

Chapter 2

Strengthening primary health care in Australia

Australia has a fragmented set of primary and community health services that can be difficult for patients to navigate. Attempts at planning across governments and facilities are limited, making it difficult to design robust patient pathways from primary care to hospital, and back into the community. As the evidence suggests that the number of people suffering from one or more chronic diseases will increase, it will be critical for primary health care services to adapt to models of health care delivery that require co-ordination across several health professionals. Alongside this, efforts to improve the ability of patients to be more proactive about managing their health and avoiding serious health conditions could be implemented.

To achieve such a transformation to higher quality primary health care services, reform will be needed to the blunt mechanisms by which doctors are paid today. Accompanying this ought to be the collection of well-selected data that allows general practitioners to be benchmarked against their peers, to assess the quality of the services they provide.

The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

2.1. Introduction

Increases in life expectancy over past decades have meant that people today are likely to live with a chronic health condition longer than ever before. This is not unique to Australia, but a challenge that most OECD countries are facing as they grapple with a tightening fiscal climate. Along with a growth in the number of people living with chronic disease shall be ever increasing numbers of people suffering from more than one condition. Combined with growth in the number of services and medical technologies, these pressures together suggest that health care will be the major source of future fiscal pressure.

As this century will herald people living with a health condition for a greater share of their lives, the importance of primary health care will only increase in importance. Primary health care offers an effective setting by which to help patients manage their condition and assist them in preventing complications that require a costly hospital admission.

A complex array of services and approaches to improving health can be considered within primary care and primary health care, including population-based health promotion and prevention strategies through to first-line care and support services. This review takes a relatively straightforward approach to the use of these terms, along with community health. Primary care and GP care are used interchangeably in this chapter, and the term community health care is used to refer to the variety of primary care and primary health care services that are largely provided by the states and territories, including maternal and child health services and drug and alcohol services. This review's focus has not been on important large-scale population-based health promotion programmes around lifestyle factors, where both federal and state and territory governments play a vital role.

The World Health Organization identifies the hallmarks of a good primary health care system as effectiveness, safety, patient-centeredness, comprehensiveness and integration, and continuity of care – with a regular point of entry into the health system making it possible to build trust between people and their health care providers (WHO, 2008).

With this aspiration in mind, this chapter provides an overview of primary health care in Australia, profiles existing challenges and discusses the implications for policy. Primary health care services in Australia are fragmented, making the co-ordination of care difficult for providers and leaving patients struggling to navigate their way through the system. There also exist inequalities in access and the cost of services. There is a need to instill quality improvement into the varied range of primary health care services in Australia. Doing so will require greater information and

flexibility with financing mechanisms, so as to better inform and appropriately reward providers.

2.2. The Australian primary health care system

General practitioners in private practice act as health system gatekeepers

Responsibility for primary care services delivered by physicians in Australia rests predominantly with the federal government, reflecting the economic reality of the substantial payments made to GPs working in private practice. The federal government is also responsible for funding the majority of vocational general practice training in Australia through the Australian General Practice Training programme.

As with the United Kingdom, Denmark and Norway, Australia has a long established tradition of GPs as the first point of call. Around 85% of the Australian population visits a GP at least once a year (Britt et al., 2014). Patients do not have to enrol with a GP, and can attend multiple doctors should they choose to. GPs act as health system gatekeepers, providing referrals to specialists that are also subsidised by Medicare. Whether GPs or specialists, doctors are allowed to set their own fees, and patients are subsidised for the cost of these services through a fee-for-service system (Box 2.1).

For some GPs in rural areas, income from Medicare is supplemented by work in local hospitals that is reimbursed by state governments. Australia relies considerably on overseas-trained doctors to fill workforce gaps in rural areas, though governments over the past decade have been making efforts to increase the number of Australian medical students.

As in many other OECD countries, GPs are increasingly being assisted in their work by nurses. The most common in Australia is a “practice nurse”, who performs procedural support for doctors such as injections and dressings, and chronic disease management. In a survey, some 81.6% of GPs reported working in a practice employing nurses (Britt et al., 2013). In recent years, the federal government has changed payment arrangements for practice nurses to encourage GPs and groups of GPs that employ a nurse, rather than reimbursing their sessional involvement. This ought to help with their integration in primary care. However, there remain challenges in maintaining wage parity with nurses in the hospital sector.

Box 2.1. Medicare in Australia: How primary care services are financed

Medicare is Australia's universal health scheme. In addition to providing free services for patients in public hospitals, it provides subsidies to patients for consultations with GPs, medical specialists, and other health professionals through a fee-for-service system. The scheme was introduced in 1984, and is financed through consolidated government revenue.

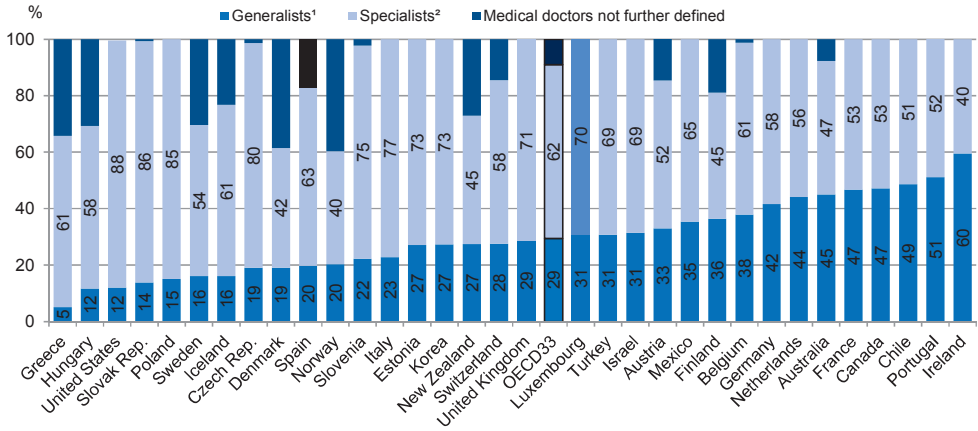
Doctors have discretion over charges while patients are paid fixed amounts set by the government. In some cases, this can lead to patients facing out-of-pocket costs, where doctors' charges are higher than the subsidy – known as a “benefit”. Where doctors' charges equal the benefit, this is known in Australia as “bulk billing”.

The Medicare Benefits Schedule (MBS), which lists the services subsidised by the government, is regularly updated. While there is no compulsion for GPs to bulk bill, most of them do so for at least some patients. GPs who bulk bill concession card holders and children under 16 are also eligible to claim an additional incentive payment, with a higher incentive available for services in regional areas. More than 80% of GP attendances are bulk-billed across Australia, so GP services for most patients are free.

Private health insurance is explicitly not allowed to cover GP out-of-pocket costs, assisting with reducing medical fee inflation.

The Extended Medicare Safety Net (EMSN) provides an additional rebate for out-of-hospital Medicare services once an annual threshold has been met. When that threshold has been reached, Medicare will pay for 80% of any future out-of-pocket costs for Medicare-eligible out-of-hospital services for the remainder of the calendar year. Some items have a cap on the EMSN benefits payable. From 1 January 2016, a new Medicare Safety Net will be introduced with lower thresholds for most people. There will be a limit on the amount of out-of-pocket costs that count towards the threshold. Once the relevant threshold has been reached, Medicare will pay up to 80% of any future out-of-pocket costs for out-of-hospital Medicare services for the remainder of the calendar year. However, there will be a maximum Medicare benefit payable for each service.

Compared with other OECD countries, Australia has a more even share of generalist and specialist doctors. Generalists (including GPs, family doctors and other non-specialists) comprised 45% of doctors in Australia in 2013, compared with an OECD average of 29.4% (OECD, 2015). The proportion of generalists in Australia is among the highest in the OECD (Figure 2.1).

Figure 2.1. Generalists and specialists as a share of all doctors, 2013 (or nearest year)

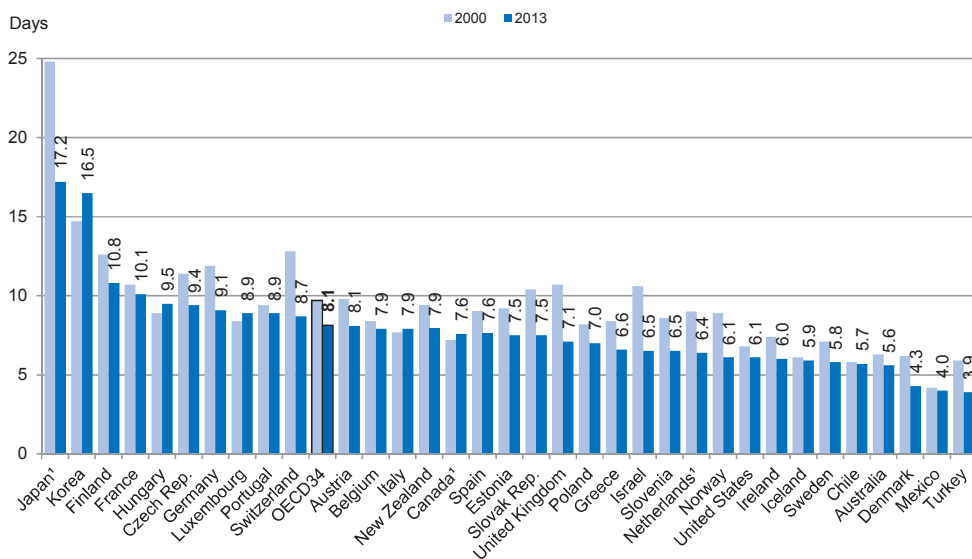
1. Generalists include general practitioners/family doctors and other generalist (non-specialist) medical practitioners.
2. Specialists include paediatricians, obstetricians/gynaecologists, psychiatrists, medical, surgical and other specialists.
3. In Ireland and Portugal, most generalists are not GPs (“family doctors”), but rather non-specialist doctors working in hospitals or other settings.
4. In Portugal, there is some double-counting of doctors with more than one speciality.

Source: OECD Health Statistics 2015, www.oecd.org/els/health-systems/health-data.htm.

