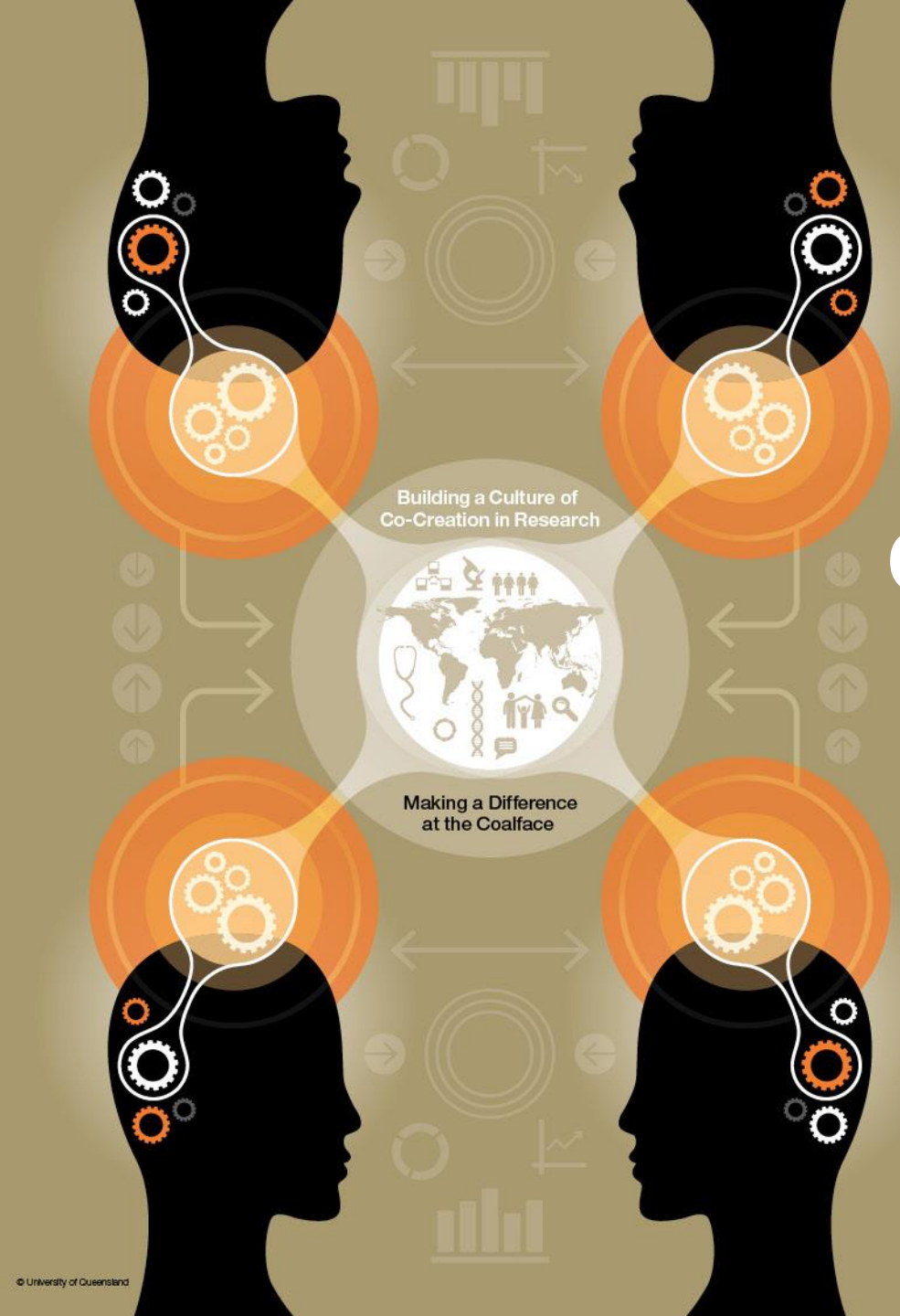

International Experiences of Primary Health Care – linkages and lessons for Australia

Professor Claire Jackson,

CRE in Primary Care Quality, Governance and Sustainability

Context: National primary care trends / initiatives

- National PHC Strategy / PHC Framework.
- PHCAG, Medicare Review, Federation reform.
- RACGP: ‘Quality General Practice of the Future’.
- NSW Government: Integrated Care Program.
- Shared boundaries: LHNs and PHNs.
- Map of Medicine / Health Pathways.
- McKeon Review.
- ‘Co-creation’ between service delivery networks, innovators and researchers.

