Fact sheet

Primary Health Care Reform – *bringing it all together*

July 2011

Introduction

Since March 2010 the Commonwealth Government has released over 150 media releases announcing various new health reform initiatives. Keeping in touch with and understanding the wide array of national health reforms is becoming increasingly difficult. The aim of this fact sheet is to shed light on the full national health reform agenda and 'connect the dots' by bringing the range of disparate information on each major primary health care reform together in one information resource.

Medicare Locals

Medicare Locals (MLs) are a key part of the Commonwealths health system reforms and are integral to delivering national health reform across disparate systems and sectors.

Key policy history

- **August 2009** - the Commonwealth Government identifies regional health care integration, through the establishment of MLs, as the first building block in its National Primary Health Care Strategy
- **April 2010** - the Council of Australian Governments (COAG) National Health and Hospitals Agreement defines the key function of Medicare Locals as improving patient navigation and health system integration NHHN_Agreement
- **Oct 2010** - release of the *Medicare Locals Discussion Paper of Governance and Functions* Discussion paper
- **Dec 2010** - release of the initial boundaries for 57 Medicare Locals across Australia www.yourhealth.gov.au
- **Feb 2011** COAG meeting - every state and territory government signs a *Heads of Agreement* on National Health Reform and a commitment to signing a full National Health Reform Agreement by second half of 2011. All parties agree that Medicare Locals and LHNs will work together to integrate services and improve the health of local communities COAG meeting outcomes Feb 13th 2011
- **Feb 2011** – release of guidelines for the establishment and initial operation of Medicare Locals, including a formal invitation to apply to all Divisions of General Practice.
- **June 2011** - a reassessment of Medicare Local boundaries identifies an additional five Medicare Locals taking the final number of Medicare Locals nationwide to 62 (18 for NSW).
- **July 1st 2011** - the first 19 of 62 Medicare Locals across Australia begin operating. The first group was drawn from high performing Divisions of General Practice with the subsequent two groups open to other primary health care organisations and service providers.
- **July 19th 2011** - the invitation to apply closes for Medicare Locals commencing in 2012.
- A further 43 Medicare Locals will be established in 2012, with around 15 scheduled to begin from 1st Jan 2012, and the remainder from 1st of July 2012 yourHealth website

Function

The Commonwealth has specified that MLs will strengthen the Australian primary health care system by identifying and addressing local needs and improving access to responsive, integrated and coordinated GP and primary health care services. Over time they will also bring more focus to prevention and early intervention. Health reform measures announced by the Australian Government have identified a number of specific early roles for MLs including:

- Coordinate after-hours primary medical care services and target gaps in primary health care for aged care recipients.
- Build on the strengths of the Divisions of general Practice Network, retaining and expanding activities currently performed by the Network.
- Support GPs, practice nurses and allied health to provide more integrated, coordinated care.
- Facilitate allied health care and other support for people with chronic conditions.
- Work closely with other government services, and with education and training providers to support the education of primary health care professionals.

As critical elements in the Government's health reforms, Medicare Locals are also expected to be closely involved with other reform initiatives to help drive and strengthen the primary health care system, including:

- Establishing effective collaborations between MLs, Local Hospital Networks and Lead Clinician Groups to deliver more coordinated, integrated, locally responsive and flexible health services so that patients transition smoothly in and out of hospital and receive the right care, where and when they need it.
- Supporting the development of e-health and health information, including shared electronic health records, data provision to drive health system performance, service planning, monitoring and evaluation.
- Improving the planning of primary health care services to respond to local needs.
- Supporting the ongoing development of primary health care infrastructure, including GP Super Clinics.
- Initiatives to increase and enhance the primary health care workforce to meet local community needs.
- Initiatives in general practice and primary health care designed to improve disease prevention and management and improve access to services.