The role of primary health care is likely to increase in importance in the future

As with most OECD countries, Australia is facing increased hospital activity. Australia had 9.4 million hospital discharges in 2012-13, of which 5.5 million were in public hospitals. Between 2008-09 and 2012-13, the number rose by an average of 3.6% per year (AIHW, 2014a). Demand for hospitalisation may grow as the population ages, and there is continuing growth in chronic disease. At the same time, the length of stay in hospital is declining, as shown in Figure 2.2.

In Australia, the average length of hospital stay fell from 6.3 days in 2000 to 5.6 days in 2012, reflecting an OECD-wide trend. It is also among the shortest lengths of stay in the OECD (OECD, 2015).

Figure 2.2. Average length of stay in hospital, 2000 and 2013 (or nearest year)

1. Data refer to average length of stay for curative (acute) care (resulting in an underestimation).

Source: OECD Health Statistics 2015, www.oecd.org/els/health-systems/health-data.htm.

This is likely to put more pressure on the primary health care sector to take on the care of more patients at an earlier stage of their recovery. The decision to release a patient earlier must be weighed up carefully against the risks. A hospital stay that is too short can have adverse effects on a patient's health outcomes. If this leads to a higher readmission rate, the costs per episode of illness may fall only slightly, or even rise (OECD, 2013). With this in mind, it is imperative that effective models of primary health care that prevent and manage disease and reduce reliance on expensive hospital care are in place.

There is also pressure for primary health care and for GPs to play a bigger role in the long-term health care of patients. With chronic diseases often implying that a patient will see multiple health practitioners, GPs are increasingly being asked to co-ordinate the care of more complex patients.

Australia has already made considerable efforts to reward doctors for engaging in mental health care. GPs provide referrals to psychiatrists, and can also provide referrals to psychologists and appropriately trained social workers and occupational therapists, which are partially subsidised by Medicare as part of a scheme that requires GPs to create a mental health

treatment plan. The federal government also provides incentive payments to general practices and private psychiatrists who engage mental health nurses to assist in providing co-ordinated care for people with severe mental illness.

There has been a shift away from GPs working in isolation, in favour of larger multidisciplinary practices

Australia has experienced a shift towards GPs working in larger practices. The percentage of GPs reporting as working in a solo practice fell from 15.7% in 2004 to 12.2% by 2013, according to the National Health Workforce Dataset. This trend reflects changes in clinical practice and potential administrative efficiencies for doctors who choose to co-locate. There is an increasing importance given to group environments in primary health care services, particularly among the younger generation of GPs who prefer to work fewer hours and alongside colleagues. At the same time, government policies have tried to nudge GPs in this direction, with the introduction of a pay-for-performance scheme (the Practice Incentives Programme, see Box 2.3), requiring practices to be accredited. The costs associated with accreditation make it economically advantageous for GPs to move to bigger practices to share costs.

As well as consolidation among doctors, there has been a shift towards horizontally integrating general practices with other primary health services, such as allied health professionals. This approach seeks to encourage collaboration between different health care providers that might be involved in a patient's care and to make it easier for patients to draw on multiple services. Health services offering a comprehensive range of services increase the uptake and coverage of preventive programmes like cancer screening. They prevent complications and improve outcomes, facilitate early detection and prevent problems (WHO, 2008).

Allied health professionals play an important role in delivering services. For example, community pharmacies play a key role through the delivery of Pharmaceutical Benefits Scheme medicines and related services. Community pharmacies provide some primary health care services, usually in consultation with GPs and other health professionals. Pharmacies are involved in screening and testing, medication reviews and post-hospital care, and also provide advice to address the needs of specific population groups. The pharmacy sector has been advocating for an enhanced role and better use of pharmacists' skills in primary health care, such as in the provision of vaccinations (discussed in more detail in Chapter 4). In 2013, there were 426.3 full time equivalent allied health professionals per 100 000 population in Australia (SCRGSP, 2015). Allied health

professionals may work in public and private hospitals, private practice, or in community health centres.

Government policy efforts have sought to accelerate the trend of consolidation, with the creation of “GP super clinics”. The federal government has been providing financial support to encourage consolidation of practices and in some cases, funding the establishment of new clinics. These facilities co-locate doctors with allied health professionals, mental health practitioners, drug and alcohol services, specialists, practice nurses and dentists. In some cases, incentives have been provided to health professionals to work in these clinics. Evaluations of this policy (Box 2.2) suggest that these clinics have helped attract clinicians, but are not necessarily changing the model of care away from one focused around GPs.

Box 2.2. Evaluations of government support for consolidation of health care services under a single location

An early evaluation of seven “super clinics” found they appeared to be meeting unmet needs in their communities, and had prompted a net increase of GPs and allied health staff in these communities – not just a transfer from other local practices. Many clinicians indicated that the multidisciplinary model of care was a major factor in their decision to work in the clinics.

A more detailed analysis of 18 clinics by the Australian National Audit Office (ANAO) indicated most had achieved, or were making good progress towards achieving, measures including opening hours, bulk billing, service mix, future medical workforce training, and electronic shared patient records. Staff recruitment and retention were the most significant challenges. Despite more allied health professionals, GPs still accounted for about 72% of patient attendances at December 2012, with nursing and allied health professionals each accounting for 14%. However, in some clinics, more than 90% of presentations were for GPs, while at one clinic GPs accounted for only 30% of attendances and more than 50% were for nursing staff. The analysis did not indicate a trend supporting the government’s objective of a shift towards more services being delivered by nurses and allied health professionals.

Source: Australian National Audit Office (2013), *Administration of the GP Super Clinics Program*; Consan Consulting (2012), *Evaluation of the GP Super Clinics Program 2007-2008*, Department of Health and Ageing.

Accreditation of primary health care services is voluntary, and general practices differ in their approaches to quality assurance

While accreditation of public and private hospitals is now mandatory in Australia, accreditation for general practice remains voluntary. About 75% of general practices in Australia participate in accreditation (RACGP and ACSQHC, 2014).

The accreditation process involves independent third-party review, in which practices are assessed against national standards developed by the Royal Australian College of General Practitioners (RACGP). There is wide variation in accreditation of other primary care services. For instance, accreditation is mandatory for community health services if they are required to access government or health insurance funding and if it is health department policy. At January 2008, 435 community services and 332 hospitals providing these services were accredited, although it is not known what percentage this represents (ACSQHC, 2008).

For most other primary care services, it is voluntary. Where accreditation is voluntary and not supported by incentives, few practices are accredited. For example, at January 2008 just 1.9% of physiotherapist practices were accredited, and 2.2% of optometrist practices (ACSQHC, 2008). With regards to community pharmacies, over 90% have been accredited against the Quality Care Pharmacy Program Standards (Pharmacy Guild of Australia, 2012). The quality assurance programme was developed by the Pharmacy Guild of Australia in 1997 in consultation with the Pharmaceutical Society of Australia and other industry stakeholders.

The aged care sector provides one example of mandatory accreditation. This information about individual facilities can be found on a website, which can help consumers make informed decisions.

Accreditation aside, many primary health services have implemented their own quality assurance systems, such as governance arrangements requiring the collection of information on safety and quality. These organisations use processes such as incident reporting, root cause analysis and safety indicators to inform their local risk management processes. However, it has been acknowledged that these types of tools are under-used in parts of the primary health care system (ACSQHC, 2011).

A number of quality assurance mechanisms exist, but practices are not compelled to use them. Practice-level safety and quality indicators developed by the ACSQHC are voluntary, and their level of uptake is not known. The Royal Australian College of General Practitioners (RACGP) developed its own set of 22 clinical indicators dealing with safety and quality of clinical care in general practice, but they are not intended to be linked to accreditation or used to measure performance, and they are voluntary.

There are challenges in accessing GPs across the country and outside standard working hours

Geography plays a significant role in determining access to GPs across Australia. This manifests in variations in out-of-pocket costs across the country, and access to GPs after hours. Compared with other OECD countries, Australia does poorly in terms of access to after-hours care. In a Commonwealth Fund survey of 11 countries, 54% of older Australian patients surveyed reported that obtaining after-hours care was somewhat or very easy. The proportion was lower in only two countries (Canada and Sweden), while this stands in contrast to the Netherlands (77%), the United Kingdom (71%), and France and New Zealand (69% each) (Osborn et al., 2014).

In part, these national results are likely to reflect significant variation in after-hours GP visits across the country, with after-hours visits ranging from 0.05 per person in the remote Kimberley-Pilbara and regional New England areas, to a high of 0.79 in suburban south western Melbourne in 2011-12. But even differences between metropolitan areas exist, with only 0.15 visits in the metropolitan area of Fremantle in Western Australia (NHPA, 2013c).

In a survey of Australian GPs, the proportion reporting they worked in practices providing their own after-hours services declined from 36% in 2004-05 to 31% in 2013-14. Fewer GPs reported working in practices providing after-hours services in co-operation with other practices (16% compared with 14%). However, the proportion of GPs working in practices solely using deputising services for the provision of after-hours care increased from 35% in 2004-05 to 47% in 2013-14 (Britt et al., 2014). Medical deputising services enable general practices to contract out the after-hours component of their patients' care to other practices.

The Australian Government has tried to deal with this issue by providing financial incentives for GPs to provide after-hours care. The government has also expanded MBS after-hours items, and reintroduced the after-hours incentive in the Practice Incentives Programme (PIP) in 2015. The government also provides funding to Primary Health Networks to support local after-hours services, with a focus on addressing gaps in service provision, at-risk populations, and improved service integration. GP and nurse-led telephone helplines also exist across the country.

Adding to the access challenge is wide discrepancies in out-of-pocket costs. In 2011-12, the proportion of people who delayed or did not see a GP due to cost in the preceding 12 months was highest in the Australian Capital Territory, where it was 13% (NHPA, 2013b). At the same time, the ACT had the nation's lowest percentage of GP attendances that were "bulk-billed", in

which patients had no out-of-pocket costs, of 49.7% (NHPA, 2013b). This is well below the national bulk-billing rate of 82% (AIHW, 2014b).

