
THE UNIVERSITY OF NEW SOUTH WALES
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# APHCRI 11 International Visiting Fellow

## Report

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# Introduction and purpose

The Visiting Fellow program aimed to contribute to the knowledge base and research capacity on the development of integrated models of primary health care and explore the implications for applied research, policy and practice in Australia.

The focus of activities o was to explore and learn from recent developments in primary healthcare reform in England and to a lesser extent New Zealand. The expected outcomes include strengthening the partnership with the English and New Zealand research groups on common research areas, and fostering linkage and exchange between the researchers and policy makers and practitioners within Australia.

The visiting fellow program involved bringing Helen Parker from the Health Services Management Centre (HSMC), University of Birmingham to Australia for a period of nine days from 27th August-5th September 2008. Helen has considerable knowledge and understanding of the range of emerging primary health care models in England, based on her current and applied research and consultancy work and prior employment in the NHS. Her visit coincided with shorter visits by Judith Smith, also from the HSMC, an internationally recognised expert on primary health care policy related research in the UK. Judith is currently at the end of a of a two year secondment with the Health Services Research Centre at University of Victoria, Wellington New Zealand, and is currently working in the New Zealand Ministry of Health as an adviser to government on primary health care reform.

The program of activities engaged researchers, policy advisers and practitioners at both national and state level. Meetings and forums were held in Sydney, Canberra, Melbourne and Adelaide (see appendix). Both Helen and Judith met with key stakeholders at APHCRI and the Department of Health and Ageing, while Helen participated in the whole program.

# Context for development in England and New Zealand

Political devolution in the UK has extended to health care reform and there are now considerable differences in the polices and approaches in each of the four countries. In both England and New Zealand there has been significant new investment in health and a focus on primary care associated with the election of Labour governments. Access to GP services was of concern, with cost barriers in New Zealand and lengthy waiting lists in England being the major causes. Health inequalities related to ethnicity and deprivation were also high on the agenda of the incoming governments, with these inequalities mirrored in patterns of access to general practice confirming the inverse care law.

## Profile of primary health care

In both countries while GPs are independent private businesses, but there are differences in their organisation and delivery. In England, patients are registered with a practice, while in New Zealand they register with a Primary Health Organisation. Practice nurses are an integral part of the practice team, and England has gone furthest with the core practice team including community nurses and health visitors employed by the Primary Care Trust (a statutory authority of the NHS) as well practice nurses. GP

accountability is strongest in England, with funding linked to quality and outcome indicators and comparatively weaker in New Zealand.

Community health services are characterised by their complexity in the mix of funding, management and service delivery arrangements. The multiple sources of funding from central and regional authorities, plus the range of private allied health providers, makes coordination difficult across community health services, let alone with general practice. In both countries, community health services have not been part of the primary health care reform agenda and the lack of investment in data sets or information systems means that very little is known about their performance.

