outcomes? The future of primary care (Office of Health Economics: London).

5 M Harris, M Kidd and T Snowdon (2008), New models of primary and community care to meet the challenges of chronic disease prevention and management, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

6 Cobram District Hospital (2008), Submission 64 to the National Health and Hospitals Reform Commission.

7 M Harris, M Kidd and T Snowdon (2008), New models of primary and community care to meet the challenges of chronic disease prevention and management, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

In Australia the primary health care sector comprises a broad array of Commonwealth and state government funded programs, and government and privately-provided services. There are several primary health care models:

- general medical practice (general practice) which is largely Commonwealth funded, and multidisciplinary teams funded predominantly by states;
- private allied health professionals who are mainly funded directly by households and private health insurers;
- community health services that may be supported by either local or visiting salaried general practitioners, medical specialists, and specialist consultants or stand-alone nursing services;
- community health programs funded by the Commonwealth and state governments that are aimed at population groups with high needs including low income people, people with a mental illness, people with new babies, the frail elderly, people with disabilities, and people living in rural and remote areas; and
- child and maternity services that are a combination of Commonwealth, state, and private providers.

## 2.2 Building on our strengths

In designing a new model for primary health care, we believe that it is important we retain and build on the elements that are already working well.

Some of these strengths include:

- universal access to rebates against the cost of medical visits and pharmaceutical coverage (Medicare and the Pharmaceutical Benefits Scheme);
- a robust general practice sector respected by consumers, noting there are access and coverage issues for some parts of the Australian community;
- a robust community health sector, including maternal and child health;
- successful prevention activities such as immunisation;
- excellent training in medical, nursing and allied health; and
- strong innovation in rural, remote and Aboriginal and Torres Strait Islander people's health.

In addition, there has been a range of positive initiatives that have begun to tackle some of the areas where primary health care does less well. They include programs to extend access to allied health services and care planning, and promote more effective patient self-care; and programs to support service coordination, including investment in an electronic patient health record.

## 2.3 Identifying the case for change

There are many people who are passionate about reforming primary health care. We commissioned some of them to give us their ideas about what primary health care should look like in 2020 and these discussion papers are available on our website.

There are real opportunities to reform and strengthen primary health care

- Many of our submissions and national consultations identified that there are real opportunities to reform and strengthen primary health care (see Figure 2.1). Areas identified include: an increased focus on prevention and wellness; multidisciplinary care to promote continuity of care while also being complementary to general practitioner care; 'one-stop shops' that provide comprehensive, accessible, affordable and reliable care; and visible and accessible services for consumers.

The issue of navigating the system was raised in one of our invited discussion papers:

*Care pathways through primary care are confusing and often poorly supported, leaving the client to find their way through the maze of overlapping services and past the gaps in service.<sup>8</sup>*

**Figure 2.1: National consultations across Australia – frequently raised issues and suggestions to reform primary health care:**

<i>Frontline health professionals</i>	<ul style="list-style-type: none"> <li>• <i>increased focus on prevention and wellness</i></li> <li>• <i>patient enrolment</i></li> <li>• <i>shared care arrangements and service integration to improve continuity of care and support for people and families with complex needs</i></li> <li>• <i>workforce redesign and enhancement or substitution</i></li> <li>• <i>greater flexibility to focus on regional priorities with resourcing for holistic needs of local communities</i></li> <li>• <i>rebates for telephone and online consultations and broader coverage of health professions and activities by MBS and PBS</i></li> <li>• <i>access via one-stop shops in primary health care</i></li> <li>• <i>gaps, duplication and overlap in services</i></li> <li>• <i>benefit of one system</i></li> </ul>
<i>Community groups</i>	<ul style="list-style-type: none"> <li>• <i>access to holistic patient-centred care with consumers as partners</i></li> <li>• <i>support for carers</i></li> <li>• <i>information to enable informed choices about health and treatment</i></li> <li>• <i>appropriate care for vulnerable and minority groups</i></li> <li>• <i>improved transport and infrastructure</i></li> <li>• <i>improved access to after hours care</i></li> <li>• <i>focus on wellness, prevention/healthy lifestyle/self-management</i></li> <li>• <i>multidisciplinary care to facilitate continuity of care and as an alternative to general practitioners for certain issues</i></li> <li>• <i>one-stop shops that provide accessible, affordable and reliable care</i></li> <li>• <i>the need for an accessible system easily navigated by consumers</i></li> </ul>

Source: National Health and Hospitals Reform Commission, National Consultations, May to July, 2008

Reform to primary health care is also the vital platform for reforms in areas such as chronic disease management, mental health, prevention and a healthy start to life.

One of the major reasons why we need to ensure that we have access to high quality primary health care services is the increasing number of Australians suffering from chronic conditions.

Current trends indicate that, by 2020 and beyond, more of Australia's population will be older and more people will have chronic conditions. Primary health care services are experiencing substantial pressure due to the growth in chronic illness. For example, recent research into the prevalence and patterns of multimorbidity (people with several health problems) in Australia has indicated that about three in ten people who saw a general practitioner in 2005, and one in four Australians, have two or more types of chronic conditions.<sup>9</sup> Among the elderly, 83 per cent of the surveyed patients had multiple conditions which have a negative impact on their quality of life and increases health service use.

■ Reform to primary health care is also the vital platform for reforms in areas such as chronic disease management, mental health, prevention and a healthy start to life

8 S Dunn, I Ellis, D Jones and A Murray (2008), New models of Primary Care, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

9 H Britt and colleagues (2008), 'Prevalence and patterns of multimorbidity in Australia', Medical Journal of Australia 189 (2): 72–77.