The Australian Bureau of Statistics' Patient Experience survey indicates that of all people who needed to see a GP in the previous 12 months, 5.4% delayed or did not see a GP at least once because of the cost (ABS, 2013). Some GPs provide bulk billing only for particular patients – such as pensioners, the unemployed and children under 16 – while charging others a co-payment. This is in part due to incentives the government gives GPs to provide free services to more disadvantaged patients.

Payment for GP-led primary care services is dominated by a fee-for-service model that struggles to promote quality

As has been noted across several OECD countries, the sessional nature of payments under fee-for-service (FFS) encourages increased activity. FFS rewards practitioners based on the number and types of services they provide, with little incentive to promote quality. In Korea, for example, FFS is likely to be encouraging the oversupply of medical services and may be contributing to the higher number of doctor consultations (OECD, 2012b). In the United States, which spends more on health care than any other country, FFS creates an incentive for the overuse of medical services. This contributes to a high cost of health care, but does not equate to better health outcomes in the United States – which are the same or worse than many other countries that spend less (Emanuel and Fuchs, 2008).

Physicians paid on a FFS basis generally have an incentive to see more patients and to provide more services than salaried physicians, since their income is linked with the volume of services. This can mean that patients receive a higher number of services per episode of care. A review of four studies including 640 primary care physicians and more than 6 400 patients suggests FFS results in more consultations compared with capitation funding (Gosden et al., 2000).

With chronic disease becoming a more challenging issue in Australia, FFS is unlikely to be appropriate in cultivating high-quality care for these patients who require proactive and co-ordinated care with an emphasis on preventive aspects. There is limited research on the impact of time on quality of care. One review suggests that visit rates above three to four per hour may lead to suboptimal visit content, decreased patient satisfaction, higher patient turnover, or inappropriate prescribing. It could also mean reduced patient participation, education and preventive health measures. Meanwhile, physicians with longer consultation times ask more questions related to health history and psychosocial concerns (Dugdale et al., 1999).

FFS is unlikely to provide a setting in which doctors are encouraged to educate patients about self-management and devise primary and secondary prevention strategies. For instance, in a survey of Australian GPs, only 34% reported providing smoking cessation advice during every routine consultation with a smoker, in accordance with national guidelines (Young and Ward, 2001). With these considerations in mind, FFS may be appropriate for one-off episodic care in patients with low complexity, but is less suited to patients requiring support for one or more long-term conditions.

The Australian Government has sought to diversify funding for primary health care away from fee for service, with mixed results

Efforts have been made to move towards more blended payment systems. In 1998, the government introduced the Practice Incentives Programme (PIP), which sought to reward a range of activities considered to be associated with quality (such as cost-effective prescribing), or policies relating to the modernisation of operations (such as take up of eHealth initiatives). While they share a common payment delivery infrastructure, the PIP is more of a compilation of 11 different incentive programmes each with their own rationale, indicators and performance monitoring arrangements (Box 2.3). Practices may apply for as many of these as they wish, providing they meet eligibility requirements. PIP holds the worthwhile potential of reducing the overall financial risk to the health budget by increasing the share of funding that is capped rather than demand-driven. More importantly, it offers a means to diversifying financing away from simply the provision of a service, and linking it to desirable clinical activities.

In 2013-14, the Australian Government made PIP payments to around 5 400 general practices and 19 000 GPs. In 2008-09, the average PIP payment to a general practice was AUS 61 000, or AUS 19 700 per FTE GP in participating practices; 5% of practices averaged AUS 426 000 (ANAO, 2010). These payments are based on a formula that takes into account practice size, and the age and gender of patients. Nonetheless, the share of GP-related government expenditure by PIP decreased from 8% in 2002-03 to 5.5% in 2008-09 (ANAO, 2010), making it a relatively modest source of financing for the primary care system at large. PIP expenditure rose by 25% in the six years since 2002-03, while MBS expenditure on general practice and GP items increased by 86% (ANAO, 2010). Despite attempts to focus on disease-specific and outcome-based incentives, FFS by far remains the dominant approach to funding primary care.

Box 2.3. The Australian primary care Practice Incentives Programme

After Hours Incentive: Aims to support general practices to provide their patients with appropriate access to after-hours care.

Asthma Incentive: Aims to encourage GPs to better manage the clinical care of people with moderate to severe asthma.

Cervical Screening Incentive: Aims to encourage GPs to screen under-screened women (i.e. women aged 20 to 69 years who have not had a cervical smear in the previous four years) and to increase overall screening rates.

Diabetes Incentive: Aims to encourage GPs to provide earlier diagnosis and effective management of people with established diabetes mellitus.

eHealth Incentive: Aims to encourage practices to keep up to date with the latest developments in eHealth. To be eligible to receive the incentive, practices must meet a range of requirements to encourage the adoption of eHealth technology.

General Practitioner Aged Care Access Incentive: Aims to encourage GPs to provide increased and continuing services in federal government-funded residential aged care facilities.

Indigenous Health Incentive: Aims to support general practices and Indigenous health services to provide better health care for Aboriginal and Torres Strait Islander patients, including best practice management of chronic disease.

Procedural General Practitioner Payment: Aims to encourage GPs in rural and remote areas to maintain local access to surgical, anaesthetic and obstetric services.

Quality Prescribing Incentive: Aims to encourage practices to keep up to date with information on the quality use of medicines, and rewards participation in activities recognised or provided by the National Prescribing Service, which provides quality use of medicines education and support to health professionals.

Rural Loading Incentive: Participating practices with a main location outside capital cities and other major metropolitan centres are automatically paid a rural loading. The rural loading recognises the difficulties of providing care, often with little professional support, in rural and remote areas. The rural loading is higher for practices in more remote areas.

Teaching Payment: Aims to encourage general practices to provide teaching sessions to undergraduate and graduate medical students preparing for entry into the Australian medical profession, to ensure they are appropriately trained and have gained experience in general practice.

Source: Australian Government Department of Human Services (2015), “Practice Incentives Programme (PIP)”, available at: www.humanservices.gov.au/health-professionals/services/practice-incentives-programme/?utm_id=9 (accessed 3 June 2015).

Today, only half the incentives under the PIP relate to driving improvements in the quality of clinical care. These are the incentives for diabetes, cervical screening, asthma, prescribing and Indigenous health. Four of these include the monitoring of outcomes; for example, the cervical screening incentive comprises a sign-on payment, an outcomes payment when at least 70% of eligible patients are screened in a 30-month period, and a service incentive payment to GPs for each cervical smear on an under-screened woman. The diabetes incentive includes a sign-on payment, an outcomes payment when at least 2% of patients are diagnosed with diabetes and GPs have completed a diabetes cycle of care for at least 50% of these patients, and a service incentive payment for each completed cycle of patient care. The Indigenous incentive also attracts outcomes payments when certain levels of care are provided, in addition to sign-on and patient registration payments.

The opt-in model of the PIP has been worthwhile in encouraging take-up to date, but having arrived at some scale, may now suffer from a selection bias among the practices choosing to participate. As practices can choose which incentives they wish to participate in, this may encourage participation in incentives that are easier to gain. The incentives related to chronic disease are harder to achieve and require more investment by practices, so may be less attractive to GPs. This is supported by an ANAO analysis, which found in 2008-09, incentives related to asthma, diabetes and cervical screening combined made up just 3.8% of payments to GPs, compared with 32.5% for payments related to the information technology incentive, which has since been replaced with the eHealth incentive (ANAO, 2010). More recently, in 2013-14, a little under half (47.3%) of practices participating in PIP had taken up the diabetes incentive (SCRGSP, 2015). However, it has been difficult to assess the extent to which PIP has improved quality (Box 2.4).

While the overall contribution of PIP to improving focus on the quality of care is difficult to measure, PIP does not have some of the worthwhile features that characterise pay-for-performance arrangements in other OECD countries. The PIP combines attempts to use financing to drive policy changes as well as desirable changes to clinical practice. However, the number of domains of clinical practice is quite limited, extending only to asthma, diabetes and cervical cancer. By contrast – as discussed later in this chapter – countries such as Israel and the United Kingdom have sought to develop a series of indicators that reach more aspects of clinical practice. The poor take-up among the three areas where PIP does touch on clinical practice is a cause for concern, particularly if they suggest that practices do not feel the clinical indicators are worthwhile.

Box 2.4. The impacts of the Practice Incentives Programme

PIP has been credited with increasing general practice accreditation, where Australia is a leader among OECD countries. To participate in PIP, a practice must be accredited against standards set by the RACGP. While PIP appears to be the primary reason for most practices attaining accreditation, this could also serve as a barrier to smaller practices. The PIP participation of solo practices was estimated at 34% at May 2009, compared with 67% of all practices (ANAO, 2010).

It has been difficult to gauge the extent to which PIP has improved quality, and a limited number of studies have sought evidence on this. The ANAO's analysis suggests that for quality prescribing, there was evidence of improvements, but the effect was limited by low take-up. For diabetes and asthma, there was evidence to indicate improvement to quality of patient care. There was also some evidence that PIP improved access to care (ANAO, 2010).

Another study assessed the impact of the incentive payment for diabetes management, as measured by the probability of ordering an HbA1c test (a test for glycated haemoglobin, which gives an indication of blood sugar levels). The study found the incentive has a positive impact on quality of care in diabetes management. The magnitude of the effect lies between a 15% and 20% difference in the probability of ordering an HbA1c test since the reform was introduced (Scott et al., 2008).

Still, a World Bank study concluded that the evidence that PIP has had an impact on quality of care and outcomes that justify its cost is limited. It found the almost AUS 3 billion spent on the programme since its inception seemed to be disproportionate to the overall results. There were modest impacts on service delivery and quality of care, but there were also serious concerns about PIP's role in exacerbating inequity between large urban practices and smaller practices serving disadvantaged populations (Cashin and Chi, 2011).

Other examples in Australia exist of alternatives to FFS, such as in the provision of mental health care where access may be more challenging. Under the Access to Allied Psychological Services (ATAPS) programme, GPs can refer patients to mental health professionals such as psychologists, social workers, mental health nurses, occupational therapists and Aboriginal and Torres Strait Islander health workers with mental health qualifications. Primary Health Networks act as fund holders for the programme. Additionally, the Mental Health Services in Rural and Remote Areas (MHSRRA) programme provides funding to Primary Health Networks and other non-government organisations to provide mental health services to rural communities with limited access to Medicare-subsidised mental health care.