Structure and evaluation

MLs will be managed by a skill based board and largely operate under an organisational membership model with members such as local health services and community groups. The actual make-up of each ML will vary and reflect the needs and nature of the local community and the range of health care and community group expertise needed to deliver an expanded suite of primary health care programs and services and address health inequities.

Each ML will be fully accredited by an agency approved by the Commonwealth and will be subject to and contribute to the broader performance monitoring and reporting requirements of National Health Reform. Healthy Communities Reports, to be published by the National Performance Authority, will include performance assessments for each ML against service and financial reporting standards which will focus on access to services, quality of service delivery, financial responsibility, patient outcomes and patient experience.

Funding

The Commonwealth will fund MLs in place of Divisions of General Practice. All core funding under the Divisions of General Practice Program will cease on 30 June 2012. Once all MLs are established, the total annual core funding for the ML network will be approximately $171 million. MLs will also be provided with funding to support their establishment and specific programs. Economic consultants will develop a funding model for each ML that is to reflect local needs based on an assessment of selected socio-demographic data, available workforce information and population diversity rates including the size and distribution of the Aboriginal and culturally and linguistically diverse populations.

From 2012-13, each ML will be provided with funding to plan and ensure the availability of face-to-face after-hours services for their region. These services will be integrated with the new after-hours telephone-based GP medical advice service (see below).

From 2013, MLs will also be provided with a flexible funding pool to target gaps in primary health care services for aged care recipients. Further information on the establishment and initial operation of MLs can be found on the yourHealth website

National Health Governance Agencies

A range of health governance agencies will be created as a key part of the national primary health care reforms including a National Preventive Health Agency, an Australian Commission on Safety and Quality in Health Care and a National Health Performance Authority. Details on how the national governance agencies will work together to deliver improvements in the Australian health system are yet to be released.

National Preventive Health Agency

The Australian National Preventive Health Agency commenced operation as a statutory body on the 1st of January 2011. The Agency provides evidence-based advice to health Ministers; supports the development of evidence and data on the state of preventive health in Australia and the effectiveness of preventive health interventions; and puts in place national guidelines and standards to guide preventive health activities.

Australian Commission on Safety and Quality in Health Care

The Australian Commission on Safety and Quality in Health Care commenced operation on the 1st of July 2011. The role of the Commission is to monitor safety and quality in health care and develop the national standards for clinical safety and quality; develop a national system for health service accreditation; improve patient safety by reducing harm caused by preventable errors; ensure more effective management of healthcare resources arising from unnecessary or ineffective treatment; and give independent and informed advice to all healthcare providers and healthcare services consumers.

National Health Performance Authority

Australian Health Ministers have reached in principle agreement on legislation to establish a National Health Performance Authority which, as an independent statutory authority, will provide independent performance monitoring and reporting of the health sector. Other functions include formulating performance indicators, collecting, analysing and interpreting performance information, and promoting, supporting, encouraging, conducting and evaluating research. Health Ministers have also agreed to refinements to the Performance and Accountability Framework, under which the NHPA will monitor, assess and report on performance of the health system. The Performance Authority will report on the performance of hospitals, health networks and Medicare Locals and make Hospital Performance and Healthy Community Reports publicly available. The Authority, as a Commonwealth agency, will not have access to data on the performance of individual health care providers, including general practices. The Authority will rely on the state and territory governments, Medicare Locals, private providers and NGOs to supply timely and accurate performance data.

GP Super Clinics

Background

In 2007 the Commonwealth announced support for the establishment of GP Super Clinics (integrated primary health care centres) to help make primary care more accessible in underserviced areas and help take the pressure off hospitals. The Super Clinics are also an attempt at improving care coordination by bringing together a number of primary care professionals under one organisational structure to deliver services additional to general practice including allied health services. They are also expected to place a stronger focus on preventive health services and chronic disease management. Each Super Clinic will bring together a range of health care providers which may include general practitioners, nurses, visiting medical specialists, allied health professionals and other health care providers to deliver better health care, tailored to the needs and priorities of the local community. They will open for extended hours and have significant capacity for inter-professional clinical training and education.