In 2007-08, chronic conditions had risen to 52.3 per cent of general practice conditions

In 2007–08, chronic conditions had risen to 52.3 per cent of general practice conditions.<sup>10</sup> The anticipatory care needed for early and better management of people with chronic diseases can only be provided by the primary health care team. Effective management of people with chronic illness requires continuity of care, and the use of a multidisciplinary team, which needs to work effectively together, with defined care pathways, and a cohesive funding system. As a health professional in one of our consultation forums commented:

*Medicare does not recognise long visits – it encourages ‘six minute medicine’. Complex cases are supposed to need a complex care plan, but what about the person coming in with six different problems? Are we supposed to make them come in for three or four separate visits and cost the system even more?’<sup>11</sup>*

There is emerging evidence that quality of care needs addressing. For example, preventive activities are not currently considered as key elements of current general practitioner care. Only 34 per cent of general practitioners, when surveyed, provided smoking cessation advice in consultations with smokers.<sup>12</sup> Moreover, ‘in 2005–6, only one in five problems in general practice were managed using non-pharmacological interventions and, out of these interventions, only 1.2 per cent were for smoking, 9 per cent for nutrition/weight, 0.7 per cent for alcohol, and 2.9 per cent were for exercise counselling.’<sup>13</sup>

In one of our invited papers on reform of primary health care, Mark Harris, Michael Kidd and Teri Snowdon have argued that there is now greater pressure on the care relationship between families and their general practitioner:

*General social changes including commodification of health care, widespread access to the web based information technology, increased medical workforce participation by women, increased mobility of the community and longer working hours have put greater pressure on the care relationship between families and their family practitioner. It is more difficult for a GP to be available at all times when families might need care. The informal linkage between a GP and their practice population has become more tenuous as personal continuity has decreased as has capacity to make best use of new internet based services.<sup>14</sup>*

At the same time, our primary health care system has a wide range of programs and services with a variety of financing arrangements. Often consumers find that it is fragmented and uncoordinated, with care at multiple locations with differing forms of payment, which reduces efficiency and creates greater potential for errors and duplication.<sup>15</sup> In our national consultations, people expressed the need for improved health system navigation and care coordination so that service delivery would be simplified.<sup>16</sup>

Other diverse factors contributing to the case for primary health care reform include the pressures on acute hospitals, the consumer preference to be treated closer to home, the issue of access to primary health care by people living in residential aged care settings, and the relationship of primary health care to other settings. For example, it is well known that a sound working system of primary health care means avoidable hospitalisations.

10 C Bayram, H Britt and J Charles (2008), General Practice activity in Australia 1998–99 to 2007–08: 10 year data tables, at: <http://www.aihw.gov.au/publications/gep/gpaia98-99-07-08-10ydt/gpaia98-99-07-08-10ydt.pdf>

11 Health professional (8 July 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Geraldton.

12 J Young and J Ward (2001), ‘Implementing guidelines for smoking cessation advice in Australian general practice: opinions, current practices, readiness to change and perceived barriers’, *Family Practice* (18): 14–20.

13 E Britt, G Miller and colleagues (2007), *General Practice Activity in Australia 2005–2006* (Australian Institute of Health and Welfare: Canberra).

14 M Harris, M Kidd and T Snowdon (2008), *New models of primary and community care to meet the challenges of chronic disease prevention and management*, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

15 J Doggett (2007), *A new approach to primary health care for Australia* (Centre for Policy Development: Sydney).

16 For example, Health professional (28 May 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Hobart.

In the words of one of our submissions:

*It should eventually be a shameful experience to end up in an acute setting from a preventable illness or injury. The whole of the community should own the shame. We must find a way to articulate the preventable status of each de-identified patient and allocate resources in the community based on this ranking.<sup>17</sup>*

One other important issue – the need to improve the responsiveness and access to primary health care services for older people living in residential aged care services – is examined later in Chapter 6.

Finally and importantly, we must acknowledge that primary health care is organised quite differently across the country, with implications for the types of services that people are able to access. People living in metropolitan, regional, and large rural areas are likely to be able to access primary health care services that are privately provided (such as GPs and allied health services). People living in small rural and remote communities are more likely to have care provided by the resident remote area nurses with visiting support provided by salaried general practitioners. In Aboriginal and Torres Strait Islander communities, primary health services are provided through community controlled health services and Aboriginal health workers. Some rural and remote communities have little or no general practitioner support, and non-government, not-for-profit organisations are more prominent providers in rural and remote areas. We return later to the issue of how to ensure access to primary health care services in areas of market failure, such as remote communities where existing models do not support access to a general practitioner.

## 2.4 Creating a better future

In reforming primary health care, we have been influenced by the life course approach to health, which focuses on how health develops over an individual's lifetime.<sup>18</sup> Key concepts are:

- Health is developmental – health development is a process of age-related changes in functional status over the life course. Experiences at the beginning of life relate to functional outcomes during the middle and end of life.
- An individual's health status and wellbeing is a consequence of multiple determinants operating in nested genetic, biological, behavioural, social, and economic contexts that change as a person develops.
- Health development is a lifelong adaptive process with interactions across each of the determinants that influence health.
- Different health trajectories are the product of dynamic, lifelong interactions between risk, protective, and health-promoting influences.

A life course approach emphasises a more comprehensive and holistic approach to optimising health development, with a greater focus on prevention and health promotion:

*Life-course health policy is essentially prevention policy with the longest time horizon possible: from conception to death.<sup>19</sup>*

It organises care around longer and more developmentally appropriate time frames, and targets long-term functional capacity rather than short-term disease outcomes.

■ A life course approach emphasises a more comprehensive and holistic approach to optimising health development

17 T Findlay (2008), Submission 360 to the National Health and Hospitals Reform Commission.

18 N Halfon and M Hochstein (2002), 'Life course health development: An integrated framework for developing health, policy, and research', *Millbank Quarterly* 80 (3): 433–79.

19 C Forrest and A Riley, 'Childhood Origins of Adult Health: A Basis for Life-Course Health Policy', *Health Affairs* 23 (5): 155–164.

The developmental and broad nature of health requires strategies for appropriate vertical, horizontal, and longitudinal integration to enable the health system to optimise health development:

- Vertical integration covers primary health care, specialist care, and hospital and sub-acute services.
- Horizontal integration recognises the interdependence of physical, mental, developmental, and oral health services.
- A longitudinally integrated system is organised around developmentally sensitive services, anticipatory guidance, and delivery pathways that optimise transitions.

Transformed primary health care services – with a focus on comprehensive, integrated care – would provide the foundations for a life course approach that supports the optimal health of a person through the critical and sensitive periods of development and ageing over the life course. They would respond to the changing health needs of people throughout their lives, ranging from child and family health services to promote early childhood development and wellbeing, to coordinated care for people with chronic diseases, and to support for frail older people to remain living in their own homes.