Blended payment systems that take patient outcomes into account will better facilitate quality and co-ordinated care for people with chronic health conditions

Primary health care services that have the capacity to meet the needs of complex individuals should be backed by flexible payment systems that reward health practitioners for demonstrating optimal patient outcomes and quality. While FFS remains an effective means of reimbursing patients for visits to the doctor, there is considerable scope in Australia to shift the balance of funding. Payment systems should not encourage doctors to “cherry pick” patients who are young and healthy, and require less management than patients with multiple co-morbidities. Nor should they stifle innovative models of care. FFS comes with the benefit of being simple and rewarding productivity. However, the tendency towards higher volumes can be moderated through a greater proportion of funding linked to outcomes.

The current MBS allows for doctors to be reimbursed more for chronic disease management. Under such an arrangement, a GP develops a care plan for a patient that can include Medicare-funded referrals with up to five allied health professionals annually. About 97% of GPs used MBS chronic disease management items for care planning or case conferencing in 2013-14, up slightly from 96.1% in 2009-10 (SCRGSP, 2015). While the existence of such a scheme might have the implication of building in incentives for better care, the extent to which it has improved quality of care is difficult to gauge, as the MBS items are not linked to performance indicators or patient outcomes. In the case of diabetes, for example, only 25% of people with the condition received the annual cycle of care in general practice in 2012-13, up slightly from 22.7% in 2011-12 (SCRGS, 2014). Harris and Zwar (2007) argue that about half of patient care for those with chronic disease does not meet optimal standards – as demonstrated by the care of children with asthma, and adults with type 2 diabetes and hypertension. They cite among the key barriers to optimal care the dominance of FFS encouraging reactive rather than systematic care, and a lack of multidisciplinary patient care teams within general practice.

With these challenges in mind, Australia should build on the current PIP, and adopt a more robust blended payment system that rewards processes associated with more indicators of quality of care and better patient outcomes. Such an arrangement would allow governments to align funding with health system goals and patient outcomes, reducing the reliance on activity-based FFS. Importantly, financially rewarding practices for providing good multidisciplinary care, as opposed to individual GPs working in isolation through FFS, is more likely to drive quality gains.

OECD countries are increasingly adopting mixed payment schemes. In an OECD survey of 26 countries, 54% used mixed payment systems for primary care, and 42% reported using a FFS arrangement (Hofmarcher et al., 2007). The added benefit of blended payment systems is they appear to facilitate better care co-ordination. The authors of the study noted that countries perceived FFS payments in primary care as making care co-ordination problems in ambulatory care more likely. Mixed payment schemes in specialist ambulatory care made system-wide perceived problems of care co-ordination less likely. Yet relatively few countries encouraged care co-ordination on a contractual basis, and the use of financial incentives was infrequent. Only 31% often had explicit payments for care co-ordination at the primary-care level, and widespread application was limited (Hofmarcher et al., 2007).

In a bid to incentivise quality improvement, Australia is among a number of OECD countries that have experimented with pay-for-performance schemes (Box 2.5) through the PIP.

Despite the existence of PIP, outcomes-based payments rewarding practices that meet particular indicators remain under-used in Australia. As earlier mentioned, only a handful of PIP incentives include payments linked to outcomes. As part of a move towards a greater emphasis on a blended payments system in Australia, there is scope for PIP to be broadened and refined, with the inclusion of more quality indicators. The current existence of only 11 incentives is very limited. General practices should be required to do more than sign up to receive incentives; they should be required to meet a range of performance indicators demonstrating high quality of care. As discussed later in this chapter, other OECD countries have implemented a comprehensive performance framework that could be used as the basis for rewarding quality care.

It is welcome that the Australian Government has established a Medicare Benefits Schedule Review Taskforce to consider how services can be aligned with contemporary clinical evidence and improve health outcomes. Building on more robust blended payment systems could be considered as part of this review. The government has indicated it will also consider introducing a PIP quality improvement incentive to encourage general practices to better manage chronic disease.

Alongside new quality incentives, the existing PIP payments to support rural practice are vital and should remain. Efforts to boost uptake of the eHealth incentive should also continue, as a means to encourage the use of electronic health to improve care co-ordination through better sharing of information.

Box 2.5. International experience with pay-for-performance schemes

Since their inception in the United States, United Kingdom and Australia in the late 1990s and early 2000s, pay-for-performance schemes have become increasingly popular payment mechanisms for primary health care across the OECD. Pay-for-performance is more widely used in primary health care than in secondary care. Primary health care schemes operate in around half of countries, focusing mainly on preventive care and care for chronic disease. Design varies widely, ranging from relatively simple schemes in New Zealand (ten indicators) or France (16 indicators) to the complexity of the United Kingdom's Quality and Outcomes Framework (QOF) – the largest scheme currently in operation. QOF covers over 100 indicators in 22 clinical areas.

Given its scale, and the fact that it was a system-wide reform, much research has focused on the impacts of QOF. Gillam et al. (2012), in a systematic review covering 124 published studies, note that evaluation is complicated by lack of a control group and the difficulty of ascribing changes in clinical practice or outcomes (each with manifold determinants) to a complex intervention such as the QOF. Nevertheless, against a background of improving care generally, they report that quality of care for incentivised conditions during the first year of implementation improved at a faster rate than prior to QOF, although subsequently returned to prior rates of improvement. Given the cost of QOF (an extra GBP 1 billion per year), much debate has focused on its cost-effectiveness. Gillam et al. reported evidence of modest cost-effective reductions in mortality and hospital admissions in some areas, such as epilepsy. Of note, however, work by Walker et al. (2010) finds no relationship between the size of payments in a clinical domain (ranging from GBP 0.63 to GBP 40.61 per patient), suggesting substantial efficiency gains by reducing the upper spread of these figures.

In a review of 22 systematic reviews looking at pay-for-performance schemes internationally (not confined to primary care), Eijkenaar et al. (2013) find that P4P seems to have led to a 5% improvement in performance of incentivised aspects of care. Effects were generally stronger in primary care than in secondary care although, given the extent of variation in findings and the paucity of rigorous study designs, the authors conclude that there is insufficient evidence to support or not support the use of pay-for-performance in the quality of preventive and chronic care in primary care.

Beyond clinical effectiveness and efficiency measures, pay-for-performance schemes have been associated with improvements such as narrowing of the quality-gap between deprived and non-deprived areas (Doran et al., 2008); systems strengthening by expanding use of practice-based IT, patient registers, call-recall procedures and audit; and expansion of nursing roles and competencies, including better team working. They may also support better dialogue between purchasers and providers, promote broader public debate and thereby clarify the objectives of primary care services (Cashin et al., 2014). Some evidence of negative effects, such as deprioritisation of non-incentivised activities or a fragmentation of the continuity of care, have also been noted.

Pay-for-performance in primary health care should not be seen as the ideal or only payment system, but a potentially useful tool in a blended payment system, particularly where it might spur other activities such as development of quality indicators and better monitoring. As stated in an editorial cautioning against over-enthusiastic adoption of the schemes, “the choice should not be P4P or no P4P, but rather which type of P4P should be used and with which other quality improvement interventions” (Roland, 2012). Fundamentally, pay-for-performance should be seen as part of the means to move toward better purchasing (including, in this case, GPs' time), in which quality plays a more prominent role.

Source: OECD (2014), “Primary Care Physicians in Norway”, *OECD Reviews of Health Care Quality: Norway 2014: Raising Standards*, OECD Publishing, Paris, <http://dx.doi.org/10.1787/9789264208469-6-en>.

Australia's health system features a division between primary care and community health that is unusual

Australia's unique split of federal-state boundaries makes a distinction between "primary care" and "community health" that is unusual among OECD countries. In broad terms, this emerges as the federal government has responsibility for the reimbursement of GPs and for Aboriginal medical services that provide primary care. Meanwhile, a range of specialist health functions that are generally undertaken in the community – such as drug and alcohol services, mental health and maternal and child health – are the responsibility of state and territory governments. There is, too, variation among the states as to the community health services they provide. The states are simultaneously responsible for running public hospitals, which accounts for the bulk of their spending and organisational focus on health. The explanation for this distinction has its origins in the history of federal-state financial relations (Box 2.6).

The Australian distinction between "primary care" and "community health" is unique among OECD countries, even those with a federal governance structure. In Austria and Germany, both primary care and community health services are run by self-governing regional associations. In Belgium and Switzerland, the responsibility falls under the regional governments, and there is no split between primary care and community health. Canada shares Australia's policy of making the health of the Indigenous population a federal responsibility but otherwise locates both primary care and community health services with its regions. Finally, in Mexico, state governments manage primary care and community health, with most of the latter funded at the federal level and provided by the same state level services that provide primary health care. The exception to this is those covered by social security (Table 2.1).

Australia's unusual split of responsibilities complicates planning across "primary care" and "community health" services that work closely together in other countries. Supervision by different levels of government can manifest in entirely avoidable difficulties for patients. Some of these challenges include different eligibility and payment arrangements, the poor transfer of health information and the irrational location of facilities at a community level. As one example, among those surveyed in Australia who had seen three or more practitioners, 12.8% reported that there were issues caused by a lack of communication between health professionals (ABS, 2013). More substantially, with state governments dominated by their hospital responsibilities, it may bias the care provided through community health facilities towards pre- and post-hospital step-down services for more acute patients, rather than identifying and intervening

early. There are, however, examples of states, such as Victoria, where community health services have a strong focus on prevention as well as on improving the health of disadvantaged populations.

Box 2.6. Community health in Australia

The federal government established the Community Health Program in 1973. Its aim was to develop a national network of primary care services with multidisciplinary teams, including primary medical care. The federal government later introduced a less centralised model and by 1981, it had rolled community health funding into block grants to the states and territories – effectively ending its involvement. When Medicare was established in 1984, the role community health centres played in providing access to GPs became very limited.

