

Toward greater integration of the health system

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Abstract

As demand for hospital and emergency services grows there will be pressure to improve the integration of primary, acute and continuing care services. Research on ambulatory sensitive care conditions suggests that a significant proportion of hospital use is potentially preventable by primary health and community care services. The desire for better health outcomes and reduced use of acute care suggests a greater focus on primary health and community care. Reforms have generally emphasised planning, funding and regulatory mechanisms including brokered management of services for an enrolled population, capitation payments and pooled funding across primary, acute and continuing care, the development of coordinated service pathways and the consolidation of responsibility for costs and outcomes. Australia's division of funding, regulatory and planning responsibilities across jurisdictions introduces a unique set of challenges to address these issues. Nevertheless, there are a number of options better aligning Commonwealth and State initiatives through the Australian Health Agreements and funding for range of primary health and community care funding programs.

Australian funding and service delivery models for primary health and community care are fragmented and often disconnected from acute and continuing care services. There is general recognition across jurisdictions and key stakeholder groups that better integration and coordination across primary, acute and continuing care services is required to improve access, equity, efficiency and health outcomes. It has been clear for some time that without reform it will be difficult to manage growing demand and increasing service complexity and intensity as new technology, demographic trends and social trends have their impact.

In response, all or nearly all Australian States and Territories have implemented structures to improve planning, coordination and reform of services at a regional level to strengthen the relationship between primary health and community care services, including general practitioners. However, there are less developed national administrative, funding or organisational strategies to promote greater integration of primary health and community care services or better coordination between these services and the acute and residential care sectors. Concrete policy and performance goals and outcomes have not been clearly articulated. There are multiple, complex and inconsistent approaches to funding programs and services across jurisdictions and for similar population needs. Administrative responsibility is split between different levels of government. Workforce planning, education, research and development approaches for the sector are less advanced than those relating to the acute care sector. Although the Commonwealth has established a range of initiatives for the reform of general practice, there are few national coordinating bodies and structures to guide the more general development and implementation of policy for primary health and community care. However, forces driving change are increasing as pressure on the acute sector grows. This paper discusses these issues and argues that an overall framework for coordinating, aligning and focusing jurisdictional efforts to improve the effectiveness of their primary health and community support services is required.

The primary health and community care sector

Primary health and community care is the first point of contact with the health system. Primary care services are provided in the community and at home. They include general medical, pharmaceutical, pathology, diagnostic imaging services and aboriginal health services funded by the Commonwealth. The Commonwealth and the States/Territories jointly fund community nursing and home and community care services. States/Territories fund non-medical services including community mental health, youth health, drug and alcohol counselling and allied health services such as podiatry, physiotherapy, occupational therapy, nutrition, and social work. There is an emphasis on continuing relationships between service providers and consumers over extended periods of time.

Primary health and community care emphasises a social model of health and a more comprehensive and holistic approach to prevention, treatment and support than is generally the case in sub acute and acute services. This includes an emphasis on early detection and illness prevention services such as maternal and child health programs and population health programs including health promotion.

Primary health and community care is the most visible and commonly used part of the health sector. About ninety percent of Australians access services in any one year. Primary health care, and especially general practice, are an important gateway to the secondary and tertiary sectors of the health system.

While there are significant difficulties in defining expenditure on primary health and community care, in 1999-00 the Commonwealth provided approximately \$6 billion for these services through the Commonwealth Medical Benefits and Pharmaceutical Benefits Schemes. States and Local Government provided about \$1.8 billion for 'community and public health'. The Commonwealth, through direct outlays (\$ 6 million) and premium rebates (\$97 million), also provided \$103 million for dental services, with the States and Territories contributing \$305 million (AIHW 2001).

The States are also responsible for emergency departments in hospital settings. Often these services are not seen as part of the primary health and community care sector. However, for many people emergency departments are an important point of primary contact with health services. They are a critical point of intersection between acute and primary health services.

Pressure on acute hospital services

It is arguable that the principal factor driving interest in the integration of primary care, acute and continuing care is that demand for inpatient hospital services and particularly emergency services is increasing beyond the funding capacity of State and Territory Governments. Demand for public hospitals has been rising at 3%-4% per annum with an even greater growth in demand for emergency services in some States. Most of this growth is due to a rise in the number of medical, rather than surgical, separations. For example, in Victoria, patients aged 70 and over make up about 40% of this growth. Over the last 5 years, there has been a 34% increase in emergency medical separations for patients aged 85 and over (Department of Human Services Victoria 2002).

