

# **Health Reform - Note 2**

*October 2009*

## **Comprehensive primary care centres and services**

### **The current proposal**

The National Health and Hospitals Reform Commission has proposed that, with full responsibility for primary care, the Commonwealth should foster the widespread establishment of comprehensive primary care centres and services. The purpose of this would be to give patients “access to an expanded range of services (for example pathology, imaging, community nursing, allied health), with better coordinated referrals, and at more convenient times through extended opening hours”.

In related proposals, it also envisaged that primary care services would have some capacity for maternity and early childhood services, rehabilitation, end-of-life care and mental health services.

### **The Alliance position so far**

In principle, we strongly support these recommendations for comprehensive primary care centres and services. The Alliance has long supported the provision, in rural and remote areas, of what we have called ‘whole health teams’, by which is meant an appropriate mix and number of health professionals working in a team to provide the range of primary care needed at the local level.

Taken as a whole, the Commission’s Report provides a good definition of ‘comprehensive primary care’. The Government’s actions to augment the availability of such services in rural and remote areas must build on services that currently exist and work in with existing practitioners – not set up new entities to compete with existing ones.

The Guidelines for the development or enhancement of services should include requirements to increase accessibility and affordability of services to groups most in need, to provide appropriate diagnostic services, and to enhance the integration of local services and programs.

A greater number of well-structured and well-resourced services will also help improve the distribution of health professionals, by providing attractive working conditions, multi-disciplinary professional development and better opportunities for high quality rural clinical education.

### **Your input is invited**

In the roll-out of a more complete network of comprehensive primary care services, specific attention must be paid to equity, accessibility, sustainability and implementation.

The Commission envisages only 25 per cent population coverage of these services by 2020, highlighting the need for a targeted approach. One approach would be to use levels of health need and current patterns of under-servicing as the prime determinants of investment. However the Commission has proposed roll-out on a targeted but competitive basis. It is not clear how this could lead to the fairest allocation of services – which would exist with the closest correlation between health need and the availability of health service resources. It is also not clear how a competitive approach would result in close collaboration with existing services and service providers.

It is of some concern that the establishment of new and attractive services in regional centres could attract health professionals from more rural and remote areas, exacerbating current workforce and service deficits.

What do you consider would be the merits or drawbacks of competitive tenders for new or enhanced comprehensive primary care centres and services?

Accessibility to services is also dependent on affordability, determined in part by access to MBS/PBS and other measures to reduce a patient's out-of-pocket costs. Successful implementation will require consideration of how to provide affordable access to the complete range of primary care services, not just those funded under the MBS and PBS.

The NHHRC's proposal for per capita funding based on voluntary enrolment of people with complex health needs provides some funding base for targeting those most in need. This includes Aboriginal and Torres Strait Islander people and people with young families. However the current Commission proposal for only \$100 per person enrolled would seem to be too small to support the development of additional services. It also leaves open the question as to how other patients in rural and remote areas relying on the same scarce services would gain access to more comprehensive services.

Other funding for more comprehensive services could come through the proposed top-up or equivalence funding in rural and remote areas that are currently under-served in access to the MBS and PBS.

Will priority access for some people result in others missing out on services? What funding mechanisms work best in ensuring access for all people in the community?

While some regional cities and towns will have sufficient population to sustain a range of centre-based and/or permanent services, more networked and flexible models will be required in smaller towns and communities not large enough to support the permanent presence of all services.

The Commission has recognised this concept, noting that some services will be 'virtual' or networked rather than centre-based. In rural and especially remote areas, the team of professionals may well be connected in a hub and spoke or outreach model, and supported from larger centres and services. Alternatively there may be visiting services, such as by

dentists, female GPs, locums and allied health professionals, or interaction through e-health and other electronic means.

Outreach or visiting models will also be required for more specialised but essential elements of comprehensive primary care, such as home support for people in subacute, rehabilitation or palliative/end-of-life situations. Local and regional centres will be the host for outreach public dental health services and visiting specialist services such as paediatricians, psychiatrists and other professionals such as midwives, psychologists, podiatrists, physiotherapists and pharmacists, or aged and community care workers.

In areas where there is not sufficient workforce or demand for a permanent service base in the community, what models of outreach are most effective in providing health services? What difficulties are encountered in services provided through outreach?

The sustainability of health services in rural and remote areas will also require attention to the key enablers, including workforce, infrastructure, equipment, and professional and technical support. The phrase ‘health care centres and services’ acknowledges the fact that in rural and especially remote areas the teams of professionals are likely to be connected by good technical and personal communications, not co-located. In all cases, such interconnections will need to be supported by good IT (eg broadband) and by the development and application of an individual electronic health record.

Start-up funding arrangements should recognise and compensate for the lack of infrastructure in rural areas. Areas that have received less than their ‘fair share’ of MBS funds over many years are almost certain to have poor health infrastructure since MBS payments include an element for capital costs. Start-up funding should also allow for the higher costs incurred in health service delivery in rural and remote areas because of the need to travel greater distances to provide services.

What are the current major deficits in service infrastructure in your area? What infrastructure is crucial to organising access to allied health services?

The establishment of the envisaged services - whether virtual or co-located - should be undertaken in a consultative fashion, with strong involvement and collaboration of the local community, including the existing health and community service professionals.

The attraction and retention of workforce is a perennial issue. Good quality infrastructure, communications, equipment, and professional and technical support will be crucial to meeting the challenge. The augmentation of services will provide more supportive working conditions for rural and remote practitioners.

The size of such centres or services should also be tailored to the needs of the local community to be served. The Report’s costing work suggests that “on average a centre or service will include 15 full work equivalent GPs able to service a population of 17,190”. Such a threshold would be far too high for the small and medium-sized population catchments which would have a very strong case for the enhanced services envisaged.

What working conditions and support measures are most beneficial in attracting and retaining

the range of health care professionals?

If you have a comment, let us know at [http://nrha@ruralhealth.org.au](mailto:nrha@ruralhealth.org.au) or by mail to NRHA, PO Box 280, Deakin West, ACT 2600.