Services available from a GP Super Clinic

There is no one model for GP Super Clinics. The potential range of services and target populations are determined in line with local community health care needs and priorities to complement and enhance the range of existing health services. Services within a GP Super Clinic may be delivered by a range of providers, including Commonwealth, State or local governments, private sector and non-profit organisations. GP Super Clinics could also provide outreach primary health care services to other primary care facilities. Alternatively, the GP Super Clinic could provide facilities or services, which could be accessed by GPs or other health professionals from the surrounding area. Examples of specific types of services that may be provided through a GP Super Clinic include:

- General practice (primary medical care).
- Facilities for regular services provided by allied health professionals, such as physiotherapists, dietitians, podiatrists, occupational therapists, etc.
- Psychology services and relevant mental health and D & A support programs.
- Visiting medical specialists.
- Facilities for practice nurses to provide comprehensive primary health care (as part of a multidisciplinary team), including early identification and intervention activities for chronic disease, risk modification counselling, care planning and coordination.
- Facilities for running regular chronic disease management programs and community education (e.g. weight management and smoking cessation programs).
- Provision of public/private dental services.

- Linkages with key components of the local health system such as hospitals, community health services, other allied and primary health care services, health interpreting services, telephone triage services (such as the National Call Centre Network or similar).
  - Community health services funded by state and territory governments.
  - Co-located diagnostic services, provided that these are consistent with relevant pathology and diagnostic imaging legislation.
  - A health resource library for patient education.

  Many services available at GP Super Clinics will be provided under fee for service arrangements that attract Medicare rebates and will be strongly encouraged to bulk bill Medicare Benefits Schedule funded services, however state, territory or local government funded services will be provided in accordance with the charging policies of the relevant government.

Numbers and NSW locations

Sixty four Super Clinics will be rolled out progressively at identified locations through a mix of competitive and direct funding processes. Existing GP practices looking to amalgamate; other health professionals; local councils and Divisions of General Practice are able to apply to become or support the establishment of a Super Clinic which will not be owned or operated by the Commonwealth Government. Start-up funding is primarily for capital works and small streams of recurrent funding will be made available to support particular costs such as on-site nurses and centre managers.

The Australian Government has established or is currently establishing nine GP Super Clinics in New South Wales at the following locations: Blue Mountains, Grafton, Gunnedah, North Central Coast, Port Stephens, Queanbeyan, Riverina, Shellharbour, and Southern Lake Macquarie. Additional location-specific applications for funding from individuals and organisations to establish GP Super Clinics in NSW have been offered to Blacktown, Broken Hill, Coffs Harbour, Lismore, Liverpool, Nowra, Lower Hunter, Port Macquarie, Southern Central Coast and Tweed Heads.

Further information:

http://www.health.gov.au/internet/main/publishing.nsf/Content/pacd-gpsuperclinic-about

e-Health

Telehealth

Since 1 July 2011, Medicare and DVA rebates have been available to patients for video consultations across a range of medical specialties. This initiative is intended to address some of the access barriers to medical specialist services. New Medicare items will allow a range of existing consultation services to be provided via video conferencing with additional rebates that recognise the increased complexity of providing a service to a remote patient. Telehealth facilities located in general practices, aged care facilities, Aboriginal Medical Services and some other, non-medical facilities, will be able to videolink patients in rural, remote and outer metropolitan areas with specialists (eligible specialists, consultant physician or psychiatrist) in cities or major regional centres.