The present system, as described by the National Healthcare Agreement, recognises that the states and territories fund community health, and provide public health, community health, public dental services, and deliver vaccines purchased by the federal government under the national immunisation arrangements and health promotion programmes. There are, however, variations across the states and territories in the delivery of community health services. Meanwhile, the federal government funds private medical care and community-controlled Aboriginal and Torres Strait Islander primary health care services, and will seek to ensure equitable and timely access to affordable primary health care, predominantly through general practice.

This split in responsibilities has been criticised as promoting fragmentation and complicating co-ordination across health facilities.

In recent years, the federal government has sought to take financial responsibility for community health services. Under the National Health and Hospitals Network Agreement, this would have given the federal government full funding and policy responsibility for GP and primary health care, and made the states “key partners supporting the Commonwealth’s responsibility for system-wide GP and primary health care policy and service planning co-ordination”. However, this policy was abandoned due to a lack of national agreement.

Source: Australian Government Department of Health and Ageing (2009), *Primary Health Care Reform in Australia*, (Information taken from Paul Laris and Associates (2002), *Community Health Centres in South Australia: A Brief History and Literature Review*, Report commissioned by the Generational health review, available from: www.library.health.sa.gov.au/Portals/0/community-health-centres-in-south-australia-a-brief-history-and-literature-review.pdf (accessed June 2009); and Australian Academy of Medicine & Surgery (2000), *Health Funding and Medical Professionalism – A Short Historical Survey of the Relationship Between Government and the Medical Profession in Australia*, available from: www.aams.org.au/contents.php?subdir=library/history/funding_prof_med_au/&filename=index (accessed June 2009); Council of Australian Governments (2010), *National Health and Hospitals Network Agreement*; Council of Australian Governments (2012), *National Healthcare Agreement 2012*.

Table 2.1. Primary care and community health arrangements in OECD countries with a federal governance structure

Country	Primary care and community health
Austria	Apart from hospitals, health care provision is organised by negotiations between the social insurance institutions and the professional or statutory representatives of the service providers. The federal government defines the legislation for outpatient care. Competencies are delegated to membership-based insurance associations and service providers that operate in the form of self-governing organisations. ¹
Belgium	The regions are responsible for primary care. There is no distinction between primary and community health.
Canada	Primary care and community health are the responsibility of provincial and territorial governments. The exception is the federal government provides some primary and/or community health services to certain “federal populations”, which may include members of the armed forces, veterans, some Aboriginal people, and inmates in federal correctional facilities.
Germany	The self-government of physicians (National Association of Statutory Health Insurance Physicians and regional Associations of Statutory Health Insurance Physicians) is responsible for organising and guaranteeing outpatient care and primary health care, including mental health and child and maternal health. Self-government is organised regionally. The legal framework is defined at a federal level and specified under law by the partners of self-government. In general, community health services are limited to official medical services, health monitoring, health promotion, implementation of the Infection Protection Act and hygiene monitoring.
Mexico	State governments manage primary care (including maternal and child health and drug and alcohol services), and community health. Community health can include all health promotion campaigns and activities, injury prevention policies, epidemiological surveillance, illness prevention campaigns and actions and prevention and control of addictions. Most community health is funded through the Ministry of Health at the federal level and provided by the same state level services that provide primary health care. The exception is that for the population covered by social security (about half the population), primary care is provided by family medicine clinics, funded and controlled at the central level through regional offices.
Switzerland	Provision of primary care is generally organised at the cantonal (regional) level. There is no division between primary care and community health.

1. Hofmarcher, M.M. and H.M. Rack (2006), “Austria: Health System Review”, *Health Systems in Transition*, Vol. 8, No. 3, pp. 1–247.

Of particular concern is poor communication between facilities funded by federal and state governments. For example, in a Commonwealth Fund survey of 11 countries, 19% of Australian respondents reported experiencing a medical, medication or lab error. While six other countries reported proportions of 20% or higher, it is in contrast to the 8% reported in the United Kingdom and the 9% reported in Switzerland (Schoen et al., 2011). In an earlier survey by the same authors, the likelihood of error increased with the number of health care providers seen. Of the Australians who saw one doctor in the previous year, 15% reported an error, and the figure almost doubled (27%) for those who saw three or more doctors. The likelihood of error also increased with the number of chronic conditions – 19% of respondents with one condition reported an error, compared with 26% of those with two or more (Schoen et al., 2007). While errors are not always necessarily due to poor communication between health providers, the risk of error seems to increase with diagnoses, along with the number of health practitioners a patient visits.

Mental health is another area that has suffered from relations between Australian federal and state authorities, and where this fragmentation is particularly evident (Box 2.7).

Box 2.7. Fragmentation of mental health services

Like many OECD countries, Australia has moved towards deinstitutionalisation of mental health services. While this shift away from institutions towards care in the community is laudable in terms of reducing stigma, it is also recognised to have brought occasional unintended consequences of homelessness, inappropriate incarceration and difficulties in accessing care in the community.

Today mental health services are split across two levels of government. The states provide acute mental health care in psychiatric wards in general public hospitals – which are jointly funded by the federal and state governments. The states also provide specialised, clinical and community-based mental health services for people with severe and persistent mental illness. Other responsibilities are some prevention programmes, community support such as housing, disability services, drug and alcohol services, police, and corrections.

The federal government funds medical care with GPs and psychiatrists through Medicare, for people with common mental health issues such as mild or moderate anxiety and depression. It also established a scheme providing Medicare funding for allied health professionals such as social workers and psychologists, if a GP prepares a mental health treatment plan. This can sometimes place those in rural areas at a disadvantage as it is harder to access a GP. The federal government also subsidises medication and provides some community and social support services in partnership with non-government organisations. It provides income support for people with a mental illness.

The existence of multiple successive national mental health agreements between federal and state governments has done little to ease the system’s fragmentation. The present system means a vulnerable patient with a mental illness can be discharged from hospital to no particular service, and then be left to seek out care in the community provided by an array of federally and state-funded providers.

Efforts to co-ordinate services across both levels of government have been hampered by a failure to establish a nationally agreed picture of the scope of each government’s responsibilities and their accountabilities. The National Mental Health Commission notes that – unlike Canada and New Zealand – Australia has no nationally agreed picture of what a good mental health service framework should look like and how it should be resourced. Such a framework would give a clear view of the appropriate coverage, levels and range of mental health services needed. The Commission also notes that at a national level, data are not collected to measure whether evidence-based mental health care is being provided, or the services available to support people in their recovery. Nor is information collected on the experience people with a mental health condition have in the system.

Efforts are being undertaken through the Council of Australian Governments to improve this situation, with a view to establishing a new national mental health plan.

Source: Council of Australian Governments (2012), The Roadmap for National Mental Health Reform 2012-2022; National Mental Health Commission (2012), A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention.

Through its history of federal-state financial relations, Australia has arrived at a split between “primary care” and “community health” that is not rational from a health policy perspective. The experience of other federal OECD countries suggests that there exist potential benefits in planning and regulating these services under the same level of government. The present system means that attempts to co-locate services can involve an unnecessarily complex process engaging two levels of government. It also promotes a

culture of health services working independently of each other. Australia's health system operates in an environment that promotes the existence of these siloes. The continuing split between primary care and community health also undermines attempts to promote the role of the GP as the care co-ordinator.

Australia should consider removing the distinction between primary care and community health, and handing responsibility for all primary health services to the states and territories, to improve the interface with hospital services. Under such a move, the states would act as regional commissioning agencies for health care in Australia. This would help promote the co-ordination of care for patients who currently move between state-managed acute hospitals and community health services, and primary care.

This shift will require a major upheaval of federal and state financial relations, and a careful consideration of the transition and management of risk given the current open-ended nature of the Medicare system. Such a move is likely to be very challenging, will take time, and will require the co-operation of governments and a sincere willingness to achieve reform that will be in the best interests of patient care. The move to align new Primary Health Networks with existing Local Hospital Networks could help facilitate further structural and funding reforms that bring more responsibility for service delivery to the states. Efforts can then be made to promote primary health care services that are shaped around the needs of patients.

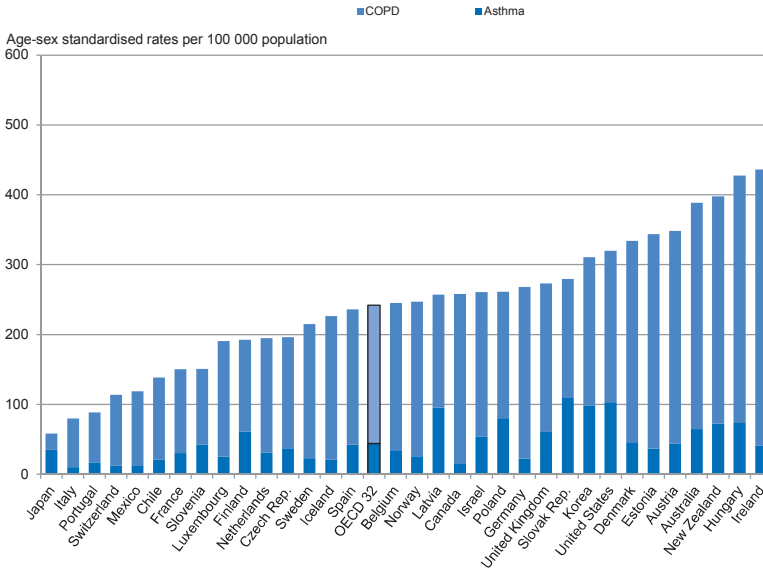
2.3. Primary health care outcomes in Australia

The few partial indicators available at an international level suggest there is scope for improving primary health care services in Australia

Data submitted to the OECD's Health Care Quality Indicator project show that hospital admission rates for asthma and chronic obstructive pulmonary disease (COPD) – an indirect measure of the quality of primary care for these conditions – are higher in Australia than for the majority of the OECD (Figure 2.3). Of note, rates are not standardised for background prevalence of the condition or other factors that are likely to influence admission rates such as, in this case, international variation in smoking rates.

By contrast, hospital admission rates for diabetes in Australia are below the OECD average (Figure 2.4).

