

"Towards a new generation of private health care in Australia"

Primary Health Care and the Private Patient Journey

2011 WORKSHOP REPORT

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EXECUTIVE SUMMARY



The workshop “*Primary Health Care and the Private Patient Journey*”, held on 2 March 2011 in Melbourne, gathered representatives from primary health care, private hospitals, peak bodies, policy think tanks, researchers and private insurers.

It was organised by the Australian Centre for Health Research (ACHR) and public policy network Global Access Partners (GAP) with a view to foster a common understanding of shared interests and identify consensus on the significant contribution the private sector can make to sustainable improvements in primary care.

The workshop further explored the issues that emerged via an extensive stakeholder consultation commissioned by the ACHR and led by external consultant Associate Professor Leanne Rowe AM in the lead-up to the workshop. The outcomes of the consultation were presented in a research paper circulated in advance to all workshop participants to inform discussion on the day.

The following report of proceedings represents a range of views and interests of the individuals and organisations participating in the workshop. They are personal opinions that do not necessarily reflect those of the organisers and sponsors of the workshop and it should not be assumed that every participant would agree with every recommendation in full.

Workshop Key Findings

- ▶ The importance and effectiveness of primary health care is acknowledged worldwide, but Australia's fractured system is proving difficult for patients with chronic and complex problems to navigate. **9.3% of hospital admissions could be avoided, if chronic disease was better managed in the community.** *The National Primary Health Care Strategy* is a step in the right direction, but an overarching primary care strategy must have the full support of private and public providers, general practitioners (GPs), pharmacists, community health services and other stakeholders.

- ▶ 48% of citizens have private insurance. The insurance and private hospital sectors are both profitable and expanding in size and capability, but there remains a constant need to restrain the inexorable growth in costs. This can only be achieved through **greater efficiency, driven by e-health innovations and cooperation with all parts of the health sector**. Although private insurers, private hospitals and primary health organisations comprise a large number of individual concerns, each with their own agenda and interests, all stakeholders share an interest in moderating costs and pursuing excellence in patient care.
- ▶ The public sector is engaged in major systemic reforms embracing e-health and other measures. This presents both great challenges and opportunities to **private insurers, hospitals and providers**, and their involvement in ongoing discussions is vital if they are to help shape their own future. Private providers remain proud of their independence, and any willingness to engage with bodies such as Medicare Locals should not be seen by public authorities as a license to dictate terms. However, the short-term risks of wholehearted involvement today may be dwarfed by the long-term consequences of being left behind by the health care revolution of tomorrow. Strict differentiation between purchaser and providers is already eroding and even **organisations in direct business or clinical competition must learn to cooperate in e-health and other matters for their mutual benefit and the public good**.
- ▶ **Specialists** constitute a crucial interface between the primary health and private hospital sectors. Despite initial scepticism, independent GPs have begun to benefit from common systems over recent years, and specialists in private hospitals should also be encouraged to meet common standards to improve information flows and post-care plans. **Preventive health information and management options should be evidence-based** and a united approach to health assessment based on the Royal Australian College of General Practitioners (RACGP) guidelines would reap dividends.
- ▶ **Patients should be the centre of any health care system, and cooperation between stakeholders to ease the 'patient journey' is vital**. They are particularly vulnerable when transitioning between care providers if critical information is not transferred with them but e-health communications can empower "joined up care". The work of the National e-Health Transition Authority (NEHTA) and others to create common standards for referrals and other e-documents is driving this agenda, but the introduction of IT solutions into the private sector must be funded properly. **Targeted incentives and technical and organisational support from government and representative groups should be offered as widely as possible to ease and facilitate change**.

- ▶ There is **scope for further discussion** of topics of mutual interest which emerged from the workshop, notably e-health, IT, service gaps, the expanding role of health funds and better advocacy of the private sector's role in pursuing quality of care. Such meetings could hone an implementation strategy and promote 'smart', productive, low cost e-health and related solutions. Workshop conveners ACHR and GAP indicated their willingness to support future events and other stakeholders are invited to contribute and participate in the future and online.

REPORT OF PROCEEDINGS



Introduction

Mr Alan Castleman, Chairman of the Australian Centre for Health Research (ACHR) and private insurer Australian Unity, welcomed participants to the workshop. A non-partisan group supported by a number of Australian health funds and hospital groups, the Pharmacy Guild of Australia and the Australian Dental Association, ACHR facilitates discussion and research into important health issues, acknowledging the importance of health to the Australian economy and people. He accepted that Australian health care is inefficiently organised, due to its complicated mix of public and private provision and the large numbers of organisations involved, noted that primary health care has received little attention until recently and hoped the day's discussion would prove fruitful. He acknowledged the partnership with GAP which had facilitated the event before introducing Dr Heather Wellington, the workshop facilitator.