International trends

USA:

- Accountable Care Organisations, and
- Patient Centred Medical Home;

UK:

- Primary Care Commissioning,
- the NHS ‘5 year Forward View’

NZ:

- the expansion of PHOs
- Alliance contracting.

Accountable Care Organisations (ACOs)

- Emerged in the United States following the Affordable Care Act.
- Primarily involve hospitals and medical groups accepting responsibility for the cost and quality of care for a defined population.
- Usually a capitated budget under a contractual arrangement with a public or private insurer. They generally fall into three types:
  - organisations with integrated delivery systems offering a relatively large number of services.
  - smaller physician led medical groups offering a smaller number of services.
  - and a hybrid group led by a combination of hospitals, physicians, and health centres that offer an intermediate range of services.
- Long-established and better-known ACOs include Kaiser Permanente, Group Health Cooperative of Puget Sound, Geisinger, and Intermountain Healthcare.

http://www.bmj.com/content/bmj/350/bmj.h2005.full.pdf

Accountable Care Organisations (ACOs)

- The US now has about 750 ACOs serving an estimated 20 million people.
- The recent second year results on the Medicare Pioneer and Shared Savings ACOs show that they saved over $372m (£250m; €350m).
- Pioneer ACOs savings were significantly greater among those with higher baseline spending.
- Measures of quality and patient experience also improved.
- Need to allow time to build the relationships and payment systems that enable general practitioners and specialists to work together to improve care.
- Focus on high risk patients and IT powerful enablers.

The patient centered medical home (PCMH) The core features

- Personal physician - each patient has an ongoing relationship with a personal physician who provides first contact, and continuous and comprehensive care. Physician directed medical practice – the personal physician leads a team of individuals who collectively provide care for the patient.
- Whole person orientation – the personal physician is responsible for meeting all the patient's health care needs or for arranging care with other qualified professionals.
- Care is coordinated and integrated across all elements of the complex healthcare community - coordination is enabled by patient registration, information technology, and health information exchanges.
- Quality and safety - hallmarks of the patient centred medical home.
- Evidence-based medicine and clinical decision-support tools guide decision making - physicians in the practice accept accountability voluntary engagement in performance measurement and improvement.
- Enhanced access to care is available - open scheduling, expanded hours, e-access.
- Payment reform - recognizes the added value provided to patients.

The patient centered medical home (PCMH)

- Primary care services particularly those provided in general practice are the most financially and geographically accessible forms of healthcare.
- A Patient Centred Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults in a health care setting that facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.
- Described in US but NHHRC estimates 70% Australians have a 'medical home'.

Overall benefits of having a medical home

- Improved health outcomes, at a lower cost with higher patient satisfaction.
- Improved continuity of care, preventive measures and reduced hospital admissions.
- Improved access to required services, including preventive screening and chronic disease management.
- Racial and ethnic disparities in access and quality are reduced or eliminated.

PCMH Cost savings

- A robust US study found there was a $10 reduction in total medical costs for **every patient** enrolled in a medical home **each month.**

- Additionally there was a:
  - 16% reduction in hospital admissions
  - $14 reduction in inpatient hospital costs - per patient/month
  - 29% reduction in emergency department use

Supporting studies – PCMH cost savings & benefits

- Grumbach and Grundy's 2010 review of the evidence from prospective studies of PCMH interventions in the US revealed:

Reduction in utilisation	Reduction in costs
32% drop in emergency department use	10.5% drop in inpatient specialist medical costs
36.3 drop in length in hospital stay	18.9% drop in ancillary costs
12.8% increase in chronic medication use	15% drop in outpatient specialty costs

Why adopt a ‘medical home’ approach in Australia?

- Promotes the essential role that general practice plays in providing evidence-based quality primary care from NPHCS.
- Builds on and formalizes the relationship most Australians have with their general practice, ACCHS or rural MPS.
- Fits neatly with the RACGP “Quality General Practice of the Future’.
- Accelerates benefits of :
    - Improved health outcomes for individual patients (effective management of chronic diseases, routine preventive screening, coordinated quality care).
    - Reduction of overall health expenditure with greater community care responsibility.
    - Current reform initiatives.
    - Builds on and links PCEHR roles and responsibilities.
    - Identifies A/H care and continuity of care responsibilities.