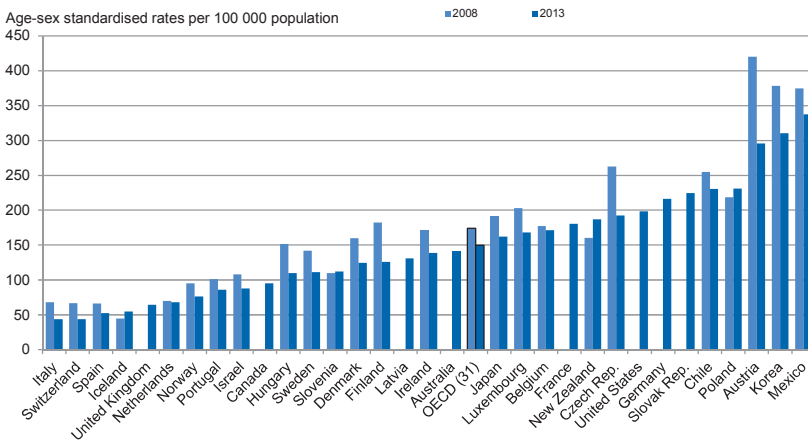
Figure 2.3. Asthma and COPD hospital admission in adults in OECD countries, 2013 (or nearest year)



Note: Three-year average for Iceland and Luxembourg.

Source: OECD Health Statistics 2015, www.oecd.org/els/health-systems/health-data.htm.

Figure 2.4. Diabetes hospital admission in adults in OECD countries, 2008 and 2013 (or nearest year)

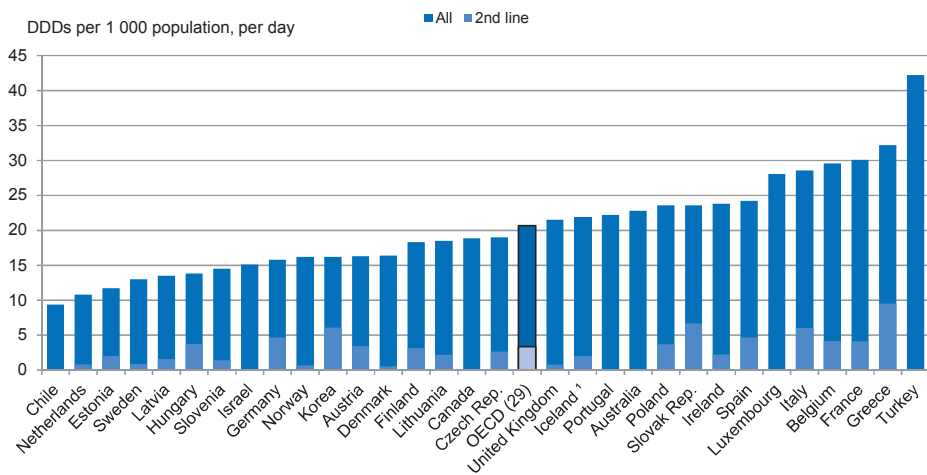


Note: Three-year average for Iceland and Luxembourg.

Source: OECD Health Statistics 2015, www.oecd.org/els/health-systems/health-data.htm.

Practices around antibiotic prescribing in primary care can be considered an indicator of quality of care. There is international recognition that the volume of antibiotics prescribed is correlated with the spread of resistant bacterial strains, and can increase antibiotic resistance in the community. As shown in Figure 2.5, Australia’s overall volume of antibiotics prescribed, of 22.8 defined daily dose (DDD – the assumed average maintenance dose per day for a drug used for its main indication in adults) per 1 000 population per day, is higher than the OECD average of 20.7 (OECD, 2015).

Figure 2.5. Overall volume of antibiotics prescribed, 2013 (or latest year)



1. Data refer to all sectors (not only primary care).

Source: European Centre for Disease Prevention and Control 2015 and *OECD Health Statistics Database 2015*, www.oecd.org/els/health-systems/health-data.htm.

The Australian Institute of Health and Welfare observes it is not clear why the volume of antibiotics prescribed in Australia is higher than the OECD average. Programmes aimed at tackling antibiotic resistance and reducing infections in primary care and hospitals exist, but there is no systematic monitoring of antibiotic prescribing in primary care (AIHW, 2014b).

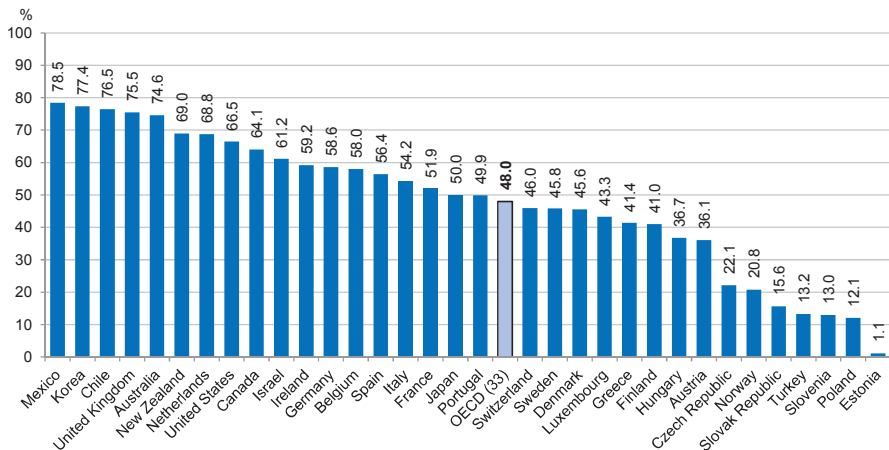
There is strong evidence that vaccines provide safe and effective protection against diseases such as diphtheria, tetanus, pertussis (whooping cough), measles and hepatitis B. Most OECD countries have childhood vaccination programmes. The proportion of children protected from these diseases as part of childhood vaccination programmes can be considered an indicator of quality in primary care. In 2013, 94% of Australian children

aged around 1 were vaccinated against measles, the same as the OECD average. Additionally, 91% of Australian children aged around 1 were vaccinated against diphtheria, tetanus and pertussis, compared with an OECD average of 95%. Australia achieved 91% coverage for vaccination against hepatitis B for children aged around 1, compared with the OECD average of 92% (OECD, 2015).

The Australian Government has sought to increase immunisation coverage by – from January 2016 – removing “conscientious objection” as a valid reason for vaccination exemptions, in order for families to continue to receive certain family assistance payments. Exemptions for approved medical conditions will continue to apply (Australian Government Department of Human Services, 2015).

Influenza is a common infectious disease that can have a significant impact on health systems, and young children and the elderly are among the most vulnerable. In industrialised countries, most deaths associated with influenza are among people aged 65 or older (WHO, 2014). In 2003, countries participating in the World Health Assembly committed to the goal of attaining vaccination coverage of the elderly population of at least 50% by 2006 and 75% by 2010 (World Health Assembly, 2003). Few OECD countries have achieved this target (Figure 2.6). At 74.6% coverage, Australia just falls short, and is among the better performers in the OECD (OECD, 2015).

Figure 2.6. Influenza vaccination coverage, population aged 65 and over, 2013 (or nearest year)



Source: OECD Health Statistics 2015, www.oecd.org/els/health-systems/health-data.htm

Significant variations in health outcomes can be seen at a more local level

In the three years from 2009 to the end of 2011, more than 33 000 Australians died prematurely on average per year from causes that might have been avoided through better prevention or medical treatment. These deaths accounted for 66% of all deaths before the age of 75 (NHPA, 2013a). These potentially avoidable deaths were more than three times higher in rural central and north west Queensland (316 deaths per 100 000) compared with the lowest rate in inner east Melbourne of 96 deaths per 100 000 (NHPA, 2013a).

The rate of potentially preventable deaths – which could have been prevented through better preventive health activities such as screening and healthier lifestyle habits – was highest in rural central and north west Queensland (206 deaths per 100 000) and lowest in northern Sydney (53 deaths per 100 000) (NHPA, 2013a). The most common causes were lung cancer, ischaemic heart disease and suicide and self-inflicted injuries.

The rates also varied for potentially treatable deaths – which might have been avoided through better therapeutic interventions like surgery – which ranged from a low of 41 deaths per 100 000 people in inner east Melbourne to a high of 110 deaths per 100 000 people in rural central and north west Queensland (NHPA, 2013a). The most common causes were ischaemic heart disease, colorectal cancer and breast cancer.

Chapter 1 documents the differences in life expectancy in different parts of Australia, and the gap between Aboriginal and Torres Strait Islander people and non-Indigenous people. Significant variations also exist in other indicators of health status. This data present an opportunity to inform prevention strategies at a local level.

The proportion of Australians who rate their health positively also significantly differs across the country. In 2011-12, 92% of people living in the Sydney north shore and beaches area reported they were in excellent, very good or good health, but the figure dropped to 77% in rural southern South Australia. That region also had the highest proportion of people reporting they had a long-term health condition (60%), while the lowest proportion (34%) reporting they had a long-term health condition was in inner west Sydney (NHPA, 2013b). Chapter 4 discusses in greater depth the poorer health outcomes in rural and remote Australia.

Patients' experience of primary care appears to be good, but more information is needed

There is insufficient information on the experience of patients in primary health care. What is known indicates that when it comes to ambulatory care, Australia fares better than the OECD average when it comes to whether patients think doctors spend enough time with them (86.5% compared with 84.9%), give patients an opportunity to ask questions or raise concerns (88.3% compared with 85%), and involve patients in decisions about their treatment (86% compared with 81.3%). Australia trails the OECD average on patients reporting their doctor provides easy to understand explanations (85.9% compared with 87.9%) (OECD, 2015).

