

Health Reform - Note 1

October 2009

Should the Commonwealth be responsible for all primary care?

What is primary care?

In the health sector, the term 'primary care' refers to an interaction between a patient and a trained health practitioner that is planned, rather than being in response to an emergency (or 'acute') situation. Primary care includes the interactions between GPs, allied health professionals, dentists, nurses (including specialists such as mental health nurses, palliative care nurses) or pharmacists and the people they see (often termed 'patients').



If the GP's surgery or the physiotherapist's clinic is within the hospital, the interaction is still part of primary care. The work doctors, nurses and specialists do with hospital in-patients is termed 'acute care'.

'Primary care', in which a health practitioner meets with a patient to diagnose, treat and manage an illness or disease, should be distinguished from 'primary health care'. The latter is a broader term which includes dealing with the social and economic determinants of health, such as education, housing, food and sanitation, as well as health promotion and primary care itself. The terms are often confused, in part because primary care professionals are proud of the primary health care work they do - for instance, through providing broad advice on health and fitness when dealing with a patient's specific illness or disease.

The current proposal

Recommendation 16 in the final report from the National Health and Hospitals Reform Commission (NHHRC) proposes that the Commonwealth should "assume responsibility for all primary health care policy and funding".

The Commonwealth already has responsibility for what most people would regard as being the core element of primary care: the interactions between a GP and their patients. It is also responsible already for the primary care provided by community pharmacists, underpinned by

the PBS. The NHHRC's proposal is that the primary care work currently undertaken by State/Territory health services, and funded by the States/Territories, should become the responsibility of the Commonwealth. This includes family and child health, alcohol and drug treatment and community mental health services, as well as aged care and basic dental health services. The draft National Primary Health Care Strategy also envisaged that the primary care system should include aged care assessments, Home and Community Care (HACC) services and school and public dental health programs.

It is unlikely that the patient would know the difference if this transfer of responsibility was to take place. But many experts believe that having one rather than two levels of government responsible for primary health care would simplify and clarify responsibility and accountability for outcomes. It would lay the basis for even stronger communications between the general practitioner who often manages a patient's care and all of the other professionals who have a part to play in it.

The NHHRC argues that this change would "require the government to confront the issue of how to integrate these [other] services with medical services now funded under the MBS."

They point out that 'integration' does not mean 'takeover'. Nor does it mean that the Commonwealth Government would directly operate these other services.

The report continues:

"We anticipate that the Commonwealth Government would need to spend some considerable time doing the equivalent of a 'stocktake' or a 'due diligence' exercise to better understand the range of primary health care services now provided by states outside of Medicare. - - Ultimately, the Commonwealth Government will need to develop a national plan for integration of these services with existing MBS services. In doing so, it will need to make decisions about what additional primary health care services could be included as part of an expanded 'universal service entitlement' and the conditions under which this would operate. - - Paying for these services could involve a mix of salary, fee-for-service, grants, payments for performance and quality, and payments for episodes of care. - - It will require the Commonwealth Government to develop experience and knowledge across the whole spectrum of primary health care services. But these reforms must go ahead if we are to create an integrated primary health care platform for our entire health system."

The Alliance position so far

We have expressed support for the proposal, seeing a number of potential advantages in having one level of government accountable for the planning and availability of primary care services available to people in rural and remote towns and communities.

The Commission considers that Commonwealth Government will need to make decisions about what additional primary health care services could be included as part of an expanded 'universal service entitlement' and the conditions under which this would operate. An overriding national 'policy' on primary care would be very useful as an aspirational goal about what should be available for particular conditions across all areas - the 'universal service entitlement' referred to by the NHHRC. (The Alliance is promoting the development

of a national rural health plan which would include specific targets for access to primary care services.)

Having one level of government responsible would provide a strong fiscal incentive to get the mix of services right to address local health needs in the safest and most cost effective way.

We also view favourably the prospect that it would require the Commonwealth to have clear responsibility for the numbers and distribution of all health professionals who make up the health care team.

There would also be advantages in being able to identify the total resources directed at primary care, in order to determine with greater accuracy than is currently possible the shares of various population need groups and locations. It is well-known that rural and remote people are currently underserved where the MBS is concerned. Having one level of government clearly responsible, and having better access to information about current expenditures on primary care, would increase the focus on under-served areas and hopefully the impetus for remedial action.

Such a change on its own would not automatically improve health outcomes for rural and remote people. However, taken with other proposals, in particular that there be investment in additional networks of comprehensive primary care centres and services, could result in better integration of services for those who have multiple care needs.

There are of course arguments against this proposal for greater Commonwealth responsibility. For one thing, it remains to be seen whether the States and Territories will agree to the change. For another, closer integration of all primary care might have the effect of increasing the gap between primary care and acute care ie between community-based services and those provided in hospital. What this illustrates is the desirability of having a completely integrated health system but, pragmatically, it seems a step in the right direction to have fully integrated primary care.

Your input is invited

Do you agree that having the Commonwealth responsible for primary care policy and funding would improve the planning, distribution, and composition of services and better establish which such services should be universally available?

You might like to comment also on potential problems.

Some States currently have good arrangements for continuity of care for people who need both community and acute-based care. A patient with a mental illness, for example, may be cared for most of the time by community-based services but in the event of an acute episode would require in-patient care.

How should very well developed arrangements in local communities for the right mix and integration of primary and acute care services be continued?

It is a clear Alliance position that the efforts and experience of all local health service providers be respected and recognised in any change process.

Who should be the provider of the services currently funded and provided by State, Territory and local governments? Should these services be transferred to the non-government or private sectors, or would this lead to gaps between vital community services eg housing, home help?

How would the changes be made in such a way as to ensure that health services professionals are properly engaged and not discouraged from coming to or staying in rural locations?

If you have a comment, let us know at nrha@ruralhealth.org.au or by mail to NRHA, PO Box 280, Deakin West, ACT 2600.