Dr Heather Wellington said the workshop had brought together a range of experienced and talented people from primary health care, private hospitals, peak bodies, policy think tanks, researchers and insurers. It would focus on the private sector, rather than the much discussed role of the public sector, and aim to generate specific actions and solutions. Its purpose was to foster a common understanding between stakeholders regarding progress and directions in primary health reforms, share information about key issues and opportunities to improve private care and its interface with other facets of the system and consider the roles of prevention, chronic disease management and information technology. Above all, it should **identify consensus on how the private sector can best contribute to sustainable improvements in Australia's primary health care system**. She then introduced the first of two initial presentations.

The National Primary Health Care Strategy – Dr Tony Hobbs



Dr Tony Hobbs acknowledged the excellent work of Dr Leanne Rowe before offering a brief overview of the *National Primary Health Care Strategy*. He noted that the current focus on primary health is not unique to Australia. Over the last twenty years, there has been international recognition that well organised, adequately funded primary health care improves public health outcomes and buttresses health system sustainability. The World Health Organisation (WHO) produced a paper in 2008 on this topic. Dr Hobbs also recommended the work of Barbara Starfield, professor of Health Policy and Management at John's Hopkins University. Australia needs an overarching primary care strategy to organise the disparate private and public providers, GPs, pharmacists, community health services and others, as the system is clearly proving difficult for patients with chronic or complex diseases to navigate.

The Australian Institute for Health and Welfare has shown that **9.3% of hospital admissions could be avoided if chronic disease were better managed in the community**. The government issued a discussion document in 2009 to this end, but although Australian Unity and Medibank Private responded with comments, as did 265 other interested parties, many other private providers spurned the opportunity to join the conversation.

The current *Primary Health Care Strategy* is based on that work and has five key building blocks involving regional integration, information and communication technology, a skilled workforce and improved infrastructure, financing and system performance. Regional integration involves the creation of *Medicare Locals* – primary health care organisations – at a regional level to improve service delivery and reduce differences in health outcomes through better population planning and the targeting of services to areas of need. **Private insurers and hospitals could join the existing partnerships of GPs, community health services and jurisdictional health networks to further improve service delivery.**

IT and communication technology, including, but not limited to, e-health, can play a vital role. A more effective health system demands modern data processing and messaging capabilities for doctors and patients alike. Both health care professionals and patients should have access to critical information and be able to add to it or amend it in a secure way. E-health records will find any number of useful applications, from allowing treatment prompts to be sent to individuals to helping health professionals track the delivery of care in local areas and compare results against wider benchmarks.

Health professionals, be they doctors, nurses or other workers, can make best use of their skills and deliver improved health outcomes when playing clear roles as part of multidisciplinary teams. Improving the capabilities of the entire medical workforce is crucial and *Health Workforce Australia* has been instituted to examine the issue nationwide, while the government has already taken action around nurse practitioners and midwives. Funding changes for doctors, nurses and practice nurses should also improve service delivery. The government has invested in *GP Super Clinics* and expanded practices, although implementation has been problematic in some areas.

Investment in infrastructure will allow the co-location of teams, enable their internet communications and accustom young health professionals to working in teams. Hospitals are already too overloaded to assume further training burdens, but **primary health care is an untapped venue for effective undergraduate training.**

In principle, the use of multidisciplinary teams, extra investment, better teaching and expanded IT should drive progress towards government's stated goal of improved health outcomes delivered in sustainable ways. The performance, quality and safety of hospitals has been a major issue in the recent past and the same focus will be applied to the primary health care sector in the near future.

The Government's four key priority areas for improved primary health care include improving access and reducing inequity. Australia's health system is the envy of the world in many respects, but **services and outcomes in marginalised populations are slipping behind the mainstream.** Exclusion can result from geography, as one third of the population live outside the main urban areas, socio-economic factors and income, indigenous status or mental health issues. Better management of chronic disease is another priority area as it now accounts for 80% of the burden of disease. Chronic disease can comprise half a GPs workload and this will be exacerbated as Australia's population continues to age. An integrated system will allow people to better manage their own conditions. **Health literacy has a role to play, and there is a major opportunity for private health insurers to become involved in supporting care plans with GPs and others.**

Prevention is another key target. A National Preventative Health Agency was legislated this year while the Preventative Health Report tackled issues including smoking, obesity and alcohol abuse. Primary care, private health insurers and others can drive further action. The final area encompasses “Quality, Safety, Performance and Accountability”. The Australian Commission on Safety and Quality in Health Care has been created as a permanent legislative body and is taking a new interest in primary care. While accreditation has long been established, new measures regarding clinical governance and safety are now being considered. Though the performance focus in the past has centred on activity, attention is now switching towards improving community health outcomes. *Medicare Locals* will be required to produce an annual report showing how they have improved care in their area.

There are clear opportunities for private insurers and hospitals to become more involved in these strengthening networks of care, with better communication between hospitals and primary care providers an obvious priority. A more integrated system of prevention, health promotion and chronic care management must evolve. Private providers can still usefully contribute to the debate, as many issues remain unresolved including Council of Australian Governments (COAG) discussions regarding a 50/50 split in health funding and the number of Medicare Locals required.