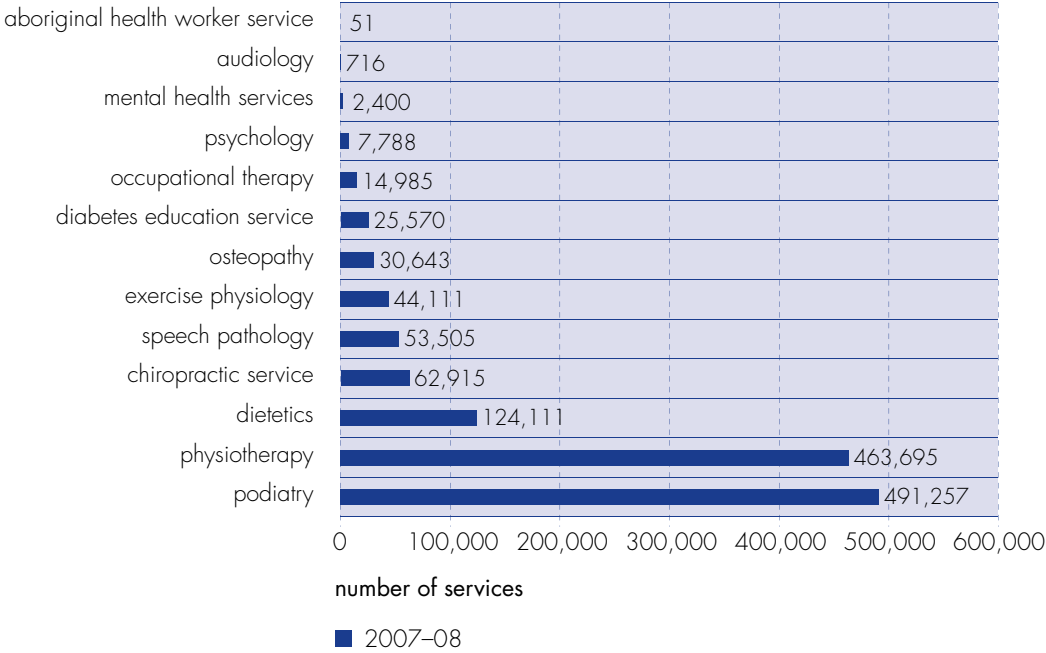
To build primary health care services that aim to optimise health development throughout the life course, we are proposing nine reform directions, discussed further below:

- integrating and strengthening primary health care nationally;
- supporting comprehensive health care through Comprehensive Primary Health Care Centres;
- providing access to multidisciplinary care;
- embedding a strong focus on quality and health outcomes across all primary health care services;
- managing care of people with chronic and complex conditions through shared care arrangements;
- improving service coordination and population health planning priorities at the local level;
- improving access to care;
- providing quality primary health care services for Aboriginal and Torres Strait Islander peoples wherever they are; and
- promoting personal control of health information.

### 2.4.1 Integrating and strengthening primary health care nationally

The Commonwealth is already the major funder of primary health care – for example, general practice through the Medicare Benefits Schedule (MBS), and allied health and other community-based ancillary services through the private health insurance rebate. Recent policy decisions have extended the coverage of payments under the MBS to provide some coverage for almost all registered health professionals in caring for chronic and complex disease. The new care planning item numbers now allow access to a range of allied health practitioners including psychologists, podiatrists, physiotherapists, and chiropractors (see Figure 2.2).

**Figure 2.2: Allied health services funded by MBS under the Enhanced Primary Care Program**



Source: Medicare Australia (2008), at: [https://www.medicareaustralia.gov.au/statistics/mbs\\_item.shtml](https://www.medicareaustralia.gov.au/statistics/mbs_item.shtml)

At the same time, over ten million Medicare item numbers involving practice nurses have been claimed in the last four years. Almost 60 per cent of practices have a general practice nurse with their roles including, for example, prevention, chronic disease management, and health assessments.<sup>20</sup>

We signalled in our first report, *Beyond the Blame Game*, our view about the desirability of the Commonwealth Government assuming responsibility for the full range of primary health care services. We continue to hold this view. For primary health care to be the platform for universal access to health services, there needs to be national leadership to strengthen primary health care and bring together the broader community health services and general practice to form larger or virtual comprehensive primary health care services. This leadership on primary health care reform can only come from the Commonwealth Government. The multiple health professionals and programs that currently make up primary health care need to be integrated under a coherent national policy and funding framework.

■ This leadership on primary health care reform can only come from the Commonwealth Government

**Reform direction 2.1**

We propose that to better integrate and strengthen primary health care, the Commonwealth should assume responsibility for all primary health care policy and funding.

This reform direction means that the Commonwealth will have an active leadership role in ensuring the adequacy and distribution of the full range of primary health care services for consumers.

20 Australian Practice Nurses Association (2008), Submission 42 to the National Health and Hospitals Reform Commission.

Under this reform direction, the Commonwealth will become responsible and accountable for all government funding of community health services including state and territory and non-government services such as generalist community health centres. This will include funding responsibility for specialised services such as alcohol and drug treatment services, sexual and reproductive health services, young people's services, school health, maternal and child health services, and the like. The assumption by the Commonwealth of responsibility for all primary health care would require a matching transfer of funds from states and territories to the Commonwealth, estimated to be about \$3 billion.

We further note that in designing a model to underpin future primary health care, there should be a mix of funding including:

- continued use of fee for service;
- some capitation payments;
- some payment for performance and quality;
- some regional grants; and
- some grant funding for primary health care services for other than medical clinical services.

Single responsibility for primary health care will mean the Commonwealth will be in a better position to take charge, fund properly, drive to achieve policy outcomes, and be accountable for equity across Australia.

## 2.4.2 Supporting comprehensive health care through Comprehensive Primary Health Care Centres

Across our life journey, we have different health needs at different times. A major stage of the life cycle is the birth of our children. Another occurs with the development of chronic disease as we age. Care for chronically ill people can require a broader range of health services than medical care, provided in a connected way over time. To address these major life cycle challenges, Medicare needs to be further expanded beyond medical care to support access to a wider range of health professionals in primary health care, using funding approaches that are better suited to care over an extended time. At the same time, we need Comprehensive Primary Health Care Centres to meet these challenges.