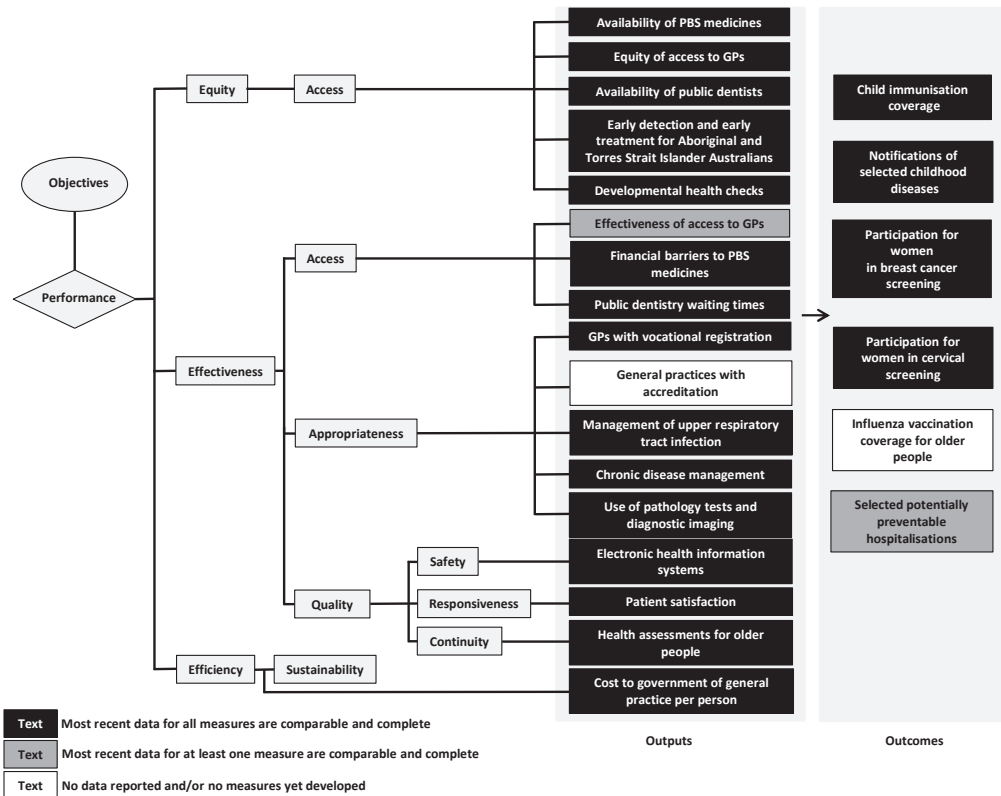
While the National Health Performance Authority publishes a wealth of information about the experience of patients with GPs, little is known about the experience patients have with allied health professionals. Given the increasing push for more multidisciplinary care in the treatment of chronic disease, developing a mechanism to measure the patient experience beyond physicians would provide a more comprehensive overview of the patient journey.

Improvements in care co-ordination and quality require a better information system and regular reporting that benchmarks general practices against their peers

Compared with some other OECD countries, and compared with the volume of hospital information that exists, there is a surprising lack of data relating to quality of care in primary health care in Australia. Ideally, an information system should have the capacity to follow a patient as they move from primary care services to hospitals, and are discharged back to the community, while tracking a patient's long-term outcomes.

A report is published annually with data reporting on the equity, efficiency and cost-effectiveness of government services. Included in this is a primary and community health performance framework (Figure 2.7). The indicators relate to objectives in the National Healthcare Agreement. The focus of the information collected is on service use and activity, while information on quality and patient outcomes is more limited.

Figure 2.7. Primary and community health performance indicator framework



Source: Based on Steering Committee for the Review of Government Service Provision (2015), *Report on Government Services 2015*, Vol. E: Health, Productivity Commission, Canberra.

Efforts are being made to improve the availability of data. For example, in 2015, the Steering Committee for the Review of Government Service Provision for the first time reported on the incidence of heart attacks by state and territory; the prevalence of type 2 diabetes by Indigenous status; and allied health workforce data.

Overwhelmingly, however, the lack of primary health care information limits the ability to track the patient pathway through the health system. For example, despite being Australia's largest general practice study, the Bettering the Evaluation and Care of Health (BEACH) study does not have the capacity to link to other health records, or the capacity to follow patients longitudinally (Britt et al., 2013).

There is also a lack of information on patient safety in primary health care. One of the few studies examining the incidence of errors by GPs is the Threats to Australian Patient Safety (TAPS) study, which suggests that when an anonymous reporting system is provided, about two errors are reported for every 1 000 individual patients seen by a GP per year (Makeham et al., 2006). But, in common with many other OECD countries, patient safety information in primary health care is not systematically collected. Australia does not consistently collect information about patient harm, over-use of pathology testing and antimicrobial stewardship in primary care.

In a survey of primary care physicians, 32% of Australian doctors said their practice had a process for identifying adverse events and taking up follow-up action, and the system worked well, while 53% said they had such a process but it needed improvement. About 15% said they had no process. Still, Australia fared better than Germany, Italy, Canada, France and the Netherlands, where nearly half or more doctors said their practices had no process for identifying adverse events and taking action (Schoen et al., 2009).

There is also a dearth of information on the performance of individual general practices. Such information could help to lift quality by enabling health professionals to benchmark themselves against their peers. Additionally, the ability of Australia's GPs to improve the quality of care they provide their patients is hindered by a lack of feedback enabling them to compare their performance to that of their peers. Unlike other OECD countries, most of Australia's GPs do not have information about their clinical practice or patient outcomes. Australia ought to look to models in Britain and Israel for examples of how quality in primary care can be measured (Box 2.8).

Australia should investigate options to begin collecting performance information at a practice level. This could be done through a refined and vastly expanded PIP that requires practices to routinely report on a comprehensive set of indicators. A transparent and consultative process should be undertaken, to construct a set of the most appropriate indicators. Disaggregating this data geographically would enable areas of need to be identified, where more resources could be directed. The collection of this data should be sensitive to recognising that solo-practitioner doctors may find it harder to administratively collect such information.

Box 2.8. Measuring primary care performance

In Israel, health funds have a sophisticated information infrastructure that supports care delivery and quality monitoring. The Quality Indicators in Community Healthcare (QIHC) programme involves the systematic collection of data for the entire population of Israel from all four health plans to create national-level quality indicators that are publically reported (Jaffe et al., 2012). The QIHC indicators cover six clinical areas: asthma, breast and colorectal cancer screening, immunisation for older people, child and adolescent health, cardiovascular health, and diabetes. The focus on prevention is demonstrated by the inclusion of indicators relating to risk factors, such as BMI. The programme is not compulsory, but its success is due to the voluntary involvement of the health funds in its conception and design, their active participation in developing the indicators, and the consensus around a scientifically robust quality measurement programme (OECD, 2012a).

There is evidence that the programme has improved quality. One evaluation found documentation of BMI for adolescents and adults increased by 30 percentage points to 61% and 70% respectively. Other improvements were an increase in the appropriate use of asthma control medication, while the rates of influenza vaccination among Israelis aged 65 and over increased from 52% to 57%. The authors concluded the overall quality of community health care in Israel had improved in the previous three years (Jaffe et al., 2012). While physicians in Israel do not receive financial incentives for participating in the programme, it could be argued that they benefit from the feedback they receive, which enables them to compare their performance to that of their peers. This can provide a persuasive incentive for doctors to improve quality.

The United Kingdom's voluntary Quality and Outcomes Framework (QOF) takes this further by linking performance to financial incentives. Payments from QOF can constitute as much as a third of a general practice's income (Willcox et al., 2011). QOF comprises almost 150 indicators covering chronic disease management and other areas. Each indicator is weighted, and general practices accumulate points that are used to determine the payments they receive. The performance of every practice is publicly reported on a website.

Some of the indicators include the establishment of disease registers. For example, one register relates to the percentage of patients aged 14 to 19 with asthma for whom there is a record of smoking status. QOF also has a stronger focus on clinical outcomes. For instance, one indicator relates to the percentage of patients on the chronic kidney disease register whose notes include a record of blood pressure, while another indicator links that to patient outcomes in that the blood pressure measure is 140/85 or less. There are also ten indicators related to mental health, such as the percentage of women with schizophrenia, bipolar affective disorder and other psychoses who have had a cervical screening test.

While the existence of more than 100 indicators may not necessarily be useful or drive quality gains, the QOF scheme demonstrates that there is significant scope for Australia to introduce a more comprehensive primary care performance framework, and link it to quality patient care.

The move to public reporting may initially seem confronting to GPs, who have not been exposed to the same level of public scrutiny as hospitals. However, this can be implemented in several stages to minimise risk. It could start with non-public, anonymous data reported to the government, progressing to non-public reporting of named practices. Eventually, this information should be publicly reported. This progression would take place over time, giving GPs a period of adjustment.

Given GPs work in private practice, it is harder to impose on them data collection requirements. There is also the risk of over-burdening general practices with red tape. The federal government should collaborate with doctors to determine the best way to move to a routine system of data collection, one that is not too administratively onerous. Incentives could be provided for this data collection, and practitioners should be educated about the value of collecting information and reporting on performance. The benefits of transparent reporting and the ability to benchmark against one's peers provide a powerful incentive to improve quality.

2.4. Maximising primary health care's contribution to high-quality health care

Considerable policy efforts have been made in recent years to try and overcome challenges with access and fragmentation in Australia

Ensuring co-operation across the two levels of government responsible for health care has been a constant policy challenge in Australia. As in other OECD countries, this has coincided with efforts to try and develop a stronger primary health care sector.

The federal government established Primary Health Networks that began operation in July 2015. The new Primary Health Networks are responsible for improving the efficiency and effectiveness of medical services delivered to individual patients by working directly with GPs, other primary health care providers, secondary providers and hospitals to ensure better co-ordination of care across the local health system. Notably, the Primary Health Networks are aligned with Local Hospital Network boundaries.

This is not Australia's first attempt to create primary health organisations to improve care co-ordination. Previous versions of the Primary Health Networks are Divisions of General Practice and – more recently – Medicare Locals. Australia is not alone in going down this path, with other models existing in countries such as the United Kingdom. In

theory, a primary health organisation that can evaluate the needs of its community and strategically construct and link services around those needs should be in a position to co-ordinate services, thus improving the patient experience. The potential – and the need – to do this is particularly strong in planning the provision of after-hours care, which has lingered as a challenging issue in Australia. There could also be the potential for shared infrastructure, promoting the co-location of services.