Advice offered to patients from insurers must be consistent, reflect best practice and be integrated with GP care plans. Better communication with private hospitals is vital and the proposed e-referral and e-discharge schemes should reduce medication mistakes and improve post-hospital care.

Discussion

The growing role of private insurers in health care provision was discussed through questions from the floor. Though insurers have traditionally limited themselves to paying bills, rather than becoming involved in health care itself, they have become more involved in their customer's treatment options in recent years and should become more proactive in the future. Federal and State government have still not taken this change fully into account, with the Health department still apparently concerned only with the level of charges, rather than any benefits offered by insurers. Federal and State Governments see themselves as responsible for the public health system and all too often appear to have little regard for private provision. Governments should take a more positive view of the contribution private organisations can make in improving overall health care. Public and private care should cooperate, rather than compete, or act as complimentary systems. The public system is clearly more coordinated than the private one, and this is an important issue private organisations must recognise and address.

Shared issues for health consumers, primary health care, private insurers and private hospitals – Adj. Assoc. Prof Leanne Rowe AM



In the second presentation of the day, **Dr Leanne Rowe AM** sought to identify the agenda shared by the four major stakeholder groups of private hospitals, health insurers, primary care providers and consumer organisations. She outlined three reasons why these groups must discuss primary care issues and cooperate on driving solutions. Firstly, she believed the Australian private health care system to be unsustainable in its current form, due in part to increasing costs, the burden of chronic disease and Australia's ageing population. Secondly, there will be an inevitable funding and clinical shift from public hospital care to community care and, thirdly, an ongoing dialogue is vital if individual patient care is to be improved.

She illustrated her argument with the patient journey of a man with prostate cancer, now diagnosed in one in five men at some stage of their lives. While patients invariably praise a private hospital's performance, given their shorter waiting times, access to 'high-tech' surgical intervention and comfortable living conditions, a more negative clinical picture emerges if the problematic transitions between private and community care are taken into account. Prostate cancer is often diagnosed late, due to confusion regarding the need to undergo cancer testing. Men receive conflicting advice on such procedures from different providers and are often not given a fully informed choice. Such confusion could be reduced with a more co-operative approach between public and private health concerns. There is also variation in the type of care offered, with private patients more likely to receive sophisticated surgical intervention, costing an extra \$12,000, despite international medical literature failing to demonstrate improved outcomes. There is also a lack of proper discharge planning for common post-operative complications, both physical and mental, and though care plans are required to manage these and have proven successful, many men 'suffer in silence'. Finally, the interface between private hospitals, chronic disease management programs of health insurers and private care is vital in palliative care and end-of-life planning.

Isolated general practice is not structured to manage complex chronic disease and continuity of care, after hours care and home monitoring and home-based attention tend to be underdeveloped for patients discharged from private hospitals. This archetypical 'journey' argues the case for **better access to evidence-based health information and treatment options, improved communication between hospitals and primary care, the uptake of multidisciplinary health care plans and closer collaboration between providers.**

Dr Rowe hoped the workshop would address a limited number of tangible solutions, rather than attempt to redraw the whole system, and answer questions which emerged from the consultation paper presented to attendees. These included consideration of how private hospitals and insurers could collaborate to improve access to comprehensive preventive health assessment, chronic disease management and communication initiatives. She urged the dissemination of evidence-based preventive health information and management options and the adoption of a standard approach to preventive health assessment based on guidelines issued by the RACGP and the Medicare guidelines on care plans and case conferencing. She underlined the need for e-initiatives, particularly e-discharge planning.

She recommended **expanding current models of best practice, including 'Hospital in the Home' and GP Partners Team Care to improve the interface between primary care, private hospitals and health insurers.** In closing, she noted that the private sector comprises an impressive range of diverse organisations, including hospitals, doctors, dentists, pharmacists and allied health professionals, while there are 26 private health care insurers catering for 10 million customers. If such groups cooperate, they can form a powerful voice to advocate mutually beneficial change and take leadership in health reform.

Discussion



In answer to an observation noting a separation between private insurers and hospitals on the one hand, and GPs and allied health professionals on the other, Dr Rowe agreed that the lack of a real funding relationship between them led to a lack of common ground in other issues. This only emphasised the value of the current workshop in identifying and pursuing a shared agenda.

Another speaker from the floor questioned the apparent assertion that private clinical care was flawed in the ways outlined and invited a rebuttal. An insurance industry representative agreed that while private hospital care was excellent, **post-discharge care needed improvement**. It was noted that specialists were essentially individual practitioners with little consistency between them in terms of the clinical decision support system. **The system of referrals between GPs, hospitals and specialists should play a central role in the discussion and the answer could lie in new e-health provisions.** The boundary between the insurer's and specialist's obligations to the patient's health care after discharge remains an ongoing debate.