In the past two decades State and Territory governments have sought to manage demand within available resources by improving the technical efficiency of hospital services. However, there are limits to efficiency gains within hospital settings.

There is strong evidence that a proportion of hospitalisations can be prevented through population-based interventions (e.g. smoking, nutrition, alcohol, physical activity and injuries). However, with the exception of injury prevention, these reductions in demand are often discounted because population based interventions to prevent chronic diseases have long lead times, often decades, before results are evident.

A further proportion of hospitalisations can be prevented by early intervention in the primary care system (e.g. screening and early detection, chronic disease management). Interventions to reduce these ambulatory sensitive hospitalisations have much shorter lead times to produce meaningful results than population based interventions for chronic diseases. In many cases, improved primary care interventions have the potential to produce measurable reductions in hospital utilisation within 12 months.

In a large scale study in New Zealand Jackson and Tobias (2001) estimate that approximately one third of hospitalisations for people aged 0-74 was potentially avoidable. Of these approximately two thirds were potentially avoidable through more effective primary health care services.

Research on ambulatory sensitive conditions in Victoria (Department of Human Services 2001a) indicates that there may be significant opportunities to reduce preventable hospital admissions through improved interventions for vaccine preventable conditions (e.g. influenza, bacterial pneumonia, tetanus, measles, mumps, rubella, pertussis and polio), some acute conditions (e.g. dehydration, kidney infection, perforated ulcer, cellulitis, pelvic inflammatory disease, ENT infections, dental conditions) and some chronic conditions (e.g. asthma, angina, hypertension, congestive heart failure, COPD). There are highly significant variations in hospital admissions associated with these conditions across catchments for primary care partnerships which cannot easily be explained by differences in disease incidence and prevalence.

Intervention recommendations for reducing hospital utilisation for these conditions largely centre on earlier detection and earlier and more coordinated intervention in the primary care system. It is arguable that better coordination between primary care services and specialist clinicians and hospitals is also important for reductions in hospital demand (Department of Human Services 2001b).

Better interventions in the primary care system for frequent users of emergency departments who have complex social and personal issues associated with their health needs also provide an opportunity to reduce hospital utilisation. There is less agreement about the definition of this group or the number of people involved. They do not easily fit into the usual disease based classifications for ambulatory sensitive conditions. Nevertheless, the available evidence suggests that people with complex needs represent a small but significant group where improvements in primary care and community support have the capacity to reduce demand on acute services (Department of Human Services 2002).

More broadly, interventions to better address the needs of people with complex health and social support requirements through better coordination and service integration have been extensively documented. These include services for people with mental illness (i.e. team based model of mental health which integrate acute and primary care services). Effort has also focused on post acute care programs and on aged care assessment services which coordinate the relationship between primary care, community support, residential care and acute services.

It seems likely that hospitals will provide increasingly more intense, short stay treatment with more closely integrated support from primary health and community care services. More complex and technologically based interventions will be delivered at home and in community settings. This is likely to have a significant impact on the way these services need to be delivered (Swerissen 2002).

Pressure to change the relationship between hospitals and primary care is driving innovation. Strategies such as coordinated care, disease pathway models, integrated disease management, hospital in the home, step down facilities and a range of primary and secondary prevention programs are part of this trend. The success of these models will crucially depend on new forms of practice, improved governance, coordination and management across the range of home, community, acute and sub acute settings and new funding, accountability and payment systems.

The policy context

Notwithstanding interest in a new relationship between primary health and community care services and acute and residential services, there is no national policy framework to guide this development across the range of jurisdictional, funding and organisational arrangements that are currently in place. This is a major gap in Australian health policy.

Internationally, there is major interest in the reform of the primary care to address emerging pressures on health systems in industrialised nations. Primary care is seen as central to managing access, quality and cost. In this respect, reforms have been introduced in New Zealand and the UK, and Canada is experimenting with a number of initiatives. There has been significant interest in giving greater control over the management of health resources, including those for acute and sub acute services, to primary care providers and organisations

through pooling, capitation, funding and managed care arrangements on behalf of enrolled or registered populations. This has driven a greater emphasis on prevention, care coordination, service substitution and closer organisational integration across service sectors through the development of disease pathways (Mays et al 2001).

In Australia, policy development has been far more piecemeal. Policy for primary health and community care has been developed through a range of Commonwealth and State initiatives. Many of these overlap and the boundaries are not always distinct. There are significant opportunities for improvement.