Twenty three new MBS items will be available for patient-end services. These enable GPs, other medical practitioners, participating nurse practitioners, participating midwives, Aboriginal health workers and practice nurses to provide face to face clinical services to the patient during the specialist video consultation. Eleven new MBS items will be available for specialist-end consultations. A list and details of telehealth MBS items for specialist services and patient-end services can be found here

Under this initiative the specialist can be located anywhere in Australia but the location of the patient at the time of the consultation must be outside an inner metropolitan area. The services must be rendered in Australia. *Telehealth Eligible Areas* are geographical areas where patients can receive telehealth services. A map locator for *Telehealth Eligible Areas* is currently provided on the Australian Government's Doctor Connect website. The locator can be accessed here

Residential Aged Care Facility residents and patients of Aboriginal Medical Services face particular barriers to accessing specialist medical services regardless of where they live. In recognition of these barriers, Telehealth MBS Items may also be billed for patients in these categories. Medicare or DVA rebates are not available for video consultations with admitted hospital patients. This applies to both public and private admitted patients.

A video consultation can be conducted in a patient's home if the specialist considers it is clinically appropriate and if the patient's home is located in a telehealth eligible area. Generally, patients will undertake consultation with specialists from general practices, eligible Aboriginal Medical Services and residential aged care facilities.

The MBS telehealth items are not available for telephone or email consultations. There must be a visual and audio link between the patient and the eligible specialist, consultant physician or psychiatrist in order for the patient to claim for a telehealth rebate. Case conferencing items remain unchanged. These items do not attract a telehealth incentive payment.

Each doctor or other health worker involved in the video consultation bills separately. Bulk billing has been encouraged with extra telehealth bulk billing incentives paid at a rate of $20 each time a practitioner bulk bills a service in the first year.
More: MBSOnline

Electronic Health Record
The Personally Controlled Electronic Health Record (PCEHR) program is working towards an electronically interoperable health care system to underpin the establishment of a personally controlled health record that will provide an electronic summary of a patients' health information and secure access for patients and healthcare providers to eHealth records. A PCEHR will include a health summary showing a patient's medical conditions, allergies, and demographic information, and an index summary of a patient's health information and medical history such as consultations, referrals, procedures, prescriptions, test results, personal health diaries and care plans. Secure access for patients and care providers to e-Health records will be available via the internet regardless of the physical location of the health records.

The PCEHR will be delivered in an incremental, phased-in approach which recognises differing stages of eHealth maturity and readiness across health providers with the level of information available on an e-Health record to increase as the number of health services participating in the national program increases. Lead implementation sites across Australia, including Divisions of General Practice, have been chosen by the Commonwealth to test core national infrastructure and standards set by the National E-Health Transition Authority to provide practical experience and learnings.

They will focus on testing and implementing components of the PCEHR system that support sharing or aggregation of electronic health information across geographies and sectors and address the agreed high priority domains for e-health such as medication management, e-referrals and hospital discharge summaries. From July 2012 all Australians who choose to have a PCEHR will be able to register online for one.
More: www.yourhealth.gov.au

After Hours GP helpline

A commonwealth funded After Hours GP Helpline commenced operation on July 1st 2011. Medibank is the operator of the after-hours line which has enlisted large numbers of General Practitioners and nurses to take calls (this will be an add-on to the nurse triage, information and advice services currently provided by the National Health Call Centre Network trading as *healthdirect Australia*). Calls are first triaged by a registered nurse who, if necessary, transfers the call to a GP. Where patients are referred to the GP, the GP will provide further medical advice and treatment options. A record of any GP consultation is sent electronically to the patient's usual GP the following morning. The after-hours service is free to call from any landline. The service operates between 6pm and 8am Monday to Friday, 6pm Friday to 8am Saturday, 12pm Saturday to 8am Monday, and on all national and State/Territory public holidays. After Hours GP helpline number: **1800 022 222**

Existing General Practice After-Hours Grants Program and PIP incentives will continue until the Medicare Locals coordination of face-to-face GP after-hours services is operational in mid-2013. After hours Medicare Benefits Schedule (MBS) items will remain unchanged.