**Table 1: Key characteristics of primary health care**

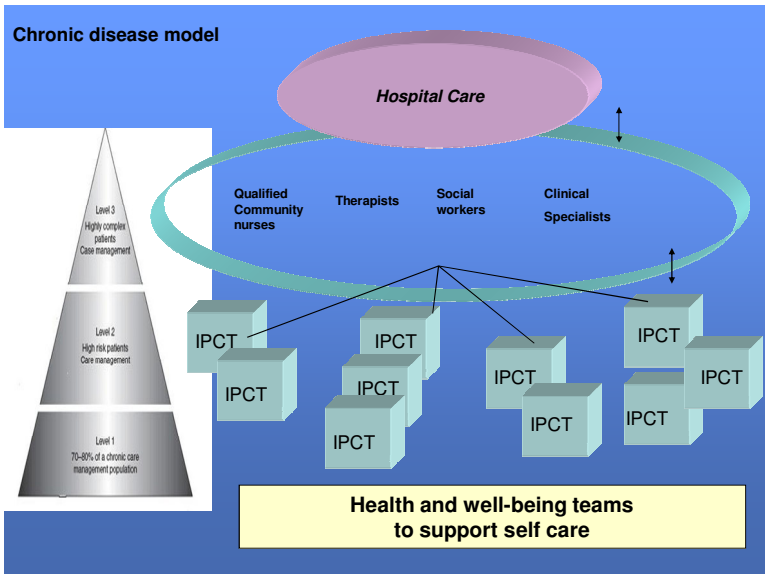
| | **Patient registration** | **Basic primary care unit** | **GP accountability** | **Community health services** |
|---|---|---|---|---|
| **England** | With practice | General practitioners<br>Practice nurses<br>Community nurses<br>Health visitors | Quality & Outcomes Framework | Mix of government funded and private sector services<br>Government funding through central and regional authorities<br>Delivered through government, NGOs & private fee-for-service providers<br>Little accountability |
| **New Zealand** | With PHO | General practitioners<br>Practice nurses | Weak | |

## Recent English reforms

The last ten years have been a period of intense reform. The healthcare budget has increased by nearly 50%; there have been repeated structural changes to primary care organisations; national targets to improve hospital care have been introduced as have and national care standards in range of service areas. The introduction of the Quality and Outcomes Framework (QOF), linked to funding, has created an important lever for change.

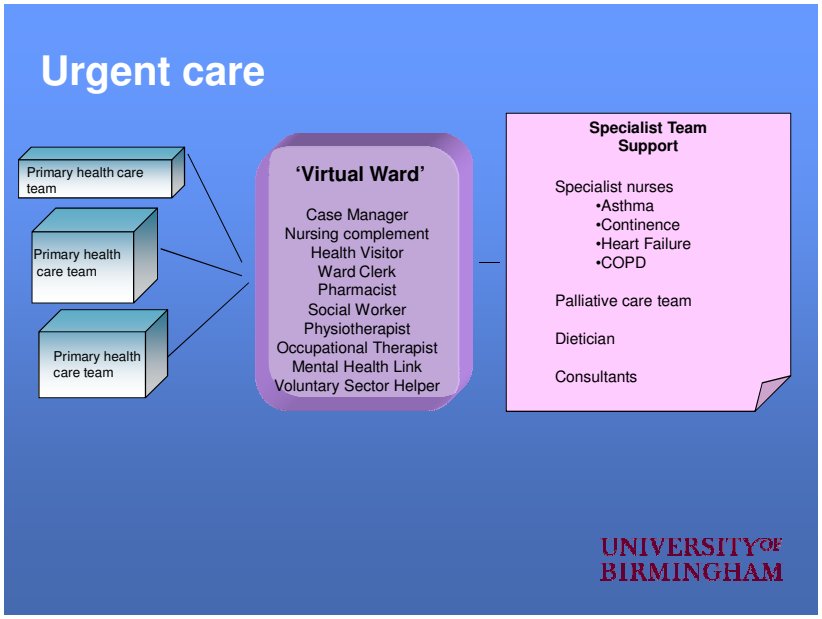
Integration developments have been stimulated by targets to reduce emergency admissions and shift care from hospital to community settings. Until recently there has been a focus on development of disease specific integrated services (e.g. diabetes, COPD), with specialist teams focusing on early intervention to prevent hospitalisation. There are signs this is now changing, with the development of more generalist approaches across chronic conditions where the practice-based primary care team is the basic unit on

which further vertical or horizontal integration is built. Two of the more generalist models being implemented include a chronic disease and an acute care model as illustrated in the following diagrams




The Integrated Primary Care Team (IPCT) comprises the basic primary care unit plus a social worker and mental health worker from the primary care trust who deliver levels 1 and 2 care as outlined in the diagram. They work in partnership with the enhanced care team of more specialised health care workers for highly complex patients needing case management.