It was acknowledged that private hospitals attending the workshop were undertaking excellent work, but that best practice is not universal. The mission statement of Melbourne's Cabrini Health was praised for targeting 'unmet needs', as was the openness of its staff in discussing how they can better serve the community. The point of the workshop was not to criticise any particular sector, but to identify how all sectors could work together to improve patient care. It was agreed that the lack of post-discharge care from private hospitals was often related to variations between the attitudes of individual specialists, rather than overall hospital policy.

In respect of dentistry, it was pointed out that many patients pay for private health services, such as dentistry, without being members of private health funds. Most dentists are in private practice and provide a higher standard of care than the emergency based, underfunded public sphere.

An insurance representative argued that all stakeholders were obviously and most importantly connected by the patient and people they served in the community. Everyone was concerned about improving patient care, the question was how individual private actors could work together to achieve this. **The differentiation between public and private is somewhat illusory, as 60% of the public health budget is spent on private health care**, while a great deal of private health care is delivered by doctors, dentists and others without any need for hospitals or community health centres. It cannot be assumed that terms such as public and private sector have distinct monolithic meanings without the connection of the consumer.

It was agreed that strict definitions of what constituted a private patient were unnecessary and that Dr Lowe's paper had acknowledged **the blurring of public and private boundaries**. This factor explained why quality of care had been the focus of the prostate cancer case study. The need to look for solutions was stressed, as it had been commonly agreed that there were problems which needed to be addressed.

Another speaker believed that peak bodies would not share a common focus except where it related to individual patients. He favoured **the adoption of regional projects with hospitals as a central entity in each local area** as problems could not be solved by government from the top down.

It was pointed out that GPs rarely know if a patient is privately insured or not and have no need to know until a referral to a public or private hospital is made. General Practice itself lacked coordination in care until the creation of the divisional network, and it was suggested the private hospital system could follow this organisational lead. Public hospitals use interns to write discharge summaries, but there is no similar system in private hospitals to ensure such summaries are properly completed, with paperwork left to the individual specialist involved. **An expectation of proper discharge summaries by hospitals had proved effective** in generating the correct documentation in some areas, and this could be leveraged throughout the private hospital system.

It was acknowledged that a competitive element between private hospitals, private insurers and primary care had previously been to the fore, rather than any co-operative ethos. Private hospitals and insurers argue over costs, while community-based and hospital-based care compete for market share. Though the importance and centrality of patient choice was clearly paramount, some felt that technology could connect the sectors in a de-facto manner without grand pledges of cooperation.

Given the general agreement that common interests had to be found among the different purposes which different service providers fulfilled, the example of **identifying habitual over-users of health services and coaching such “frequent flyers” in better chronic disease management techniques** was put forward. A need to rebuild community infrastructure was raised as GPs have lost much of their former role in primary care. Programmes such as ‘Hospital in the Home’ are essentially hospital outreach programmes and could become part of the community by involving GPs. The importance of acute units in ‘Hospital in the Home’ programmes was also stressed and the Silver Chain model was discussed. Epworth Hospital in Melbourne offers GP run clinics which allow prolonged consultations and are popular with patients and GPs alike.

With the focus on the patient journey, particularly for those who have multiple problems and ongoing interactions with public, private, hospital and community provisions, the aim should be to provide patients with the right people at the right time at the right place to provide the best healthcare. This will inevitably involve a piecemeal solution of both public and private care and, as GPs, private hospitals and specialists are all frustrated by the current system, new ways have to be found to facilitate it. **An optimised system depends on the sharing of information** which, at present, tends to sit in isolated and incompatible databases with the various health stakeholders, all of whom would benefit if such information could be shared as required. The GP Partners Programme is based on sharing and improving such information to drive care planning and demonstrates the potential of similar approaches. The potential such information sharing schemes present for improved population health planning should be fully exploited to create individual and regional solutions.

About 80% of a private hospital's patients come through specialists and so the hospital's relationships with its individual specialists are vital to its ongoing business. Hospitals do not make judgements about clinical need, leaving those decisions up to the specialists who are in charge of patient care during their hospital stay. Specialist practice remains ‘a cottage industry’ with no consistency in the way they refer back to GPs. The rules around referrals remain ill-defined, but hospitals have little leverage to change this. It was suggested that GPs have been locked out of all hospitals in recent years and deprived of the ability to manage the care of their patients. GPs in Melbourne do not have access to private hospital beds and are forced to go through a specialist. This is another problem with the ‘Hospital in the Home’ programme, as GPs have to refer the patient to a specialist at the hospital. Insurers pay fees for hospital care and have no role to play in fees charged by GPs or specialists in their consulting room. Patient with cancer, for example, may see oncologists many times and opportunities to improve links to GPs to manage their care clearly exist and should be developed. **The ACHR has been developing e-discharge summaries for private hospitals which help forge a direct relationship between private hospitals and GP.**

Other participants were less optimistic, noting that the current system provides a good living for all concerned despite its inefficiencies, creating no financial imperative to reform it. The only organisation with a real motivation to press for change is the Health Department. Preventative education should not be seen as a panacea to financial or clinical problems. The bulk of health spending on any individual comes in the last two years of their life and preventative health measures can only postpone this expenditure, rather than eliminate it.