UK: Primary Care Commissioning

Key findings:

1. **CCG members have mixed views on primary care co-commissioning**
   On 1 April 2015, the majority of CCGs took on fully delegated or joint responsibility for commissioning primary care with NHS England. New responsibilities include designing incentive payments and performance-managing GP practice contracts.
   Although most governing body members felt positive about co-commissioning (81%), a majority of GPs and practice managers without a formal CCG role felt 'negative' (26%) or 'neutral' (43%). Many may be waiting to see how the policy is implemented before forming a view.

2. **Most GPs do not support performance management by CCGs**
   The majority of GPs accepted that their CCG has a role in supporting primary care development, particularly in influencing GPs' prescribing patterns (which 83% support) and encouraging collaboration with neighbouring GPs and others (77%).
   However, few GPs supported their CCG's use of performance management tools such as targets (25%) and sanctions (13%) to achieve these ends.

UK: Primary Care Commissioning (Cont.)

3. Clinical engagement in CCGs is declining, but, is higher than under PBC

2013 – 2015: the proportion of GPs highly engaged with their CCG declined from 19% to 11%; those who felt they could influence their CCG's work declined from 47% to 34%.

However, overall GP engagement remains higher than estimates under Practice-based Commissioning (PBC).*

The survey identified a number of possible reasons for declining engagement: the majority of CCG leaders felt they lacked the time or training to fulfil their role; CCG managers were seen to be more influential in commissioning decisions than GPs on the governing body; referral and prescribing patterns had reportedly changed since the establishment of the CCG, but only 21% of GPs felt the quality of care had improved.

4. There are some positive signs for the future

The majority of CCG leaders planned to continue in their role for the foreseeable future, and a fifth of GPs and practice managers not currently in leadership positions were interested in getting involved.

UK: Primary Care Commissioning (Cont.)

- **Maintain positive clinician-to-clinician relationships**: in implementing co-commissioning, CCGs must make full use of their links with members to influence practices and avoid alienating members when performance-managing GP practice contracts – a CCG role that few respondents support.

- **Avoid a perception of CCGs as manager-led organisations**: clinical engagement is declining and CCG managers are already seen as more influential than GPs. To be successful in co-commissioning, CCGs must forge strong partnerships between members and managers that maximise the clinical voice, while ensuring they manage the conflicts of interest that arise as GPs Commission primary care.

- **Focus on improving quality in primary care**: few GPs feel CCGs have improved the quality of care locally. However, co-commissioning gives CCGs an opportunity to make positive changes that are visible to GPs in their day-to-day practice. This will be vital to maintaining GP engagement and driving much-needed change in primary care.

UK: PC Commissioning (Cont.)

- **Sustain clinical leadership**: as CCGs implement the Five Year Forward View, they will have to compete with emerging provider organisations for GP leaders' time. Some GPs were keen to get more involved in CCG work and this enthusiasm needs to be harnessed. Practice managers appear to be an under-utilised resource, with the potential to play a more defined role in supporting the work of CCGs, as well as in the development of new delivery models.

NHS ‘Five Year Forward View’ Oct 2014

- Radical upgrade in prevention and public health
- Patient’s gain greater control over their own health
- Multispecialty Community provider
- Integrated Primary and acute care systems (ACOs)
- Redesign urgent and emergency care
- Meaningful local flexibility

NZ: Alliance Contracting

- From mid 2013, New Zealand moved to implement a governance model across the entire country, aimed at integration.

- required an alliance between each DHB and corresponding PHOs (followed investment in nine pilots).

- The alliance concept derives from the construction industry, where independent companies collaborate, rather than compete, to ensure that large, complex projects are delivered on time and within budget.

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What should governance for integrated care look like? New Zealand's alliances provide some pointers

Multidisciplinary leadership teams and flexible approaches are helping streamline New Zealand's health care system

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While the search continues for governance arrangements that support health system and service integration,[1,2] developments in New Zealand provide useful new insights. New Zealand presently has 20 district health boards (DHBs) planning and funding regional hospital and other services, and around 30 primary health organisations (PHOs) that plan and fund elements of general practice and primary care for enrolled patients. These two sets of arrangements have functioned largely separately from one another, despite DHBs funding PHOs and both having common populations.[3] New Zealand's policymakers and health care providers have concluded that it is no longer acceptable nor sustainable to operate a health system with parallel structures that lack coordination or a governance model that supports this.