Acute and primary health services

The Australian Health Care Agreements (AHCAs) are the main financial instrument for the ongoing development and implementation of national hospital policy. Through these agreements the Commonwealth and the States jointly fund universal access to public hospital services. Although increased demand and the changing role of hospitals are driving much greater integration with primary health and community support services, the relationship between acute and primary health and community care has not yet been addressed comprehensively in the AHCAs.

Responding to the changing role of hospitals, the States and Territories have implemented a range of innovations to improve integration between acute, sub acute and primary health services. These include hospital in the home, post acute care and integrated disease management programs. There is a raft of state based initiatives along these lines. Most recently, there has been considerable interest in strategies to manage emergency demand.

At the same time, the Commonwealth has initiated coordinated care trials to test whether multi-disciplinary care planning and service coordination leads to improved health and well-being for people with chronic health conditions or complex care needs. Funds pooling between Commonwealth and State/Territory programs has been trialed as a means of providing funding flexibility to support this coordinated approach to service delivery. More recently the Commonwealth has also funded Commonwealth Care Link Centres to provide information on community services to the public.

There is now a proliferation of similar initiatives and arrangements to improve the integration of acute, sub acute and primary health and community support services for people with chronic disease and complex care needs. The Commonwealth and the States are both at risk for increased demand for acute services and for services for people with chronic and complex conditions. Despite variable results produced so far (e.g. DHAC 2001) there are substantial opportunities to improve the funding, organisational and service delivery arrangements to address these issues.

Primary medical, allied health, dental, counselling, nursing and pharmaceutical services

The Commonwealth has the major responsibility for medical and pharmaceutical services including general practice. The Commonwealth Medical Benefits Schedule (CMBS) and the Pharmaceutical Benefits Schedule provide fee for service rebates for general practice and pharmaceutical services. These programs provide universal access to medical and pharmaceutical services for the Australian population, although more recently concerns are emerging about reductions in the rate of direct or bulk billing.

The Commonwealth has implemented a range of initiatives to promote the integration of general practice with acute, sub acute and continuing care services and with other primary care providers. For general practice, these include the introduction of Divisions of General Practice to improve planning, communication, innovation and coordination of general practice. Research and development funding has been introduced. Workforce strategies including vocational registration and incentives for rural practice have been implemented. As well, a range of blended payment arrangements and modifications to the CMBS has been designed to improve continuity of care, care planning and coordination and involvement in disease prevention programs.

Other primary health services, such as allied health, dental, counselling, drug and alcohol, community mental health and health promotion are largely funded and administered by the States. They vary considerably in their funding, organisational and administrative arrangements and the models of program and service delivery that are in place. These programs are generally budget capped and targeted on the basis of need and ability to pay. Compared with access to GP and pharmaceutical services, there are significant levels of unmet need, and inequities of access across geographic areas and population groups for primary dental, allied health and

counselling services. A number of States have recently introduced strategies to improve the coordination and integration of their primary care and community support services.

However, there is little joint planning, funding and development of primary medical, allied health, dental, counselling and nursing services between the Commonwealth and the States. While there is a well developed national strategy for general practice, this is not the case for other areas of service delivery. There is almost no population based integration of primary care services and there has been little by way of piloting or experimentation with capitation, enrolled populations or fund holding. There are significant opportunities for greater cooperation between the Commonwealth and the States particularly around strategies for more integrated service planning and service coordination to improve continuity of care over time, between primary health and community care services and between these services and the acute and sub acute sectors.

Continuing care and support

The Commonwealth and the States are jointly responsible for home and community care services through the Home and Community Care (HACC) program, which is funded by both the Commonwealth and the States to provide support services to frail older people and younger people with disabilities. However, the objectives of the HACC program are closely tied to the Commonwealth's objective to reduce the inappropriate use of residential aged care services. There is less recognition of the home and community care needs of younger people with disabilities, people with mental illness and people who require support services following discharge from hospital.

The States have developed separate community support programs for younger people with disabilities and people with mental illness and those who have drug and alcohol problems. There is significant overlap across the range of community support programs that have developed. Often they involve similar agencies, practitioners, service models, funding mechanisms, performance monitoring, planning and reporting arrangements. This leads to substantial inefficiency, duplication and fragmentation across very similar programs and services and inequity in access, utilisation and outcomes for people with similar needs.