While some private hospitals are seen as surgery factories and others seek to vertically integrate the health care system, other speakers stressed the picture was not universally bleak. There are 530 private hospitals in Australia and some of them do have close relationships with local GPs. E-health had permeated GPs surgeries because they were given incentives to adopt it, and similar incentives would encourage private hospitals to adopt similar solutions, even those as simple as ensuring secure wireless internet coverage throughout the hospital. **Funding, rather than a lack of interest, is the major barrier to adoption** although, as previously mentioned, the lack of a junior medical workforce in private hospitals to produce comprehensive documentation remains a major problem.

The idea that the more power is given to patients, the better their health outcomes become was explored. The Dutch system of 100% health insurance ensures the patient journey belongs to the patient in question, rather than the health department bureaucracy. Some felt that, however useful proposed e-health schemes were, a chance had been missed to transform patients from recipients to participants in care. Non-governmental avenues should also be more widely harnessed. Microsoft serviced far more Australians with information than government health sites during the bird flu health scare.

Others felt that the interests of consumers had been underplayed compared to those of clinicians. Australians now pay \$17 billion a year in out-of-pocket charges and it was agreed that informed consumers would 'vote with their feet' and force service providers to change. There will inevitably continue to be a mix of funding models and instead of aiming for perfect all-encompassing solutions, **a much simpler set of standards for reporting on key issues in different diseases would improve care**. Technology can enable these solutions as long as accessible personally controlled electronic health records are simple and effective. IT experience shows that **standardisation, rather than creating extra interfaces, is the preferred solution**. Assuming that information is the lifeblood of healthcare, the question should be how information can be standardised and made available to all who need it, including the patients themselves.

Preventive Health and Chronic Disease Management in Primary Care – Prof Michael Kidd AM



Dr Heather Wellington restated the topics under discussion and summarised the discussions so far, before inviting **Prof Michael Kidd AM** to offer a global perspective on preventive health and chronic disease management in primary care. Prof Kidd shared developments from around the world and highlighted their lessons for Australia. Preventative health and primary care is as old as medicine itself. Hippocrates, 'the father of medicine', noted that sudden death was more common in overweight people over 2,000 years ago and the observation is more pertinent than ever today. Though the Australian Bureau of Statistics report that 84% of the population rate their own health as good or excellent, 60% never exercise, more than half are overweight, nearly a quarter still smoke and a significant percentage consume risky amounts of alcohol.

The WHO recognises that primary health care facilitates ongoing relationships between patients and clinicians and opens opportunities for prevention and health promotion and the early detection and effective management of chronic disease. It relies on coordinated teams of health professionals, and Australia is seeing an increasing move towards team care in this area. It also requires adequate investment, but provides better value for money than its alternatives. Australia is seeing some shift in funding, but heavy investment in a relatively small number of 'super-clinics' will not deliver benefits to all Australians.

There have been welcome federal reforms in recent years, including the *National Chronic Disease Strategy*, which directs some Commonwealth funding towards improving the management of chronic disease, and the recent creation of the Australian Preventive Health Agency. Australia's new *National Primary Health Care Strategy* targets the management of chronic disease, access, inequity and the safety, quality and accountability of health care. These are far from novel ideas, with GPs traditionally instructed to see every consultation as an opportunity to encourage prevention.

“Principles of General Practice” encourages GPs to see themselves as part of a network of community health care providers, to cooperate with others in chronic health care and view their patient population as a population at risk. English physician and academic Ian McWhinney also opined that doctors should 'share the same habitat' as their patients – to understand a community's needs, one must be a member of that community.

UN members pledged to create or maintain strong systems of primary care in the Alma-Ata Declaration of 1978, with the goal of 'health for all by the year 2000'. Unfortunately, decades of global failure to invest in health infrastructure, services and human resources have ensured that a billion people will still lack access to health care workers throughout their lives.

Given the failure of 'Health for All', the UN's “Millennium Goals” include a reduction of child mortality, the improvement of maternal health and the fight against AIDS, malaria and other infectious diseases. It is accepted that **the UN targets lack a focus on chronic disease, an ever more important factor in morbidity and mortality around the world.** By comparing data on health care systems in both developed and developing countries, Prof Barbara Starfield has demonstrated that a greater focus on primary services can control the overall cost of health care, improve community health outcomes and reduce inequities. A special session of the UN in September 2011 will focus on chronic disease, the first time in over a decade that the UN General Assembly has specifically addressed a health issue.