To deliver a wider range of services, locations/facilities for the delivery of primary health care need to become larger. Larger centres can support a larger and more diverse team of primary health care health professionals, are better able to invest in support infrastructure such as clinical information systems, and can open for extended hours using rosters that do not require professionals to be on duty every second night of the week, and support clinical training. They can also be more convenient for people needing care, enabling them to access more of the services they need in one place, without the need to coordinate their information and appointments across several different providers in different locations.

We heard considerable support for this concept of a 'one-stop shop' through a number of our submissions<sup>21</sup> and in the national consultations. This will involve the appropriate mix of public and private health service provision:

*Private hospitals are a vital and complementary partner to the larger public sector in the provision of a wide range of services and contribute significantly to the balance and sustainability of the Australian health system.*<sup>22</sup>

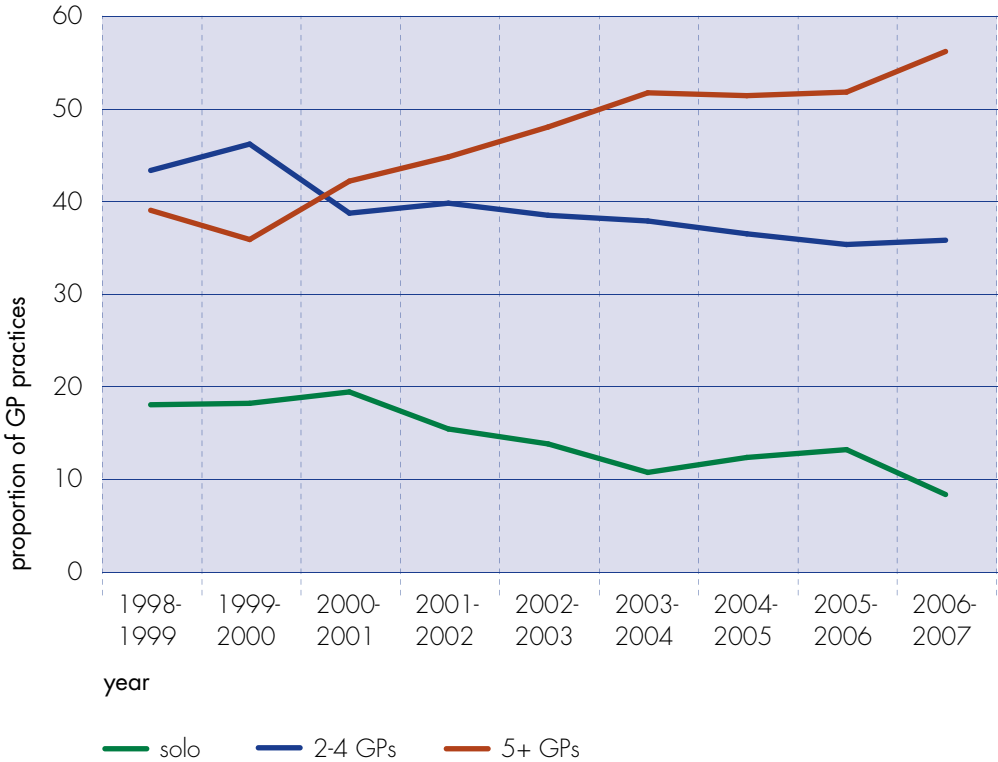
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21 For example, Centre for Policy Development (2008), Submission 60; Plenty Valley Community Health (2008), Submission 146; Aged Care Association (2008), Submission 440 to the National Health and Hospitals Reform Commission.

22 Australian Private Hospitals Association (2008), Submission 10 to the National Health and Hospitals Reform Commission.

Although general practices have been growing in size in recent years (see Figure 2.3), it is a trend that needs further strengthening. In 2006–07, over 50 per cent of practices consisted of five or more general practitioners but 30–40 per cent were still in smaller practices of between two and four practitioners.

**Figure 2.3: More than half of general practices have five or more full-time equivalent general practitioners.**



Source: C Bayram, H Britt, J Charles and colleagues (2008), *General practice activity in Australia 1998–99 to 2007–08: 10 year data tables* (Australian Institute of Health and Welfare: Canberra)

We want to see the widespread formation of Comprehensive Primary Health Care Centres in most local communities.

**Reform direction 2.2**

We propose that, in its expanded role, the Commonwealth should encourage and actively foster the widespread establishment of Comprehensive Primary Health Care Centres.

Our preliminary views about the possible features of such Comprehensive Primary Health Care Centres are as follows:

- The centres could provide a range of services to become 'one-stop shops' for medical and non-medical services including general practitioners; secondary care; co-located diagnostic services – pathology collection and diagnostic imaging – nursing and other health professionals; with proximity to pharmacy.
- The centres could have the skills and facilities for urgent care such as suturing, plastering, and minor procedures.
- Centres could generally be open extended hours – for example, from 6 am to 10 pm.
- There could be agreed protocols with local hospitals for swift transfer of patients who present to a Comprehensive Primary Health Care Centre but who require emergency care, specialist assessment, or admission.
- Comprehensive Primary Health Care Centres could have established arrangements with local home care providers to ensure coordinated delivery of care to clients, and to avoid unnecessary hospitalisation.
- Comprehensive Primary Health Care Centres could be encouraged to enter into arrangements with local residential care facilities to provide visiting and on-call medical and allied health services to residents.
- Embedding the strategy of ensuring a healthy start to life for all children will require child and family services to be co-located in the Comprehensive Primary Health Care Centres or linked by a nurse if child and family services stand alone (see Chapter 3).
- Comprehensive Primary Health Care Centres could be encouraged to establish through the offer of initial fixed capital grants on a competitive basis. Criteria for selection could include the range of services to be offered, size, commitment to meet minimum opening hours, and evidence of established partnerships with local hospitals, home and community care providers, and aged care services. Also, consortia to be eligible would need to involve current medical and allied health providers and community participation in planning. Importantly, they would be expected to have a role in the training and education of the next generation of primary health care professionals.

It is vital that the implementation of the proposed Comprehensive Primary Health Care Centres involves all local stakeholders and the community

- We believe it is vital that the implementation of the proposed Comprehensive Primary Health Care Centres involve all local stakeholders and the community.

We note that among the submissions and the commissioned papers on primary health care reform, there have been models identified to improve the organisation and delivery of primary health care. Some of the successful working concepts included in such models may also be relevant to the establishment of Comprehensive Primary Health Care Centres (see Figure 2.4).