Primary medical, allied health, nursing and counselling services are often critical elements of the overall care and support required by people with more ongoing and complex needs (Department of Human Services 2000). However, these services are not generally well integrated with community support programs. As a result consumers often find it difficult to navigate through the service system to get the treatment, care and support they need. Improved planning, funding, communication, coordination and service delivery models are needed to provide better outcomes for consumers with continuing care needs.

Toward integration

Pressure for expansion and reorientation throw up a number of challenges for government. Both the Commonwealth and the States are under fiscal pressure to contain growth in health service expenditure, particularly for technologically intensive hospital and pharmaceutical services. Greater integration of policy and funding objectives for acute, residential, sub acute services and primary health and community care across different levels of government will therefore be required if effective demand management strategies are to be successfully introduced.

New systems of care and coordination across acute, continuing and primary care will be needed as the complexity and intensity of the services and support provided at home and in the community increases. Innovations such as hospital in the home, post acute care, coordinated care trials, enhanced primary care items and brokerage funding for aged care and disability services have been designed to address these trends.

Efforts to improve integration of primary, acute and continuing care in industrialised nations have focused on planning, regulatory and funding mechanisms including brokered management of a basket of health (and sometimes community) services for enrolled populations, capitation payments and pooled funding across primary, acute and continuing care, the development of coordinated service pathways and the consolidation of responsibility for costs and outcomes for an enrolled population with a system manager or broker. Market based competition or funder (government) driven benchmarking and performance management are then used to drive innovation and best practice through the broker or local system manager. This trend is exemplified by the development of managed care organisations in the US and primary care trusts in the UK (Mays et al 2001).

In Australia, virtually all jurisdictions have recognised these issues and are experimenting with innovations to address them, but generalised systemic changes to national policy, funding and organisational arrangements have yet to be agreed and implemented to consolidate these arrangements. The renegotiation of the Australian Health Care Agreements presents a major opportunity for the introduction of systemic change to improve integration across primary, acute and continuing care, particularly for ambulatory sensitive care conditions such as asthma, angina, diabetes, hypertension, congestive heart failure and COPD.

There are opportunities for better aligning existing Commonwealth and State funding to promote integration. AHCA growth funds, practice incentive payments for GPs, GP Division funding, the recently introduced enhanced primary care funding program and the various State initiatives for inpatient and emergency demand management could be brought together within a framework to produce better health outcomes and reduce costs for people with ambulatory sensitive care conditions. In particular, funding incentives for integrated service delivery should promote stronger planning, coordination and management relationships between GP Divisions, hospitals and state based primary health and community care organisations for geographically defined populations with ambulatory sensitive care conditions.

A national framework to address these issues is needed, particularly for the ongoing improvement of the primary health and community services sector, which, apart from Commonwealth GP initiatives, is relatively under developed. The tentative discussions between the Commonwealth and the States that have begun around the negotiation of bilateral primary health and community care agreements should be extended. Further work is needed to develop a set of national objectives and performance outcomes, a work force strategy, more flexible funding arrangements to promote vertical and horizontal integration, new arrangements for joint planning and a greater investment in research and development.

References

- Australian Institute of Health and Welfare 2001, *Health Expenditure Bulletin No. 17, Australia's Health Services 1999-00*. Canberra Author
- Commonwealth Government 2002, *Budget Paper No. 5, Intergenerational Report*, AGPS, Canberra
- Department of Health and Aged Care 2001, *The Australian Coordinated Care Trials. Final Technical National Evaluation Report*, DHAC, Canberra.
- Department of Human Services (2000). *Literature review of effective models and interventions for chronic disease management in the primary care sector*. Melbourne
- Department of Human Services 2001a, *The Victorian ambulatory care sensitive conditions study: Opportunities for targeted intervention*, Public Health Division, Melbourne.
- Department of Human Services 2001b, *The Victorian ambulatory care sensitive conditions study: Preliminary analysis*, Public Health Division, Melbourne.
- Department of Human Services Victoria 2002, *Hospital Admission Risk Program (HARP) Background Paper*, Department of Human Services, Melbourne.
- Jackson G & Tobias M 2001, 'Potentially avoidable hospitalisations in New Zealand, 1989-98', *Australian and New Zealand Journal of Public Health*, vol 25, no 3, pp 212-19
- Mays N, Wyke S, Malbon G & Goodwin N 2001, *The purchasing of health care by primary care organisations*, Open University Press, Buckingham.
- Swerissen, H 2002, 'Implications of hospital deinstitutionalisation for primary health and community support services' *Australian Journal of Primary Health*, vol 8, no 1, pp
- World Health Organisation 1978, *Health for All Series*, No. 1