

OPINION

Primary Care and General Practice in Australia

18 March 2013

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The overall health of a population is directly linked to the strength of its primary care system; a strong primary care system delivers higher quality of care and better health for less cost. Placing primary care, as delivered through general practice and supported by Medicare, at the centre of the health care system has long been a key tenet of Australia's health care system. It is a major reason for Australia's consistently high health rankings.

In a recently-released paper, *Primary Care and General Practice in Australia 1990-2012: A Chronology of Federal Government Strategies, Policies, Programs and Funding* (available on the Australian Primary Health Care Research Institute website¹), I have attempted to summarise, from a policy and budget perspective, the way in which the delivery and funding of primary care in Australia has changed over the past twenty years.

The Australian Government introduced the General Practice Reform Strategy in 1992 to overcome problems in the primary care system which had arisen as the Commonwealth retained responsibility for general practitioner (GP) services via Medicare funding and the states and territories retained responsibility for community health care funded via the Medicare block grants and their own resources. The Strategy aimed to address some specific issues facing general practice in Australia, focusing on workforce initiatives, the development of a primary care accreditation system, and remuneration strategies to more appropriately reward quality care. Funding was also committed for the establishment of the Divisions of General Practice to support GPs to work with each other and with other health professionals to improve the quality of service delivery at a local level.

Commencing in 1996, an effort was made shift GPs towards a 'blended payments' model of funding. Initially introduced as the Better Practice Program, and subsequently reworked as the Practice Incentives Program (PIP), these initiatives were intended to allow the Government to 'purchase' particular quality improvement activities. At the time there was also an intent to reduce overall financial risk to the federal health budget by increasing the share of GP funding which was capped rather than demand driven. Over time, the PIP has evolved to include a range of outcome-based incentives, disease-specific incentives and an incentive to support practices to employ practice nurses and allied health workers. However it has not moved the pendulum far in terms of a greater focus on health outcomes rather than the number of health services delivered.

Over time, new MBS items have been introduced to improve the delivery and coordination of health services, reward bulk billing, support rural providers and to encourage the use of practice nurses and referrals for allied health services. And alongside changes to general practice funding and the introduction of the Divisions Network, programs to address specific service gaps, for example in Indigenous health and rural health, and to educate, train and retain a GP workforce with the needed skills and geographical distribution were introduced.

¹ <http://aphcri.anu.edu.au>

As Australia looks to manage the growing burden of chronic disease and reduce health care costs and reliance on the acute care sector, there has been a focus on strengthening primary care. GPs have a central role in determining the future use of health care resources by patients and so there has been an increased emphasis on incentives for GPs to ensure provision of the most cost-effective care possible, while maintaining quality standards.

While general practice is very successful at meeting the needs of the majority of people requiring treatment for isolated episodes of ill-health, it is less successful at dealing with the needs of people with more complex conditions or in enabling access to specific population groups that are 'hard to reach'. Incentives are provided to encourage care coordination, multidisciplinary care teams, after-hours care and preventive services.

Under Labor, the Commonwealth Government has moved to implement reforms in the governance, funding and delivery of health care services in Australia. A number of seminal reports have been commissioned, all of which see a greater focus on primary care and prevention as the key to improved health outcomes and a sustainable health care system into the future. Regrettably new policy directions and the investment of resources have not always accurately reflected the recommendations of the expert advice that has been provided to the Government.

Currently the Australian model of general practice falls short of the ideals of Alma-Ata: a true primary health care model requires collaboration across care providers with the creation of primary health care teams, provision for local planning and community input, an explicit commitment to equity in health care, and strategic planning across all levels of government.

Recent reforms, specifically the implementation of Medicare Locals, have seen some progress towards these goals. Indeed it can be argued that the main barrier now to full implementation of the primary health care model is the fact that responsibility for delivering and funding these services is split across the federal and state and territory governments. A significant secondary barrier is the growing rate of out-of-pocket costs experienced by patients using private services provided on a fee-for-service basis.

One of the key issues that emerge from this analysis is that while, over time, many innovative and interesting new reforms and initiatives have been introduced, too often these have fallen away through lack of sustained funding, poor uptake or political changes. There has been little or no effort to understand what worked, what did not work and why, or to measure the results in terms of economic value and health outcomes. Investments in research in primary care and health services and analyses of data are well below what is needed. My experience demonstrates how difficult it is to track budgets and programs using publicly available information, and begs the question of whether any of this work is done inside the bureaucracy.

We need to learn from the past and implement robust and timely evaluations in the future. Only then can we be sure that we can provide the direction and support that is needed to ensure a primary care system for the 21st century.

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