Figure 2.4: New South Wales is developing new models of primary health care involving community hubs

*HealthOne Mt Druitt is located at Mt Druitt Community Health Centre in a purpose built 'hub' extension to the facility. Its service model is based on a 'hub and spoke' virtual service approach. It brings together GPs, community health staff and other service providers involved in the care of identified clients to facilitate communication between providers, support care planning and coordination.*

*Its core service components include: criteria-based enrolment system; agreed care partnerships; designated care communicator; case conferences; co-case management; agreed care plan; and multi-levels of service provision.*

*Two GP liaison nurses employed by community health (one for chronic, aged and complex care; and for child and family) are the linchpins of the model as they identify clients needing care coordination and link GPs and other service providers.*

*The HealthOne Mt Druitt hub functions as a resource and planning base and a central point for multidisciplinary assessments and case reviews, plus the delivery of a range of service clinics including the complex wound clinic; child and family health clinic; falls clinic (in development); and antenatal clinic (in development).*

*Outreach clinics are also planned at identified isolated locations which do not have ready access to GPs and other health service providers.*

*Target population groups include people with complex and chronic conditions; frail aged; families with children where there are vulnerabilities/at-risk factors; young people with health needs including mental health; and people in the community who have difficulty accessing services due to disadvantage or isolation*

Source: New South Wales Department of Health (2008), HealthOne Mt Druitt, at: [http://www.health.nsw.gov.au/Initiatives/HealthOneNSW/sl\\_mt\\_druitt.asp](http://www.health.nsw.gov.au/Initiatives/HealthOneNSW/sl_mt_druitt.asp)

### 2.4.3 Providing access to multidisciplinary care

In the future, we will need a primary health care model that provides the right match and mix of services, rather than a 'one size fits all' approach. While universal access under Medicare has served us well, it does not necessarily ensure that people with the highest needs get access to the best range of health care services.

We have already noted that we have different health needs at different times, with particular needs at particular times. For example, it is important for young families to have ready access to a primary health care service with multidisciplinary clinical services. In this way, the right mix of services, together with continuity and quality of care, can be assured.

In general, people with chronic and complex care needs require continuity of care, over time, from health care professionals who are familiar with the history of their condition or conditions and their treatment. It is unsurprising that most older people, who generally have a higher prevalence of chronic conditions, also tend to stay with a single general practice.

We would like to strengthen the relationship between patients and primary health care services through voluntary 'signing up' or enrolment. One of our invited papers saw the benefit of enrolment for consumers as being:

- We would like to strengthen the relationship between patients and primary health care services through voluntary 'signing up' or enrolment

... to enhance access to multidisciplinary preventive and chronic disease care and make primary care organisations accountable for this.<sup>23</sup>

The concept of voluntary enrolment is strongly supported in a number of submissions<sup>24</sup>, including the joint submission from General Practice Queensland and Queensland Health<sup>25</sup> which suggests a more integrated, multidisciplinary approach to prevention and management of chronic disease, including voluntary patient enrolment. The submission from the Royal Australian College of General Practitioners stated:

*To help general practices better manage complex clinical cases, and to create accountability for community health, the RACGP supports the exploration of a voluntary patient register in which patients can identify their preferred general practice. Both patient and doctor should then be provided with incentives for the management of the whole person needs of people enrolled.<sup>26</sup>*

We believe that voluntary enrolment will fund more coordinated and innovative models of care including the development of care pathways, self-management programs, carer support and video and telephone support.

We are of the view that early childhood services are fragmented, with little efficient and effective communication between the health service providers (see Chapter 3). These services are complex and include Commonwealth, state and territory governments, and private providers.

■ We support better training of health professionals to ensure they can cater for the needs of people with disabilities

We are also concerned that children and adults with disabilities, and families with special needs, fall through the 'health service gaps' with resulting long delays in accessing services and poor coordination of care. It is our view that formal voluntary enrolment with a Comprehensive Primary Health Care Centre will foster the total care of children and their families over the life journey. At the same time, we support better training of health professionals to ensure they can cater for the needs of people with disabilities.

The proposed features of how a voluntary enrolment model might work include:

- People with chronic and complex care needs, and people with particular care needs, including expectant mothers and parents with young children (and their children), would be able to choose to enrol with a service.
  - For those enrolling, enrolment means that they will have chosen to get all their primary health care from that practice except in limited circumstances such as when they are away from home. Practices/services would be able to choose whether or not to participate in the program.
  - Patients could, however, elect to shift to another practice/service after a specified period.
- Primary health care services would receive additional funding in proportion to the number of people they enrol, and the chronic conditions or particular care needs that those people have, and the outcomes the practice achieves.
  - They could use the funds to engage nurses and other registered health professionals to work in the service to provide a broader range of services to their enrolled clients. Primary health care services may also use some of the funds to acquire infrastructure such as clinical information and practice management systems to support care delivery, and non-clinical support staff to assist in managing the service.
  - As an alternative to in-house staff, a practice could choose to have arrangements with nearby independent allied health practitioners, and maternal and child health and community health to provide services to the practice's enrollees.

23 M Harris, M Kidd and T Snowdon (2008), New models of primary and community care to meet the challenges of chronic disease prevention and management, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

24 For example, Australian General Practice Network (2008), Submission 34; SA Health (2008), Submission 458; Primary Health Care Research and Information Service (2008), Submission 148 to the National Health and Hospitals Reform Commission.

25 GP Queensland and Queensland Health (2008), Submission 209 to the National Health and Hospitals Reform Commission.

26 Royal Australian College of General Practitioners (2008), Submission 511 to the National Health and Hospitals Reform Commission.

- Doctors would remain on fee for service.
- Practices would compete for enrolees by the expanded services they offer and their responsiveness in meeting the needs of their enrolees.
- People could change the practice with which they are enrolled at any time. Enrolments would be notified to Medicare Australia, which would calculate the grants that a practice receives based on the enrolee profile for the quarter.
- There would be no compulsion for people to enrol, and there would be no compulsion for practices to seek enrolees – practices may choose to remain as fee for service, and people could continue to see multiple general practitioners as they choose.
- Participating practices would be required to capture and provide data including Medicare card number to Medicare Australia on all services provided to enrolees including for grant-funded services.
- Participating practices would also be required to produce a greater range of data on the coordination of enrolled practices.
- This model would foster alternative models of service contact including email, telehealth phone consultations, telephonic health coaching from professional call centres, or from the practice itself for telephone/online advice – for example, Map of Medicine (see Chapter 15) and Health Dialog.