In response, from mid 2013, New Zealand moved to implement a governance model across the entire country, aimed at integration by requiring an alliance between each DHB and corresponding PHOs. This followed investment in 2010 in nine pilots. The alliance concept derives from the construction industry, where independent companies collaborate, rather than compete, to ensure that large, complex projects are delivered on time and within budget. While the health alliances are forced by policy, they are an example of an experimental governance model[4] that, evaluations of the pilots suggest, provide considerable promise.[5] For example, alliances have helped drive important new initiatives that provide better support for complex patients in primary care settings by enabling general practitioners to work together with hospital specialists and other providers. While early days, there is some evidence of reductions in emergency department admissions and of more services traditionally provided in hospital settings being delivered in the community, such as specialist outpatient consultations, older people's health, and emergency response services that might otherwise require a hospital visit. Importantly, those involved in alliances believe it is a model that helps steer health system and service design in an important new direction.[5,6]

Some important factors underpin the alliances. Members should:

- be clinical leaders from across the health system, with influence and respect among colleagues;
- have capacity to bring resources to the alliance table so decisions can be implemented; and
- very importantly, cast aside sectoral interests, work to assist one another, and take a whole-of-system approach to planning and decision making based on what is best for the patient and health system.

Alliance goals variously include shifting services from hospitals to primary care or creating new arrangements combining elements of both service domains to, for example, reduce avoidable hospitalisation or improve chronic condition management. The key, as noted, is to focus on and work towards what makes best sense in the context of integration to the players in the local health system.

All DHBs now have an alliance leadership team (ALT), membership of which is determined by the DHB and PHO and evolves as an ALT sees fit. Members are likely to include doctors, nurses, allied health professionals, others from hospital and primary care settings, and those with resources, such as the chief executives of the DHB and respective PHOs and consumer representatives. Each member signs a charter spelling out the rules of engagement and focus of the ALT, which then sets local priorities and plans how these will be met.

There is flexibility for how an alliance goes about its activities. Many ALTs are focused on developing service-level alliance teams (SLATs). These are work streams that include, again, a combination of clinical leaders and management. The Southern Health Alliance Leadership Team, of which I am Independent Chair, has chosen initially to create SLATs for acute service demand management; outpatient services; diagnostics; rural health; community and hospital pharmaceuticals; frail older people; and respiratory conditions. To illustrate how a SLAT functions, initial respiratory SLAT work involved a workshop including hospital emergency department and respiratory physicians, GPs, nurses and ambulance services. Resulting actions include identifying frequently hospitalised patients, providing nurse-led care plans for them and ensuring that the patient's GP and, where necessary, hospital services are involved in this, and developing primary care-based options for ambulance services. Development of web-based clinical pathways aimed at integration, involving health professionals from the primary and hospital sectors, is also governed by the ALT.

In the Canterbury region, where alliance development is more established, dozens of people from different parts of the health system are involved. With care design decided on advice of a SLAT, it is then up to the ALT and its member organisations to pool or shift resources to support new configurations. This process is being propelled by new flexible funding arrangements, whereby the PHO can use existing ring-fenced allocations in new ways as decided by the ALT. The DHB is expected to contribute to this pool which will grow with time, along with the level of joint risk sharing, as an alliance work program advances.

How alliance performance will be measured is an important question that the government is tackling. An impending

Online first 21/07/14

NZ: Alliance Contracting

- Important factors underpin the Alliances.
- Members should be clinical leaders from across the health system, with influence and respect among colleagues;
- have capacity to bring resources to the alliance table so decisions can be implemented; and
- very importantly, cast aside sectoral interests, work to assist one another, and take a whole-of-system approach to planning and decision making based on what is best for the patient and health system.

Alliance Contracting- early results

- Reduced ED admissions.
- Avoidable hospitalisations.
- Improved primary care support for complex patients in primary care settings.
- Improved Older People's health.
- Out-patients services in the community.
- Rural health.
- Pharmaceuticals.