Such an organisation should ideally extend the thinking around health care to tackling the broader social determinants of health, and have the capacity to link patients with welfare and other services that can provide them with broader support. Developing strategies to improve health literacy, keeping in mind the unique needs of local communities, should be a key role adopted by primary health organisations. Given the complexity of Australia's health system, the existence of a primary health organisation whose main brief is to co-ordinate services, improve population health and facilitate shared knowledge across service providers could go some way to easing fragmentation. It could also be the basis for a more robust system of nationally consistent data collection, which remains a weakness in Australian primary care.

The alignment of Primary Health Networks with Local Hospital Networks is a necessary initiative to help join the dots between federally and state-funded services. Such a move should foster improved planning around local population needs, help identify service gaps, enable health services to forge relationships with other providers in their local areas, and facilitate a more seamless patient pathway.

Primary Health Networks should be subject to a performance monitoring framework. The quality clinical governance that had been embedded in Medicare Locals should be strengthened in the Primary Health Networks. Medicare Locals had great diversity in their structures, objectives and activities. While this had the advantage of allowing innovation, it also came with the risk that some core functions may be variably delivered.

The funding approach to these organisations should also promote flexibility to adapt to the local needs of their communities. They should be permitted to have a greater proportion of their budget in flexible funding rather than specific funds for certain outputs. Agreeing on more general outcomes – such as reducing avoidable hospital admissions – and allowing them to determine how they do this, would be a better approach than tightly prescribing their activities. Primary Health Networks should not duplicate existing services by becoming service providers, unless a need is identified, including where there is demonstrable market failure.

Encouraging the development of a continuous relationship with a single clinic could help improve the co-ordination of patient care

A co-ordinated primary health care system is ideally straightforward for patients to navigate. Where complications arise, patients should be equipped with the information they need to move around the system. Health professionals should be educated in communicating with patients in a manner in which patients are able to understand important information about their own care, particularly where there are potential safety issues such as medication use. Educating patients about the self-management of chronic disease should form part of an integrated care approach, and is a role that could be adopted increasingly by general practice nurses working closely with physicians.

The health system entry point for patients with chronic health conditions should ideally be in the form of a comprehensive primary health care clinic that offers a range of co-located services delivered by a multidisciplinary team of health practitioners, incorporating prevention and health promotion activities. Such a system is more patient-centred and more efficient, the likelihood of duplication of services is reduced, and the patient experience is improved. People who use the same source for most of their health care needs tend to comply better with professional advice, rely less on emergency services, require less hospitalisation and are more satisfied with their care (WHO, 2008).

One approach to providing more co-ordinated care is the “medical home”. There is evidence that medical homes that help co-ordinate patient care are associated with more positive experiences. Such a model enables a patient to have a regular doctor or place of care; the practice staff know important information about the patient’s medical history; the patient received an appointment the same or next day the last time they were sick, or the practice always or often called back the same day to answer questions; and the practice always or often helped coordinate or arrange care from other providers. If the patient reported a chronic condition, there was one person responsible for care received for that condition (Schoen et al., 2007).

The benefit of such a system is a patient with chronic disease is likely to be better managed. In a survey, 45% of Australian patients with a chronic disease who had a medical home reported they were given written instructions on managing their care to take home, compared with 32% who had no medical home. Those who had a medical home were also less likely to report any kind of medical, medication or lab error (18% compared with 30%) and less likely to report receiving conflicting information from a

variety of health professionals (11% compared with 18%). Similar results were reflected in six other countries in the survey (Schoen et al., 2007).

The current trend in Australia towards the establishment of multidisciplinary clinics is worthwhile, and policy efforts to support this should continue. Such clinics not only potentially improve co-ordination between a number of services, they can also provide patients with a setting in which they can be seen by a team of professionals. They also provide shared services infrastructure, to help improve coding of patient conditions and measure outcomes.

A high proportion of Australians already report having a family doctor. However, the current FFS payment system does not support a medical home-type model, or encourage GPs to take on the role of care co-ordinator. Another barrier is that while eHealth remains weak in Australia, attempts to co-ordinate care by sharing information with other health providers will continue to be compromised.

It is welcome that Australia is currently exploring policy levers to enhance care co-ordination for more complex patients. The Diabetes Care Project was a three-year pilot that aimed to improve the quality of care and health outcomes of adults with either type 1 or type 2 diabetes. Type 2 diabetes patients account for almost 10% of patients presenting to GPs, and most of these patients have additional comorbidities (Britt et al., 2013). The pilot sought to take a more patient-centred approach by providing more choice, and better co-ordinated care. The pilot tested:

- a new IT system to enable better care co-ordination through enhanced information sharing;
- a flexible funding model that included quality improvement support payments for practices;
- a care facilitator role to support more integrated care; and
- an education and training programme for consumers and health care providers.

The trial has been evaluated and should be used to inform future policy development regarding arrangements for the management of chronic disease. The results should also inform the new National Diabetes Strategy that is expected to be developed.

Government policy should support the creation of more multidisciplinary and integrated primary health centres. This is already happening to some degree with the GP super clinics, although the federal government is providing funding for capital infrastructure for only

61 clinics, of which 45 were open as at August 2014. Such comprehensive primary health care centres could become the hubs by which performance of health care services might more readily be tracked. A greater emphasis of these clinics should be teaching patients to self-manage chronic conditions. However, in a Commonwealth Fund survey, only 24% of Australian physicians reported routinely giving chronically ill patients instructions on managing their care at home, compared with a high of 63% in Italy and more than 30% in the United Kingdom and the United States. Just 12% of Australian physicians said they routinely gave chronically ill patients a written list of their medications, compared with 83% in the United Kingdom (Schoen et al., 2009). The primary health care system needs to get better at engaging patients as partners in decision making, and in taking responsibility for managing their care.

Another approach to chronic disease co-ordination worthy of exploration can be found in Germany. The country's disease management programme enrolls patients with a chronic disease at an early stage, and there is an emphasis on care co-ordination, secondary prevention and the use of evidence-based guidelines. To be eligible for the programme, patients must be willing to participate in managing their own disease (Stock et al., 2011).

Improvements in quality and co-ordination of care have been reported, alongside a reduction in expensive complications such as heart attacks – pointing to the programme's cost-effectiveness. In some areas, close to 90% of patients with diabetes and more than two-thirds of primary care physicians are participating, and much of this is attributed to financial incentives. Co-payments for patients are waived if they enrol in the programme, while doctors are paid a fee for enrolling patients and for documenting certain parameters. Doctors can also be paid more for patient education and counselling, and referral to specialists. Sickness funds receive lump sum payments for enrolled patients. The programme has quality assurance mechanisms in the form of feedback to physicians and benchmarking a practitioner's performance to that of a peer group. Another quality assurance measure is national standards requiring, for example, a GP to refer a patient to a specialist if the GP cannot bring a patient's HbA1c or blood pressure level into the recommended range within six months. The specialist in turn has to refer the patient back to the GP in a specified time. The mandatory use of electronic medical records helps ensure care co-ordination between providers (Stock et al., 2011).

The German experience demonstrates that Australia could enhance its management of chronic disease in general practice with a combination of financial incentives and quality assurance mechanisms that encourage care co-ordination and ensure a patient's outcomes are followed. Such a system requires the GP to take on the role of care co-ordinator.

Governance should be strengthened, with a greater focus on quality assurance across all primary health services

In addition to the lack of information about quality in Australian primary health care, little is known about the quality assurance initiatives individual health services engage in. A starting point to improving quality in primary health care is gaining a better understanding of the mechanisms that general practices and other health professionals are using to maximise quality.

With 75% of general practices accredited, Australia should investigate the barriers to accreditation. The RACGP and the ACSQHC are developing a governance and reporting framework for general practice accreditation. The project aims to identify issues practices have with the existing scheme, maximise opportunities to enhance safety and quality, and identify options for the co-ordination of accreditation, including an appeals mechanism (RACGP and ACSQHC, 2014).

These results should be used by the federal government to determine what supports it can provide general practices – particularly smaller clinics – to gain accreditation. The ANAO's analysis indicates that PIP incentives alone do not appear to be enough to encourage smaller practices to seek accreditation (ANAO, 2010). The government should investigate what supports smaller general practices require, with a view to moving towards a system of mandatory accreditation.

A model that Australia could consider is the United Kingdom's, where general practices must all be registered with the Care Quality Commission, the independent health care regulator. It is anticipated that by April 2016, every GP surgery in England will have been inspected and rated (Care Quality Commission, 2013). Notably, among the inspection measures is how well people with long-term conditions are cared for by the practice, and whether the care helps to avoid unnecessary hospital admissions. After-hours services are also subject to inspection. Detailed individual practice inspection reports are publicly available on a website.

The quality assurance of other primary health care services also needs to be strengthened. As previously mentioned, when accreditation is voluntary, the rates tend to be very low. The rate of practice accreditation for community pharmacies under the Quality Care Pharmacy Program is high, due to government remuneration for certain professional services tied to accreditation. The design of the programme also lends itself to quality with inspections and self-assessment. Similar drivers could be considered for other primary health care services.

The government should engage with stakeholders to determine how rates of accreditation can be bolstered, perhaps drawing on the pharmacy experience. Consumers have the right to expect that any health service has met minimum standards before opening its doors to patients.

2.5. Conclusions

Australia is facing the same challenges as many other OECD countries, in trying to combat a rise in chronic disease. While efforts have been made to move towards a multidisciplinary system of care, these attempts have been undermined by a largely fragmented and unnecessarily complex primary health care system.

To promote a more patient-centred system, primary health care services should adapt to the needs of the patient. The current practice forces patients to navigate their way through a complicated system, where the federal and state governments play different roles as funders and managers of different aspects of primary health care. Removing the distinction between primary care and community health services and devolving responsibility of primary care services to state and territory governments would ease fragmentation and facilitate better co-ordination.

Australia should also strengthen its preventive efforts, or risk being overwhelmed by chronic disease. The creation of more flexible payment systems that align funding to health system goals and patient outcomes provide incentives to promote quality care for those requiring more complex health care.

A necessary first step in the improvement of quality in primary health care is its measurement. Given that primary care is for many patients the front door to the health system, measuring and publicly reporting on quality should be a priority. Such a move is challenging, but should not be too arduous a task, given Australia is already moving towards greater transparency.

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