We expect that enrolment would promote continuity of care, allow appropriate measurement of the quality of care provided, allow for identification of needs in a local environment, and would, over time, allow the development of the building of capacity and sustainability in primary health care.

■ We expect that enrolment would promote continuity of care

### Reform direction 2.3

We want young families and people with chronic and complex conditions (including people with a disability or a long-term mental illness) to have the option of enrolling with a single primary health care service to improve care. To support this, we propose that:

- There will be grant funding to support multidisciplinary clinical services and care coordination for that practice tied to levels of enrolment of young families and people with chronic and complex conditions.
- There will be payments to reward good performance in outcomes including quality and timeliness of care for the enrolled population.
- Over the longer term, payments will be developed that bundle the total cost of care of enrolled individuals over a course of care or period of time, in preference to existing fee-based payments.

In considering enrolment for people with chronic and complex conditions, it is likely that this could include a broad range of conditions. For example, it would include people with chronic mental health problems, people with an intellectual disability or a degenerative condition, as well as people with chronic diseases such as diabetes. The identification of this category relates to whether patients would benefit from the enhanced continuity and coordination of care that would be expected to be achieved through voluntary enrolment.

We believe that, over time, there could also be consideration of a model of voluntary enrolment that applies to all consumers, carers and their families.

## 2.4.4 Embedding a strong focus on quality and health outcomes across all primary health care services

*The meteoric rise in the prevalence of chronic disease in Australia owes as much to our lifestyle as the ageing phenomenon .... The health system of the future must broaden its scope to include such measures and promote personal responsibility for lifestyle.<sup>27</sup>*

Primary health care has a key role in delivering prevention and wellness strategies

■ Primary health care has a key role in delivering prevention and wellness strategies. Many hospital admissions could have potentially been avoided if timely and adequate care in the community had been provided; for example<sup>28</sup>, in the case of:

- acute conditions which may not be preventable but would not result in hospitalisation if care was received at the right time;
- chronic conditions which may be preventable through behaviour modification, falls prevention and lifestyle change, but can also be managed through timely care to prevent deterioration and hospitalisation;
- vaccine preventable diseases; and
- medication adverse events (approximately \$6 billion in hospitalisation).

Recent Medicare reforms acknowledge the primary health care role in prevention and wellness with new Medicare Preventive Health Care items such as the facilitation of early intervention strategies through the Healthy Kids Check Medicare items, and a Type 2 Diabetes Risk Evaluation Medicare item.

We support introducing new MBS item numbers for preventive activities in primary health care where appropriate evidence, including economic value, has been established. In Chapter 12 we consider the role of national assessment of all health interventions, including assessing the cost effectiveness of clinical prevention activities.

The importance of an increased focus on prevention and early intervention was a constant theme in submissions<sup>29</sup> and national consultations:

*We are so busy with our fingers stuck in the dyke of 'treatment' that we cannot get around to what should be our real job – preventing the need for treatment.<sup>30</sup>*

*Consumers advocate the value for individuals and for the health system of a significantly stronger focus on wellness and prevention ...<sup>31</sup>*

There is a growing imperative to create and foster a health care system that highly values quality and safety. As a consequence, the concept of paying for performance has gathered momentum in other health systems (see Chapter 13). In Australian general practice, the Practice Incentives Program rewards practices for improvements in areas including information systems, after hours care, teaching, care plans, participation in National Prescribing Service quality use of medicines, care of diabetes, asthma, cervical screening or mental health, practice nurses, and rural location.

The following is suggested as a model for payment for performance for prevention and quality.

In addition to fee for service for doctors and supplementary grants to provide a broader range of services for people with chronic and complex care needs, primary health care practices may be

27 C Jackson and D O'Halloran (2008), Achieving a patient-centred, effective, efficient, robust and sustainable primary and community care sector 2020, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

28 Australian Institute of Health and Welfare (2008), Australian hospital statistics (Australian Institute of Health and Welfare: Canberra).

29 For example, ACT Health (2008), Submission 5; National Seniors Australia (2008), Submission 127 to the National Health and Hospitals Reform Commission.

30 Health professional (12 June 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Alice Springs.

31 Consumers Health Forum of Australia (2008), Submission 509 to the National Health and Hospitals Reform Commission.

eligible in future for payments for performance in relation to illness prevention, chronic disease, avoidable complications, and other measures of quality:

- These payments could be based on improvements achieved rather than absolute levels of attainment, so that, for example, practices whose patients happen to have low rates of smoking or high rates of compliance with good chronic disease self-management would not automatically attract a payment, whereas practices whose patients have high rates of smoking which subsequently decline or low rates of chronic disease self-management that improve may attract a significant payment.
- The choice of illness prevention outcomes and interventions to be rewarded could be considered following assessment of the relative cost effectiveness of prevention interventions. We propose in Chapter 12 that a new 'umbrella' approach to health intervention assessment be developed across medical services, pharmaceutical services and clinical prevention.
- The chronic disease outcomes, avoidable complications, and other measures of quality to be rewarded could be based upon the advice of relevant bodies such as the Australian Commission for Safety and Quality in Health Care.

#### Reform direction 2.4

We support embedding a strong focus on quality and health outcomes across all primary health care services. This requires the development of good outcomes data for primary health care. We also want to see the development of performance payments for prevention and quality care.

### 2.4.5 Managing care of people with chronic and complex conditions through shared care arrangements

People with chronic and complex conditions will need support from an extensive range of health services. Based within the community are a group of vital medical specialists and specially multidisciplinary teams providing care in the community – for example, in geriatrics, paediatrics, sexual health, and cancer/diabetes/renal teams. It is important that the care provided by these specialists for people with chronic and complex conditions is more effectively integrated into primary health care. We received a number of submissions that outlined innovations in fostering this partnership.

For example, one example of an innovative model of multidisciplinary care was described in General Practice Victoria's submission<sup>32</sup> regarding the Diabetes Cardiovascular Risk Management Program. In the case of people newly diagnosed with diabetes in Victoria's Dandenong Division of General Practice, patients are referred to a central coordination unit involving specialist care by their general practitioner.