The WHO's World Health Report of 2008 was dedicated to the reinvigoration of primary health care. It highlighted four areas of attention for developed and developing countries alike: universal coverage, people centred rather than disease oriented systems, reliable and accountable health authorities and community health promotion. It also identified five common shortcomings of 'inverse care', 'impoverishing care', 'fragmented care', 'unsafe care' and 'misdirected care'.

'Inverse care' occurs when the people with the greatest means consume the lion's share of health resources, while those with greater needs receive inadequate services. Public spending on health services all over the world tends to benefit the rich over the poor, and people in rural or remote areas of Australia often have less access to services compared to those in urban centres.

'Impoverishing care' sees patients paying out of their own pockets for care at the point of service, meaning an accident or bout of ill health can inflict catastrophic expenses. This can affect Australians confronted by sudden and serious disability, but recent reforms in disability support should ease such impacts in the future.

A common tendency in developed nations including Australia, **'fragmented care'** sees excessive specialisation of health care providers and a narrow focus on specific diseases. This discourages a holistic approach to individuals and families and hampers continuity in care.

'Unsafe care' involves poor system design leading to adverse and avoidable effects, while **'misdirected care'** sees undue resources given to expensive curative services at the expense of more effective and economic primary and preventative measures. Solutions to this problem have been emphasised in recent Australian health reforms, but their impact on the ground is uncertain.

Australia has parallel systems of primary health - the Medicare funded primary care delivered by GPs and others in private practice and state funded community health services. The original plan to integrate these into a single system was abandoned in a recent round of COAG discussions. Prof Kidd's research found that each group has limited knowledge and understanding of each other's services and minimal contact outside referrals and chronic disease care plans. **Patients are most at risk when crossing a boundary between providers, as vital information may not follow them, leading to a break in the continuity of care.** Greater coordination is therefore a priority, but each stakeholder group has expressed concern about the proposed role of *Medicare Locals* and underlined the need for the new bodies to genuinely improve the situation and help patients navigate the diverse and confusing landscape of care.

Whatever the future of health reform, the crucial work of primary care will continue and perhaps find new avenues. It is possible that low-carbon solutions for global warming will improve public health, for instance, as people drive less and walk and cycle more, reducing obesity, increasing fitness and reducing deaths from accidents and pollution. **Health considerations should be incorporated into all government policies, from roads and city planning to education.**

The book by Prof Kidd and Dr Rowe *"Save Your Life and the Lives of Those You Love: Your GP's 6 steps guide for staying healthier longer"* (Allen and Unwin, 2007) outlines how people can work through simple steps in consultation with their GPs to improve their own health. These include having regular check-ups, knowing the family's medical history, improving diet, taking exercise, avoiding risky behaviour and responding immediately to medical 'red alerts'. The book includes charts, based on the RACGP 'red-book' on preventative medicine, showing which checks should be carried out at what intervals. The RACGP has evidence-based 'SNAP' guidelines educating people about diet, exercise, smoking and alcohol while another acronym, NEAT (nutrition, exercise, avoiding toxins and tranquillity) can also be usefully employed.

There is a pressing need for person-focused, rather than single-disease-focused, guidelines. Information focused on a single disease ignores the challenge of co-morbidity and most patients suffer from a multiplicity of chronic problems. However, much advice is on offer, doctors must 'mind the gap' between the advice for managing chronic disease and what they see in the patient sitting in front of them. There are also the problems left behind by limited reforms, as when Tony Abbot introduced a '45-year health check', when evidence showed the benefits of yearly exams the system could not afford. Bowel cancer checks are now advised every five years, to give another example, when evidence suggests these should occur every two years. Prof Kidd's presentation ended with **a call to harness the information captured in primary care to improve the health of individuals, families and communities.**

E-Health in Primary Care and the Private Sector – Dr Mukesh Haikerwal AO



Dr Mukesh Haikerwal AO spoke on e-Health in primary care and the private sector. He discussed health promotion systems, the sharing of information, “Personally Controlled Electronic Health Records” (PCEHR) and the role of GPs, private insurers, private hospitals and other stakeholders in e-health innovation and reform.

Various forms of electronic health records have been discussed in recent years, but PCEHR gained prominence in the last budget and the concept will be examined by ministers in the near future. Every practitioner has a different idea of what the PCEHR should contain and its technology is continually evolving, but the hope is to create a limited, tangible product of demonstrable utility built on the wealth of work already completed. **98% of GPs use computers for clinical purposes while all pharmacies employ them for billing and supply.** The problem lies in the failure to connect GP and individual hospital computer systems, meaning records must still be printed and sent by mail or faxed between individual GPs or GPs and hospitals, rather than sent instantly by electronic means. The task is to create **a common set of document standards**, then 'lay the tracks' which allow them to be instantly and easily disseminated to all who need them.