The second model is for urgent care as depicted in the following diagram.




In this acute care model, workers from the primary care team and specialist team come together to form a 'virtual ward' and provide integrated services to keep patients out of hospital.

However, while there have been pockets of innovation and take up of models such as these, systematic change has not occurred. The recent review of the NHS led by Lord Darzi concluded that an unacceptable variation and consistency in quality remains and key issues to be addressed were outlined in the report entitled *High Quality Care for All,* released in June 2008. These issues include low adoption of innovation; a two-fold variation in inappropriate hospital admissions; GP access barriers, particularly for young people and workers; patient confusion in navigating through services; a lack of patient centredness and control over their care; weak governance and accountability for the patient experience and outcomes; and ill defined productivity measures.

The report also highlighted that the cost, activity and benefit of community services remains unknown. While this has been a long standing issue, the current policy focus on a primary care market and contestability requires the availability of comparable data that allows both purchasers and patients to make choices and decisions. Strengthening the community health services sector is part of the broader strategy to ensure there is a range of competitive primary health care options.

As part of the *NHS Next Stage Review*, a 10 year vision for primary and community care was released in July 2008 entitled: *Our vision for primary and community care (DH 2008)*. This ambitious primary care strategy focuses on a number of areas including the availability of comparative service data on both general practice and community health services to aid patient choice; productivity and value for money; service integration to achieve health (and social care) outcomes; and the patient experience and satisfaction as a measure of quality and linked to funding.

For the first time reforms to community health services will be on the agenda. A major initiative will be the development of a national data set to enable performance monitoring. The policy agenda to separate commissioning from provision is set to continue, which has implications for community health services still currently delivered by primary care trusts. As primary care trusts progressively withdraw from their service delivery role, it is not yet clear who will provide community health services. The options include: social enterprises; general practices; or other arrangements.

Pilot projects will be funded to test the purchasing of 'integrated care organisations' based around groups of practices responsible for a health care budget and shaping local services They will test and evaluate how purchasers can most effectively hold these 'virtual organisations' accountable for health outcomes, quality and patient satisfaction. The three major types of pilots will be:

1. GP practices and community health services with focus on 'predicting and preventing ill-health'
2. GP practices, community and hospital services to 'provide seamless care and high quality outcomes'
3. GP practices, community and social care services 'to provide integrated health and social care'.

The patient experience and journey will be measured via an annual patient survey and indicators linked to the QoF. This of course depends upon having patient registration.

## Recent NZ reforms

Primary health care became a national priority with the release of the Primary Health Care Strategy in 2001, with dual aims of improving population health and reducing health inequalities. Key elements included establishing 80 primary health care organisations (PHOs) to plan, fund and develop primary health care; the introduction capitation funding paid through PHOs; an enhanced focus on prevention and long-term support; significantly increased funding, including an additional $2.2 billion over seven years and additional money for rural services. This additional funding was intended to lead to reduction in patient fees and also prescription costs. There has been a stable primary health care policy environment since 2001 and the strategy remains very much a 'live' policy.

The evidence suggests that the aims are being achieved, with significant reductions in the cost of access to first-contact care, increased utilisation of primary health care services, a wider range of preventative services being delivered, greater focus on management of chronic conditions and apparent decreases in inequalities in health status. However, like the English experience, improvements have not been universal.

The implementation of the strategy has deliberately been a 'bottom up' and evolutionary approach, which has led to considerable diversity in the size oh PHOs, with registered populations ranging from less than 5,000-350,000 and a lack of clarity in relation to their roles. They have lacked the levers to shape what has happened to capitation funding at the practice level. The vast majority of PHOs have simply continued to pass on the funding received from the district health boards (akin to Australia's regional health authorities) to practices. There was also an unwillingness to challenge or negotiate the fee-for-service arrangements, and the process of rolling out new funding was played out amidst mutual mistrust between government and general practice. The lack of engagement of GP clinical leadership in the reform process did not help this atmosphere.