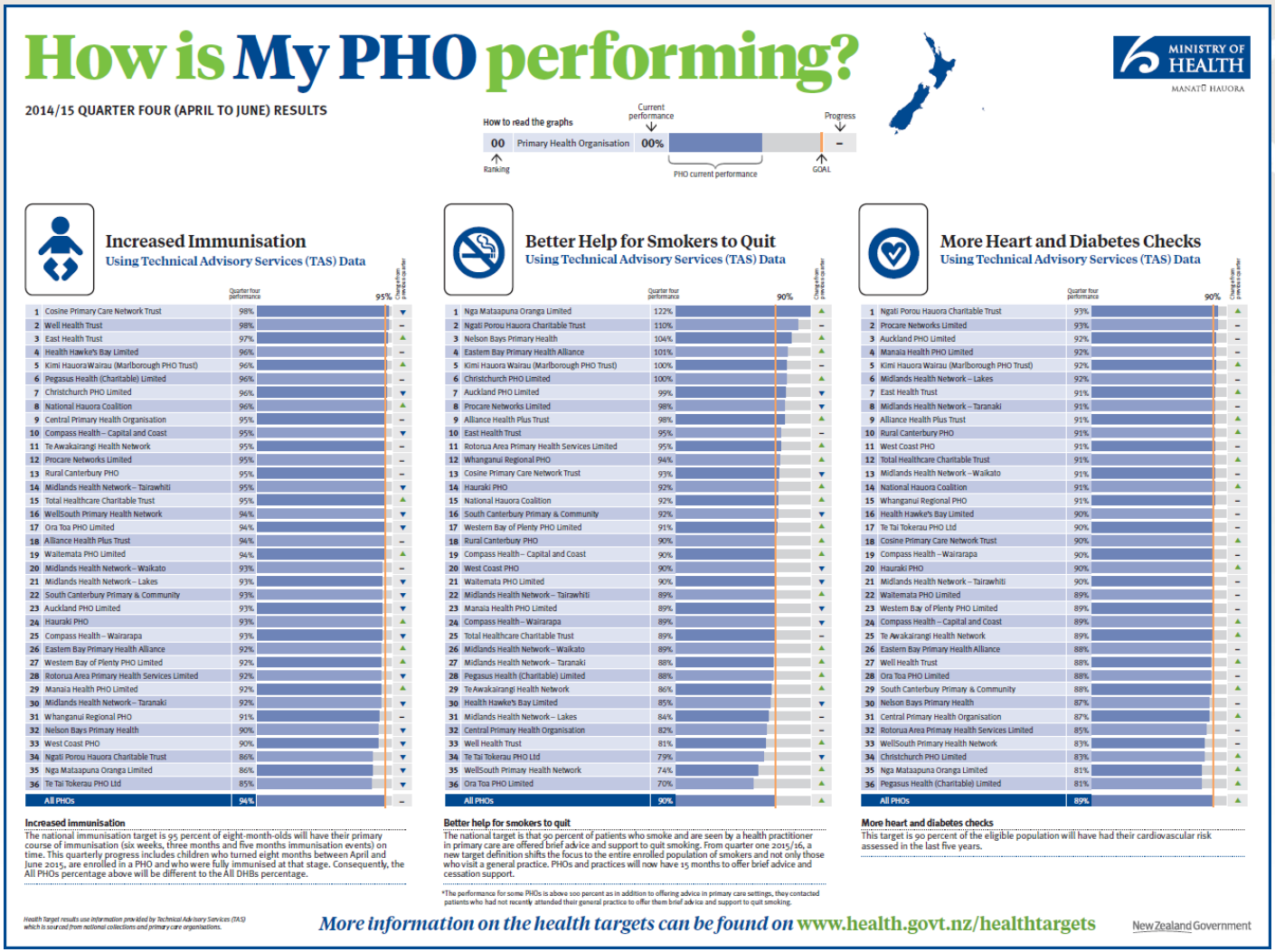
NZ: PHOs

- Primary health organisations (PHOs) are funded by district health boards (DHBs) to ensure the provision of essential primary health care services, mostly through general practices, to those people who are enrolled with the PHO.

- Currently there are 32 PHOs that vary widely in size and structure, although all are not-for-profit organisations. A PHO provides primary health services either directly or through its provider members. These services are designed to improve and maintain the health of the enrolled PHO population, as well as having responsibility for ensuring that services are provided in the community to restore people's health when they are unwell. The aim is to ensure GP services are better linked with other health services to ensure a seamless continuum of care.