Under this model, patients receive a comprehensive diabetes and cardiovascular assessment, develop a diabetes and cardiovascular management plan, and are referred to self-management education services and a multidisciplinary diabetes and cardiovascular clinic located at the hospital. The patient's general practitioner is linked to every point of service delivery, and the central coordination point facilitates the linkage of all required patient services to support the general practitioner in their role as coordinator.

Results of this program include 'high GP satisfaction, reduced emergency department presentations, reduced bed days by participants, improvements in HbA1C, HDL, an increase in the patient's ability to access appropriate support and a reduction of \$1700 per participant hospitalisation cost.'<sup>33</sup>

32 General Practice Victoria (2008), Submission 84 to the National Health and Hospitals Reform Commission.

33 General Practice Victoria (2008), Submission 84 to the National Health and Hospitals Reform Commission.

Similarly, another major group of people who are likely to need access to specialist services in the community are those with a long-term disability, including those with an intellectual disability. (We have indicated earlier that we need a broad definition of 'chronic and complex' when thinking about which people might benefit most from enrolment with a primary health care service.)

The National and NSW Councils for Intellectual Disability and Australian Association of Developmental Disability Medicine Inc<sup>34</sup> argued that:

*It is very important that the existence and nature of an intellectual disability is diagnosed as early in childhood as possible and that the child's family then has access to specialised advice on health care issues that may be associated with the disability. Integration across the sectors, including multidisciplinary diagnostic and assessment teams, is very important for timely diagnosis and access to support services for child and family.*

*Specialist children's health services, including paediatricians, are commonly accessed by children with intellectual disabilities and complex health needs. However, there is a major problem in transition to adult health care with there being very few adult doctors with specialised skills in working with people with intellectual disabilities and complex health needs. There needs to be a network of specialised intellectual disability health services to back up mainstream services across the lifespan.*

They go on to outline a model which we support that would be a key element of reformed and strengthened primary health care aimed at people with intellectual disabilities. This model includes:

- ensuring that all Comprehensive Primary Health Care Centres have a specific focus on people with intellectual disabilities with robust links to specialist multidisciplinary health teams who are skilled in the management of people with intellectual disabilities;
- ensuring ready access to diagnostic and prevention activities, and assessment services across all ages; and
- developing excellent systems that allow for effective transition from paediatric to adult care.

#### Reform direction 2.5

We support improving the way in which primary health care professionals and specialists manage the care of people with chronic and complex conditions through shared care arrangements in a community setting. These arrangements should promote the vital role of primary health care professionals in the ongoing management and support of people with chronic and complex conditions.

### 2.4.6 Improving service coordination and population health planning priorities at the local level

Service coordination and population health planning priorities could be enhanced at the local level through regional structures

- We believe that service coordination and population health planning priorities could be enhanced at the local level through regional structures. The advantages of this approach are highlighted in one of our invited papers by Jackson and O'Halloran as follows:

*Real community participation in setting priorities for the local delivery of primary care is rare and could be better addressed within regional governance arrangements for health care ... Regional governance structures which align Commonwealth and state, public and privately-funded services around integrated service delivery within a region are a top reform priority.*

34 National and NSW Councils for Intellectual Disability and Australian Association of Developmental Disability Medicine (2008), Submission 450 to the National Health and Hospitals Reform Commission.

*This arrangement would also allow better management of diversity and complexity in local service delivery.<sup>35</sup>*

It is important that these regional structures have a critical mass of clients. It is envisaged that their size will vary across Australia, taking account of the fact that in remote and rural communities population sizes are usually insufficient to sustain traditional models of service provision.<sup>36</sup>

We believe the name of these new structures should reflect their core business, and suggest 'Divisions of Primary Health Care'. Rather than creating a new body, the divisions could be based on the existing Divisions of General Practice, taking into account alignment with other health region boundaries – for example, state and territory and Commonwealth programs such as those funded through OATSIH regions or natural regions in cross-border situations. Other factors to be considered could include their capacity to deliver on their core role and their ability to facilitate networks. Some of the tasks could be:

- Adopt a 'health stewardship' role for the health and wellbeing of the region.
- Complete primary and community health plans that identify current strengths and gaps within service provision.
- Develop a wellness and prevention profile of the region which outlines numbers of people and families at risk with an emphasis on the life journey.
- Gather, analyse and report data and information on outcome indicators for national agreed public and preventive health targets, clinical indicators from local health providers, and consumer and community measures.
- Plan and advocate for local workforce needs.

#### Reform direction 2.6

We believe that service coordination and population health planning priorities could be enhanced at the local level through the establishment of Divisions of Primary Health Care, evolving from or replacing the existing Divisions of General Practice. These divisions will need to be of an appropriate size to provide efficient and effective coordination.

### 2.4.7 Improving access to care

Workforce reform was one of the most commonly raised issues in the national consultations:

*We need primary health care practitioners ahead of anything else. Stop the body parts funding – the system is meant to look after people, not a kidney.<sup>37</sup>*

Using the primary health care workforce more efficiently and maximising multidisciplinary practice for the best care was a constant theme in consultations and submissions.<sup>38</sup>

35 C Jackson and D O'Halloran (2008), Achieving a patient-centred, effective, efficient, robust and sustainable primary and community care sector 2020, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

36 J Humphreys and J Wakeman (2008), Primary health care in rural and remote Australia: achieving equity of access and outcomes through national reform, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

37 Health professional (3 July 2008), National Health and Hospitals Reform Commission consultation meeting with frontline health professionals in Darwin.

38 For example, Parkinson's Australia (2008), Submission 143 to the National Health and Hospitals Reform Commission.

For example, the Royal College of Nursing<sup>39</sup> discussed expanding the scope of practice including access to MBS and PBS for nurse practitioners and stated:

*Greater utilisation of the nurse practitioner role that delivers health care based on the nursing fundamentals of holistic, flexible, accessible, effective and equitable health care provision would be a sizeable move towards building a comprehensive health care system.*

We are not proposing that nurse practitioners or other health professional services be directly eligible for fee-for-service rebates under Medicare. Under current arrangements, simply adding additional professionals whose service would be eligible for rebates under Medicare would increase the total volume of services covered by Medicare and significantly increase total outlays, with the benefit and distribution of care in terms of improving health of the population unlikely to be commensurate with the increase in outlays.