A NEHTA commission report outlined how the system should work. It encompassed the individual responsibilities of patients for their own health and how messages should be communicated between the myriad stakeholders involved to ensure continuity of care. Reducing inequity was another priority, as were unfashionable areas such as mental health. It argued for better measurement of outcomes to make performance targets meaningful, more research in public hospitals and improved and continuing education for all health practitioners. Each of the report's 'four pillars' can be empowered through IT and it targeted **the summary health records habitually produced by GPs as the starting points for PCEHR**. Such GP patient summaries, containing core information and noting medical events, are widely produced and recognised by all stakeholders.

Furthermore, over 80% of people see their GP at least once a year and 98% of GPs use computers for data collation. The PCEHR must be accurate, comprehensive and up to date with clear and trustworthy clinical provenance. The input of carers will be valued, but not allowed to dilute the necessary element of professional veracity.

There are many places where additional information is already gathered – the desktop computers of GPs and specialists, in hospitals, radiology and pathology labs and the databases of Medicare and private insurers. Such data can be added to the basic PCEHR as required and every Australian now has an **individual health identifier** allowing the information to be accessed, managed and protected effectively. NEHTA has cooperated with a wide variety of interested medical, insurance, consumer and private groups to create the system, and its successful implementation could revolutionise Australian health care. However, Microsoft's vision of patients becoming the integrators of the health care information compiled and stored by various health organisations in their name is still far from realisation.

'Joining the dots' between health providers would place the GP at the centre of a web of communication. Private hospitals use IT for financial and business purposes and this must spread to clinical operations for the system to benefit all. **A nationally agreed format for electronic discharge summaries (IT14) has been produced after consumer and clinical consultation,** and this should be widely adopted in private, as well as public hospitals. **E-referrals** also have commonly agreed IT and clinical standards, which include the incorporation of vital clinician discussions. The challenge now is to encourage their adoption. E-health will allow more sustainable and equitable health care of higher quality to be delivered, but the solid business case for its adoption is still to be sold to private health providers.

Other desirable IT solutions include **the introduction of a single, standard, secure messaging service within hospitals.** Currently up to 12 different systems are used, with pathology labs and radiology all employing their own systems, which must then be checked individually by busy clinicians. A common standard is being issued in July 2012 and the challenge is to encourage its take-up. **Video-conferencing** will also be more widely employed for regional and remote consulting, now standards for its use are being issued, and private hospitals should be part of the scheme.

Discussion



Dr Heather Wellington thanked the speakers and suggested the workshop debate how stakeholders in private hospitals, primary healthcare and insurers can work together to improve care for the patients which unite them. The role of peak bodies was also raised and the possibility of holding a further conference to address these issues. Before the groups broke for discussion, it was observed from the floor that public funding still failed match political rhetoric regarding the importance of primary care. The political debate was still dominated by hospital spending and the situation would not improve until this was corrected.

It was agreed that **a shared interest in e-health could encourage cooperation between the 13 organisations which represent GPs, 26 insurers groups and thousands of private specialists and other practitioners.** E-health should cut costs, improve efficiency and augment service quality for everyone and enable other issues to be progressed in turn.

It was stressed, however, that e-health and other schemes must remain relatively inexpensive to initiate and show real benefits in operation if they are to be widely adopted.

The meeting was assured of the intention of public authorities to enlist the private sector in the nascent e-health revolution. The question was how, rather than if, the private sector should be involved. After standards for health identifiers became operational in July 2010, users have been able to appreciate their utility and ease of use and this success has generated increasing interest. NEHTA is hosting meetings of a 'four cornered roundtable' of consumers, clinicians, policy makers and the health industry and while the deadlines for implementing various standards are tight they are adding impetus to the debate.

It was hoped Global Access Partners (GAP) could help generate suggestions for **incentives to encourage stakeholders to adopt e-health** and other initiatives. Private health insurers might give incentives to private health providers themselves to join the e-health network, as it would also benefit their own operations. By working together and communicating more efficiently, the three sectors could become more than the current sum of their individual parts. Pharmacies were given limited, but real incentives to become computerised, and now all pharmacies are linked in an e-prescription system. They were encouraged to join the scheme through evidence of productivity gains, while the fate of specialist pharmacies in the USA and UK also proved a powerful incentive. The Prime Minister has acknowledged the importance of incentives to encourage consultation teleconferencing and the offer of technical support through GP divisions and other bodies will also be important. The offering of discounts on e-claims, rather than mechanical claims, might also be effective. **The major problem is the lack of new public funding for such incentives, at present any additional money must come at the cost of cuts in other areas.**

Private health insurers are already health care providers as three quarters of privately insured Australians are covered by some form of chronic disease self-management service and, to a lesser extent, post-acute care services, such as rehabilitation in the home. Private hospitals also play an increasing role in post-acute care and, as previously discussed, this can be better coordinated with more communication between stakeholders. These are practical schemes which could be scaled and implemented immediately, improving service profiles and accessibility, ahead of prospective e-health schemes which may or may not eventuate in the future.

However, it was felt by some that Federal and State Governments still pigeonholed private health insurers as merely means for paying bills and did not properly acknowledge their role in improving the quality of care. It was also claimed that many patients and insurance customers want their insurers to have access to their e-health information in order to provide a better, more seamless service.