Other challenges include the patchy take up of new models of care in order to address chronic disease and more proactive care approaches. While PHOs are developing and delivering a range of services, including health promotion, it is not clear the extent to which the strengthening and extension of first contact care has occurred at practice level. Given New Zealand's population size, the overall infrastructure of 80 PHOs and 21 district health boards is also vulnerable in terms of capacity and sustainability.

Challenges facing the next phase of the strategy's implementation include the need to clarify the roles, functions and accountabilities of PHOs or types of PHOs, (including Independent Practitioner Associations (IPAs), which are GP member organisations, and the not-for-profit, community governed primary health care organisations, serving Maori, Pacific Islander and other disadvantaged communities), and in relation to the roles and expectations of district health boards. Clinical leadership in primary health care that includes general practice needs to be developed, that that goes beyond the 'fees issue'. Models of integrated primary health care provision could be tested, including alternative funding and budget holding approaches, and within a performance framework that can ensure value for money and quality nationally and that address chronic disease, proactive care and workforce pressures. Finally the recent change of government raises interesting issues regarding the future role of IPAs and their place in the strategy.

## Learnings and reflections for Australia

Recent Australian developments in linking general practice and community health services may learn from the experiences in England, where the core primary care team comprises a mix of private and public services, but which has not required the creation of new organisational entities to bring these groups together. The functional approach to developing the multidisciplinary primary care team and its focus on clarifying roles, contrasts with the structural approach being considered for GP Superclinics and HealthOne Centres. Having a nursing team as part of the core practice team has strengthened the capacity of primary care to provide an extended range of services and achieve the QOF indicators. This expanded team enhances the continuity of care across conditions and across the range of primary care providers, provides a broader base on which further integration initiatives are being built and has enabled a shift from specialist to more generalist models of care.

Australia may also learn from the experiences in both countries as part of the ongoing discussions about the level of government responsibility for differing service entities. As PCTs move away from their service delivery role, this raises questions about the future of community health services and options are being explored for where they will be located in the system. English developments maybe pertinent to recent discussions in Australia about level of government responsibility for different health programs areas.

The New Zealand experience of multiple structures with responsibility for primary and community health services is akin to Australia's. Both countries have meso level PCOs with some level of responsibility for general practice, although their levers for change are relatively weak. Community health services are predominantly the responsibility of regional health authorities and have not been the subject of much reform. Planning and development of integrated and coordinated primary healthcare services thus remains a challenge. Attempts in New Zealand to move community health services to PHOs have been unsuccessful to date: there has been considerable public resistance and fear that public services were being privatised. This experience the highlights the importance of ensuring genuine public engagement and participation in reforms to better integrate primary and community health services.

The appropriate mix and balance of top down and bottom up reforms has been a challenge in both countries. While England has adopted more of a top down approach and New Zealand more a bottom up style, in both instances the take-up of evidence-based innovation has been patchy, and there remains considerable variation in quality. Recent Australian primary health care integration developments such as GP Superclinics, HealthOne Centres and GP + Centres are largely bottom up initiatives, albeit it within state/national level guidelines. There is a risk that, like PHOs, there may be considerable variation in their capacity and sustainability and a lack of clarity regarding their relationships with other parts of the primary care and community health sector.

The linking of funding to outcomes is a powerful lever for change. This has been more realised in the English than New Zealand system. It has also largely been confined to general practice. The proposed development of a national data set for community health services in England will for the first time enable the performance and productivity of this sector to be monitored and the development of an outcomes focus. Given the underdevelopment of the community health sector in Australia and lack of high quality data, much may be learned from this English initiative.

The assigning of accountability for patient outcomes and experiences to multidisciplinary teams operating as 'virtual organisations' that will be tested in the English integration pilots, involves quite a shift in thinking. Establishing and maintaining links with people involved in the implementation and evaluation of these pilots could be very useful.