In the reform direction outlined below (see also reform direction 14.2) we are arguing that increased access to the MBS and PBS, where doctors are scarce and under defined scopes of practice, should be available for registered non-medical practitioners. Supervision will be required in circumstances where work is performed by a competent health professional but billed to a specific medical practitioner. This supervision in some areas will be local but could be via videoconferencing or telehealth.

It is expected that use of information technology to provide primary health care services to people without the need to attend a practice or centre physically will be commonplace. This could include local primary health care services providing follow-up consultations (including by other health professionals) with a videoconference over the web, telephone contact, or by remote monitoring for people with chronic and complex conditions.

In some instances, these forms of care will need to be recognised for reimbursement, where they are best undertaken by professionals on a fee-for-service basis.

#### Reform direction 2.7

We propose facilitating access to care where doctors are scarce. Commencing in remote and some rural areas:

- Medicare rebates should apply to relevant diagnostic services and specialist medical services ordered or referred by nurse practitioners and other registered health professionals according to defined scopes of practice determined by health professional registration bodies.
- Pharmaceutical Benefits Scheme subsidies (or, where more appropriate, support for access to subsidised pharmaceuticals under section 100 of the *National Health Act 1953*) should apply to pharmaceuticals prescribed from approved formularies by nurse practitioners and other registered health professionals according to defined scopes of practice.
- Where there is appropriate evidence, specified procedural items on the Medicare Benefits Schedule should be able to be billed by a medical practitioner for work performed by a competent health professional, credentialed for defined scopes of practice

### 2.4.8 Providing primary health care services for Aboriginal and Torres Strait Islander peoples

In Chapter 8 we consider reforms to 'close the gap' and improve health outcomes for Aboriginal and Torres Strait Islander peoples. This includes the establishment of a National Aboriginal and Torres Strait Islander Health Authority.

<sup>39</sup> Royal College of Nursing Australia (2008), Submission 164 to the National Health and Hospitals Reform Commission.

## Reform direction 2.8

In accordance with our later proposal for the establishment of a National Aboriginal and Torres Strait Islander Health Authority, we would expect that this Authority should be responsible for the purchasing of services that encourage and promote best practice and quality outcomes in primary health care for Aboriginal and Torres Strait Islander peoples wherever they elect to seek their health care.

Subject to consideration by the Authority of how it wishes to purchase or fund, it is anticipated that all of the approaches outlined in this section of the report for primary health care would also be available to and/or apply to health services specifically for Aboriginal and Torres Strait Islander peoples, such as community controlled health services. For example, Aboriginal and Torres Strait Islander peoples would be able to voluntarily enrol with a primary health care service (which may be a community controlled health service) if they have a young family or chronic and complex conditions.

### 2.4.9 Promoting personal control of health information

We are of the view there is an urgent need to develop a personal health record to support better care delivery for people, especially for those with chronic and complex care needs. Despite the fact that a large number of general practitioners have become proficient in the use of electronic medical records, we have little connectivity across primary health care, hospitals and the patients. We commissioned a report on ehealth<sup>40</sup> which observed that:

*The patient journey in the current system functions with disjointed communications and poor/inaccessible information causing duplication of services, a significant number of adverse events, and frustration for patients and their providers.*

As we have already noted, health care in Australia is delivered in a range of community- and hospital-based settings. In these settings, the sharing of information is limited and fragmented, or may not occur at all. There is the potential that poor information transfer due to the inefficiencies of outdated processes will undermine the delivery of care at each care interface for the patient.

A high dissatisfaction from patients, exasperation from clinicians, occurrence of adverse events and sub-optimal care scenarios can generally be attributed to the following factors:<sup>41</sup>

- failure to have sufficient and accurate patient information accessible at the point of care – rather, it is fragmented across different sites and clinical settings;
- poor sharing of information between healthcare providers, partly due to the lack of infrastructure (e.g. computer desktops, broadband connectivity, secure access, privacy regime) and poor ability to rapidly share information when it is required; and
- difficulty some patients have in remembering the complexity and breadth of their medical history and in explaining the various interactions they have had with health services.

Our invited paper on ehealth continues:

*For example, the inability of a healthcare professional to discover what medications a patient takes, the sources of and reasons for medications being prescribed, and the confounder of numerous brands of the same drug can lead to confusion and adverse drug interactions. This is particularly a problem when patients go to more than one healthcare provider, have multiple medical conditions and medications, are stressed and are vulnerable. Preventable medication*

■ There is an urgent need to develop a personal health record to support better care delivery for people, especially for those with chronic and complex care needs

40 C Bartlett and K Boehncke, Booz & Company (2008), Ehealth: Enabler for Australia's Health Reform, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

41 C Bartlett and K Boehncke, Booz & Company (2008), Ehealth: Enabler for Australia's Health Reform, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

errors are very costly, with inappropriate use of medicines in Australia costing \$380 million per year in the public hospital system alone.<sup>42</sup>

*The lack of high quality health information, and the ability to capture this and share it in a timely and useful format (i.e. content and media), has a particular impact on the treatment of chronic disease. Patients with chronic diseases often are complex and develop conditions that require referrals to a variety of medical and other specialist services. They frequently use multiple medicines and require care over extended periods of time from multiple providers.<sup>43</sup>*

We would argue that creating a robust and integrated primary health care service will require the finalisation and implementation of a person-controlled electronic personal health record.

An electronic health record for each Australian is one of the most important systemic opportunities to improve continuity, safety, reduce waste and errors and promote best care

■ The most important health information is a person's own health information. An electronic health record for each Australian is one of the most important systemic opportunities to improve continuity, safety, reduce waste and errors and promote best care. An electronic health record, which can be accessed by all health professionals and across all settings, with the person's agreement, is arguably the single most important enabler of truly person-centred care.

We will explore the prerequisites and incentives to allow us to reach this goal in our final report.

#### Reform direction 2.9

We support the development of a person-controlled electronic personal health record. We will explore the prerequisites and incentives to allow us to reach this goal in our final report.

42 Australian Institute of Health and Welfare (2002), Australia's Health No. 8 (Australian Institute of Health and Welfare: Canberra).

43 C Bartlett and K Boehncke, Booz & Company (2008), Ehealth: Enabler for Australia's Health Reform, Discussion paper commissioned by the National Health and Hospitals Reform Commission.