It was noted that some private hospitals, including Epworth and Mater, have invested heavily in IT, while sites in East Melbourne, Newcastle and Brisbane already use e-health systems and health identifiers with GP Partners. Sydney's Macquarie Private Hospital has been particularly proactive in its aim of becoming a paperless 'digital' hospital, but such experience is not captured by public policy makers due to lack of engagement with the private realm. This fundamental problem of the public sector ignoring private providers in policy considerations is slowly changing and the meeting was assured that NEHTA would make a wholehearted attempt to engage with the private sector.

It was agreed that while private insurers had secondary care programmes designed to keep people well and out of hospital and that several private hospitals had promising outreach programmes, the role of *Medicare Locals* was increasingly unclear. There were fears they may be diluted into GP divisions by another name and not embrace the totality of primary and community care, including pharmacies, dentistry and other sectors, as originally envisioned. Others maintained that it was vital for private insurers and hospitals to pursue dialogue with *Medicare Locals* which, whatever their final structure, remain charged with the task of planning health provision within defined populations. Such schemes must obviously include private provisions to be comprehensive, but most of the discussion has so far revolved around public services, GP divisions and community health.

As private providers value and protect their independence and freedom of action to provide care as they think best, they tend to shy from engagement with *Medicare Locals* and other public bodies lest they start to dictate terms and conditions. A willingness to engage with these bodies should not be taken as an invitation to interfere, but all stakeholders, public and private, purchasers and providers, have an interest in pursuing excellence in health care. It is vital that patient with common, but serious problems such as prostate cancer or cardiovascular failure, do not come to grief in the gaps between different health providers.

One speaker emphatically agreed with statements in Dr Rowe's report that portrayed private health provision as 'sitting at a crossroads' and unsustainable in its current form. He agreed with her that private and public health provision cannot continue to run in 'parallel universes' and that cross-sector cooperation is vital to ensure continued relevance. **Public provision is moving ahead quickly with e-health and other tools to improve patient service, and private insurers, hospitals and providers must catch up and join the effort if they are not to risk irrelevance.** The strict differentiation between purchaser and providers are beginning to erode and all stakeholders must react to the consequences. Organisations which are in business or clinical competition must learn to cooperate in e-health and other matters for their own mutual benefit and the public good.

Others felt that general practitioners and private hospitals will continue to be powerful players into the foreseeable future, regardless of e-health or other developments, given that state governments already contract with private health insurers and providers for chronic health management services. Though the opportunity to create further mutually beneficial arrangements is real and should be pursued wherever possible, several representatives from the private sector saw no 'burning deck' and maintained that the system, by which federal government regulates the private sector and purchases a large percentage of its services but concentrates on managing the public sector, was workable and convenient to all.

They saw the private sector as active in innovative technology and partnership schemes and more people taking up private health insurance all the time. This success generates no imperative to join public schemes, given that the private sphere is growing faster than the public domain and the Productivity Commission report it as just equally efficient, if not more so.

However because, rather than despite, the fact that 48% of Australians have some form of private health insurance, there is a constant need for private insurers and hospitals to restrain the inexorable growth in health costs. This can only come about through **greater efficiency, which can be driven by e-health and cooperation with all parts of the health sector.** Better chronic disease management will cut expensive hospital admissions and save money for both private hospitals and insurers while cooperation across organisational boundaries will improve patient care and meet community expectations.

It was noted that terms such as 'primary care', 'Medicare Locals' and 'primary health-care organisations' are used almost interchangeably in the debate. Clear definitions of what primary care is, who is responsible for it and where it links with prevention and general practice could be pursued at a later meeting.

Mr Alan Castleman reiterated the ACHR's uniquely diverse mix of members from private hospitals, health funds and other stakeholders and its long-term interest in these issues. Dedicated as it is to improving health care for the public good, the ACHR is keen to collaborate with NEHTA and others to drive this agenda and might support further meetings of the workshop group, seeing the current session as part of a process rather than an end in itself. Workshop participants were invited to contribute their thoughts to ACHR or through GAP's policy discussion and blogging site, Open Forum, www.openforum.com.au.

Dr Heather Wellington closed the debate and declared her excitement at the continuing opportunity the group provided.

Mr Alan Castleman thanked attendees for their contributions, the speakers for their presentations and Dr Leanne Rowe for producing her comprehensive and thought-provoking report. He closed the workshop by noting that history suggests that ever growing health expenditure is both inevitable and sustainable. He did not perceive this remorseless trend as the pressing problem usually envisioned because the costs of staple goods such as food, clothing and consumer goods continue to decline due to globalisation and improvements in productivity, technology and design. People may well continue to spend these gains on improving health care for themselves and their families, rather than other individual or national pursuits. Whatever society decides, it is the responsibility of all concerned to ensure maximum efficiency and clinical effectiveness for every dollar spent.

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