- Some PHOs have recently amalgamated but still report separately, which is why 36 PHOs are shown in the How is my PHO performing? information.

NZ: PHOs



How is My PHO performing?

2014/15 QUARTER FOUR (APRIL TO JUNE) RESULTS

MINISTRY OF HEALTH
MANATŪ HAUORA

How to read the graphs

Current performance ↓ | Progress ↓

00 Primary Health Organisation 00% –

↑ Ranking | PHO current performance | ↑ GOAL

Increased Immunisation
Using Technical Advisory Services (TAS) Data

Quarter four performance | 95% | Change from previous quarter

1	Cosine Primary Care Network Trust	98%	▼
2	Well Health Trust	98%	–
3	East Health Trust	97%	▲
4	Health Hawke's Bay Limited	96%	–
5	Kimi Hauora Wairau (Marlborough PHO Trust)	96%	▲
6	Pegasus Health (Charitable) Limited	96%	–
7	Christchurch PHO Limited	96%	▼
8	National Hauora Coalition	96%	▲
9	Central Primary Health Organisation	95%	–
10	Compass Health – Capital and Coast	95%	▼
11	Te Awakairangi Health Network	95%	–
12	Procare Networks Limited	95%	–
13	Rural Canterbury PHO	95%	–
14	Midlands Health Network – Tairawhiti	95%	▼
15	Total Healthcare Charitable Trust	95%	▲
16	WellSouth Primary Health Network	94%	▼
17	Ora Toa PHO Limited	94%	▼
18	Alliance Health Plus Trust	94%	–
19	Waitemata PHO Limited	94%	▲
20	Midlands Health Network – Waikato	93%	–
21	Midlands Health Network – Lakes	93%	▼
22	South Canterbury Primary & Community	93%	▼
23	Auckland PHO Limited	93%	▼
24	Hauraki PHO	93%	▲
25	Compass Health – Wairarapa	93%	▼
26	Eastern Bay Primary Health Alliance	92%	▲
27	Western Bay of Plenty PHO Limited	92%	▲
28	Rotorua Area Primary Health Services Limited	92%	▼
29	Manaia Health PHO Limited	92%	▲
30	Midlands Health Network – Taranaki	92%	▼
31	Whanganui Regional PHO	91%	–
32	Nelson Bays Primary Health	90%	▼
33	West Coast PHO	90%	▼
34	Ngati Porou Hauora Charitable Trust	86%	▼
35	Nga Mataapuna Oranga Limited	86%	▼
36	Te Tai Tokerau PHO Ltd	85%	▼
	All PHOs	94%	–

Increased immunisation
The national immunisation target is 95 percent of eight-month-olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time. This quarterly progress includes children who turned eight months between April and June 2015, are enrolled in a PHO and who were fully immunised at that stage. Consequently, the All PHOs percentage above will be different to the All DHBs percentage.

Better Help for Smokers to Quit
Using Technical Advisory Services (TAS) Data

Quarter four performance | 90% | Change from previous quarter

1	Nga Mataapuna Oranga Limited	122%	▲
2	Ngati Porou Hauora Charitable Trust	110%	–
3	Nelson Bays Primary Health	104%	▲
4	Eastern Bay Primary Health Alliance	101%	▲
5	Kimi Hauora Wairau (Marlborough PHO Trust)	100%	–
6	Christchurch PHO Limited	100%	▲
7	Auckland PHO Limited	99%	▼
8	Procare Networks Limited	98%	▼
9	Alliance Health Plus Trust	98%	▲
10	East Health Trust	95%	–
11	Rotorua Area Primary Health Services Limited	95%	▲
12	Whanganui Regional PHO	94%	▲
13	Cosine Primary Care Network Trust	93%	▼
14	Hauraki PHO	92%	▲
15	National Hauora Coalition	92%	▲
16	South Canterbury Primary & Community	92%	▼
17	Western Bay of Plenty PHO Limited	91%	▲
18	Rural Canterbury PHO	90%	▲
19	Compass Health – Capital and Coast	90%	▲
20	West Coast PHO	90%	▼
21	Waitemata PHO Limited	90%	▼
22	Midlands Health Network – Tairawhiti	89%	▲
23	Manaia Health PHO Limited	89%	▼
24	Compass Health – Wairarapa	89%	▼
25	Total Healthcare Charitable Trust	89%	–
26	Midlands Health Network – Waikato	89%	▲
27	Midlands Health Network – Taranaki	88%	▲
28	Pegasus Health (Charitable) Limited	88%	▲
29	Te Awakairangi Health Network	86%	▲
30	Health Hawke's Bay Limited	85%	▼
31	Midlands Health Network – Lakes	84%	–
32	Central Primary Health Organisation	82%	–
33	Well Health Trust	81%	▲
34	Te Tai Tokerau PHO Ltd	79%	▼
35	WellSouth Primary Health Network	74%	▲
36	Ora Toa PHO Limited	70%	▲
	All PHOs	90%	▲