Lead Clinician Groups

Research has shown that effective clinical leadership is an essential part of a well-integrated, functioning health system. Lead Clinician Groups are structures purposely established through Commonwealth government funding to improve clinical engagement in health care practice and system design with a priority to promote evidence based clinical practices and standards, safety and quality improvements, and more effective (and efficient) care processes. They also ensure that health professionals have greater input into service planning and delivery.

By working across the primary, acute, ambulatory and aged care sectors Lead Clinicians Groups are designed to contribute to achieving better integrated or coordinated patient-centred care.

Fifty six million dollars is allocated over four years to establish Lead Clinicians Groups at both national and local levels. Key functions of the national group are to provide high level leadership and advice on clinical issues to government; act as a conduit for both the systematic dissemination of best practice guidelines and play a key role in identification and prioritisation of evidence gaps.

Local Lead Clinicians Groups will draw on data and other information sources to provide advice and guidance on a range of clinical matters, across the continuum of care, that reflect local community needs and priorities. The national and local groups were planned to commence operation from July 2011.

Practice Nurse Incentive Program

The Practice Nurse Incentive Program (PNIP) starts on the 1st of January 2012 and provides incentive payments to eligible practices to support an expanded and enhanced role for nurses working in general practice. The commencement of the program comes with the removal of six Medicare Benefit Schedule (MBS) practice nurse items where practice nurses provide a range of specific services on behalf of a GP without the patient having to see the GP such as immunisation and wound management services; Pap smear services; preventive health checks; provision of monitoring and support for a person with a chronic disease on a GP Management Plan, Team Care Arrangement or MBS Multidisciplinary Care Plan; Antenatal services; and Healthy kids checks. Current funding arrangements cease on 31st December 2011. Practice nurses can still contribute to care remunerated through other MBS item numbers (such as care planning), however these require the patient to see the GP as part of that service.

The PNIP will provide incentive payments to eligible practices of $25,000 per year, per 1000 Standardised Whole Patient Equivalents (SWPE) where a Registered Nurse works at least 12 hours 40 minutes per week and $12,500 per year, per 1000 SWPE where an Enrolled Nurse works at least 12 hours and 40 minutes per week. The SWPE value of a practice is the sum of care provided to practice patients, weighted for the age and gender of each patient.

The PNIP will be capped at five per practice, meaning that practices will be eligible to receive up to $125,000 per year to support their practice nurse workforce.

To be eligible for the PNIP, the practice must be accredited (or working towards accreditation) under the current Royal Australian College of General Practitioners *Standards for general practice*. Practices can apply for the PNIP from 1 October 2011, when application forms will be available on the Medicare Australia website. More information

Coordinated Care for Diabetes

A pilot of prepaid funding for care of patients with diabetes in general practice is about to commence. The pilot of the *Coordinated Care for Diabetes* reform will see patients register with a practice that coordinates their care and manages pre-allocated funds to provide services instead of billing Medicare. The purpose of the pilot is to assess the effectiveness of the key elements of the measure (i.e. voluntary patient enrolment, flexible funding arrangements, and pay for performance incentives) to inform future policy considerations regarding arrangements for chronic disease management in the primary care setting. An important focus will be to assess how coordinated care for diabetes can support a more consumer-centred approach to care through expanding the choices available to people with diabetes and providing structured multidisciplinary diabetes patient education packages. The Commonwealth government will provide $30 million over four years to trial the proposed design and identify patient outcomes. A Diabetes Advisory Group has been formed to support the design and evaluation of the pilot. The Commonwealth Government has deferred a national full roll-out of *Coordinated Care for Diabetes* until after the pilot results are known.

Under the original proposal, practices would have been paid an average of $1200 per year for each diabetic who signed up to the scheme. Practices would create personalised care plans for patients and coordinate access to other health providers such as dieticians, physiotherapists and podiatrists. Practices would be eligible for yearly performance payments if diabetics stayed healthy and out of hospital.