Finally, engaging clinical leadership in the policy reforms has been less of a focus in both England and New Zealand, and has weakened GP support for the primary care reform agenda. For instance, the take up of practice-based commissioning has been slow in England, and despite the somewhat implicit expectation that IPAs would largely disappear with the introduction of PHOs, this has not been the case, and has added to the lack of clarity and confusion about the roles and authority of PHOs. The GP voice in the Divisions' movement remains strong, but this clinical leadership has not extended to other professions, despite increases in the number of practice nurses and the fact that team care arrangements for people with chronic and complex conditions extends the team to involve other allied health providers. There are challenges for Divisions in achieving a balance between meeting the needs of their dual constituencies: members and the Commonwealth government. The demise of the General Practice Partnership Advisory Council has also meant that there has been less of a GP voice in influencing the primary care policy agenda. The establishment of an expert reference group for the development of the primary care strategy is a positive initiative. However ongoing mechanisms to support the engagement of GPs, nurses and allied health professionals in the primary health care reform agenda are still lacking.

## Conclusion: watch this space

Developments in England and New Zealand that are pertinent to Australia and are worth keeping abreast of include:

- The proposed community health reforms in England including the development of a national data set for community health services and the associated performance measurement; and options being explored as to where they'll be located as PCTs move away from their service delivery role.
- The pilot projects in England to test the development of more integrated services and the creation of 'virtual organisations' that are held accountable for the patient experience and outcomes.
- The future of PHOs and their relationship with IPAs and the 3rd sector primary health care services.

# Appendix: Timetable of visits

| Date | Name of institution | Activities |
|---|---|---|
| Wednesday 27/08<br>Sydney | CPHCE (Sponsor)<br>(Helen Parker) | Informal meetings between staff and Helen Parker re information exchange on work of both research Centres and opportunities for furthering links |
| Thursday 28/08<br>Sydney | CPHCE<br>(Helen Parker) | Forum: Integrating primary health and community services in England - an insider's perspective.<br>Presentation, followed by discussion<br>Attendees: CPHCE staff, NSW Health, Alliance of NSW Divisions, divisions of general practice and, and area health services |
| Friday 29/08<br>Sydney | CPHCE<br>(Helen Parker | Informal meetings with Centre Directors re linkage & exchange systems, processes and research interests |
| Monday 01/09<br>Canberra | DoHA (am)<br>(Helen Parker, Judith Smith) | Seminar on NZ & UK experiences with integrated PHC models<br>Meetings with representatives from the PC Strategy Branch, including those involved in the development of the PHC Strategy and GP Superclinics |
| | APHCRI (pm)<br>(Helen Parker, Judith Smith) | Informal meeting with Director and staff<br>Public lecture on English and New Zealand reforms, with attendees from APHCRI, area health services, ANU |
| Tuesday 02/09<br>Sydney | CPHCE<br>(Helen Parker, Judith Smith, Jackie Cumming, Julie McDonald) | Workshop with team re collaborative research project on a cross country review of integrated PHC models |
| Wednesday 03/09<br>Melbourne | Department of Human Services, Victoria, Primary Health Branch<br>(Helen Parker, Julie McDonald) | Linkage and exchange meetings with representatives from the Primary Health Integration Unit, including the Partnerships Team, as well as representatives from General Practice Victoria, the Australian Institute of Primary Care (Latrobe University), selected divisions, community health services involved in PCPs. |
| Thursday 04/09<br>Adelaide | Department of Health, South Australia<br>(Helen Parker, Julie McDonald) | Linkage & exchange meetings with representatives from GP Plus strategy & operational areas<br>Visit to a GP Plus Centre |
| Friday 05/09<br>Sydney (am) | CPHCE<br>(Helen Parker, Julie McDonald) | Reflection on the visit, and implications for the cross country comparison review, and discussion on future research linkage & exchange opportunities |