Better help for smokers to quit
The national target is that 90 percent of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking. From quarter one 2015/16, a new target definition shifts the focus to the entire enrolled population of smokers and not only those who visit a general practice. PHOs and practices will now have 15 months to offer brief advice and cessation support.

*The performance for some PHOs is above 100 percent as in addition to offering advice in primary care settings, they contacted patients who had not recently attended their general practice to offer them brief advice and support to quit smoking.

More Heart and Diabetes Checks
Using Technical Advisory Services (TAS) Data

Quarter four performance | 90% | Change from previous quarter

1	Ngati Porou Hauora Charitable Trust	93%	▲
2	Procare Networks Limited	93%	–
3	Auckland PHO Limited	92%	–
4	Manaia Health PHO Limited	92%	–
5	Kimi Hauora Wairau (Marlborough PHO Trust)	92%	▲
6	Midlands Health Network – Lakes	92%	–
7	East Health Trust	91%	▲
8	Midlands Health Network – Taranaki	91%	–
9	Alliance Health Plus Trust	91%	▲
10	Rural Canterbury PHO	91%	▲
11	West Coast PHO	91%	–
12	Total Healthcare Charitable Trust	91%	▲
13	Midlands Health Network – Waikato	91%	–
14	National Hauora Coalition	91%	▲
15	Whanganui Regional PHO	91%	–
16	Health Hawke's Bay Limited	90%	–
17	Te Tai Tokerau PHO Ltd	90%	–
18	Cosine Primary Care Network Trust	90%	▲
19	Compass Health – Wairarapa	90%	–
20	Hauraki PHO	90%	▲
21	Midlands Health Network – Tairawhiti	90%	–
22	Waitemata PHO Limited	89%	–
23	Western Bay of Plenty PHO Limited	89%	–
24	Compass Health – Capital and Coast	89%	▲
25	Te Awakairangi Health Network	89%	▲
26	Eastern Bay Primary Health Alliance	88%	–
27	Well Health Trust	88%	▲
28	Ora Toa PHO Limited	88%	–
29	South Canterbury Primary & Community	88%	▲
30	Nelson Bays Primary Health	87%	–
31	Central Primary Health Organisation	87%	▲
32	Rotorua Area Primary Health Services Limited	85%	–
33	WellSouth Primary Health Network	83%	–
34	Christchurch PHO Limited	83%	▲
35	Nga Mataapuna Oranga Limited	81%	▲
36	Pegasus Health (Charitable) Limited	81%	▲
	All PHOs	89%	▲

More heart and diabetes checks
This target is 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years.

Health Target results use information provided by Technical Advisory Services (TAS) which is sourced from national collections and primary care organisations.

More information on the health targets can be found on www.health.govt.nz/healthtargets

New Zealand Government

http://www.health.govt.nz/system/files/documents/pages/pho-q4-2014-15.pdf

Available online https://www.mja.com.au/journal/2014/201/3/supplement

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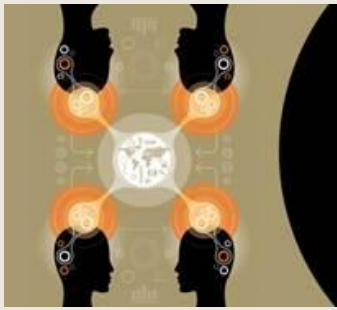

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Professor of Primary Care Health Sciences, Nuffield Department of Primary Care Health Sciences, UK

Dr Paul Grundy
Patient-Centred Primary Care Collaborative, USA

Prof Kevin Grumbach
University of California, San Francisco, Dept of Family and Community Medicine, San Francisco, USA

Dr Rachael Addicott
The Kings Fund, London, UK

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