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GRATTAN Institute

The Policy Pitch – *Getting primary care right*

Melbourne 16 August 2016

Everyone agrees we need to improve primary care. The Commonwealth government is proposing 'health care homes' as part of the answer and a move to paying GPs to look after the whole patient. What issues does that raise? Do we have the information to do that? It's often claimed that improved primary care will lead to reduced hospitalisations. Will it? A recent Grattan Institute report found that there are places in Victoria – Broadmeadows as an example – with very high rates of potentially preventable hospitalisation for a whole decade. What should we do in those places?

In this Policy Pitch, Stephen Duckett, Director of the Health Program at Grattan Institute presented some findings from Grattan Institute research. He was then joined on a panel to discuss these issues by Anne Congleton, Deputy Secretary, Community Participation, Sport and Recreation, Health and Wellbeing Division in the Victorian Department of Health & Human Services; and Jane Gunn, Professor of Primary Care Research and Head, Department of General Practice, Melbourne Medical School.

Moderator: James Button, Grattan Institute

Speakers: Anne Congleton, Deputy Secretary, Department of Health & Human Services
Jane Gunn, Foundation Chair, Primary Care Research
Dr Stephen Duckett, Health Program Director, Grattan Institute

SARAH SLADE: My name is Sarah Slade and I'm Head of Storage and Digital Collection Services here at the State Library. It gives me great pleasure to welcome you all to *The Policy Pitch*. Tonight's topic is *Getting primary care right*. This seminar is held on the traditional lands of the Kulin Nation and I wish to acknowledge them as the traditional owners. I would also like to pay my respects to their Elders and to the Elders of other communities who may be here this evening. I'd like to give a warm welcome to tonight's speakers, Anne Congleton, Dr Stephen Duckett and Jane Gunn, as well as our moderator, James Button. I'd also like to welcome Grattan Institute members and staff and Friends of the Library. We're really delighted to present *The Policy Pitch* series in partnership with Grattan Institute. All of Grattan's reports and most of their events are free and can be viewed online and, as Head of Storage and Digital Collection Services, I am pleased to say that the seminars and related reports are being added to the library's digital collections for future use by researchers.

Last week, along with libraries across Australia and New Zealand, we held Born Digital 2016, our inaugural digital preservation week. This explored questions around collecting and preserving digital content, raising awareness of the importance of preserving it for the public good and as a record of 21st century history. It's in fact 25 years almost to the week since the first public website went live. Digitally created material has expanded exponentially and replaced a huge number and variety of physical records. Libraries, such as State Library of Victoria, are working hard to ensure that this information doesn't disappear and I encourage you all to view some of our recorded interviews on the Library's website. As Victoria grows and technology transforms the way we live and work, the Library is constantly evolving to meet the changing needs of the community and, like the Library, Grattan

Institute is community-minded and forward-thinking. They provide independent, rigorous and practical solutions to some of the country's most pressing problems. They run seven policy programs in areas vital to shaping Australia's future and tonight we will hear about the significant policy area of healthcare.

Anne, Jane and Stephen, I'm looking forward to hearing your expert opinions about getting primary care right and I'm pleased now to introduce James Button, tonight's moderator, who will introduce the panel and lead the discussion. James worked for many years as a reporter and editor at The Age, both in Australia and as the newspaper's European correspondent. He has won two Walkley Awards for feature writing and he also worked as a speech writer for the Prime Minister Kevin Rudd, a role for which he was awarded the 2010 Australia Day Award for Excellence in Speech Writing. Please join me in welcoming James.

JAMES BUTTON: Thank you very much Sarah and thank you all for coming tonight. I'm going to just talk a bit about the subject and then talk about how the evening will go. We're here to discuss a huge issue, a huge change in the health system which is the rise of primary care and salience in the health system. The health system was created really to address episodic health problems, infectious disease, war and accidents, and over time that has changed, especially as the population has gotten older. 90% of us will die from a chronic disease and 75% of Australians older than 65 have at least one chronic disease that is likely to lead to serious complications or premature death. Some of these conditions can be treated, but they are not being properly treated. For example, a million Australians have diabetes, but only a quarter of that number are being properly treated. So the consequences for the lives of people are huge and the consequences for the health system are huge, and that's what we're here to talk about this evening.

We're going to talk about three Grattan reports, which are a sequence of reports on the primary care system. The first of these, *Chronic failure in primary care* published earlier this year, really sets out the dimensions of the problem and the failure of primary care to address the problems that are emerging. The second, *Perils of place: identifying hotspots of health inequality*, looks at places that have specific and acute problems with chronic illness, places in Queensland and Victoria, places such as Broadmeadows and Frankston, and it suggests a specific place-based approach to addressing these health inequalities. The third report, which hasn't been published yet, is called *Risk and reward* and it takes the first two reports further by looking at how a new system of payment for general practitioners might help to address the problem. We've got a terrific panel tonight to address this question. Dr Stephen Duckett is the Health Program Director at the Grattan Institute. He's an economist and a former Secretary of the Commonwealth Department of Education and he's done a lot of work also down here in Victoria in the 1990s when some quite significant changes took place in the health system. Stephen will talk for 20 minutes and then Anne Congleton will respond to Grattan's place-based proposals and will give an analysis of those proposals.

Anne is the Deputy Secretary Community Participation, Sport and Recreation, Health and Wellbeing at the Department of Health and Human Services. Before this role, Anne was the Deputy Secretary in the West Division, which starts in Geelong and goes to the border, between 2012 and 2015. She has worked across many parts of the Department and has had many roles in the Department, but also before that in the Department of Treasury and Finance. After Anne speaks for ten minutes, Professor Jane Gunn will look at the specific challenges for GPs in responding to the problems in primary care. Jane is the Foundation Chair of Primary Care Research and is the current Head of the

Department of General Practice and the Deputy Head of the Melbourne Medical School at the University of Melbourne. She's also a general practitioner herself and recently she's taken a role as a Director of the Board of the Eastern Melbourne Primary Health Network, and I'm sure Jane will talk about that this evening in terms of the on-the-ground experience that she's acquired in those roles. After that we'll have about 25 minutes for questions, there have been some questions already sent to us which we will also put to the panel, but we want to hear from you about what you want to know and what you feel.

So Stephen, can I ask you to come up and start our conversation. Thank you.

STEPHEN DUCKETT: Thanks James, and I too would like to acknowledge the traditional owners of the land, the Wurundjeri People of the Kulin Nation, and to pay my respects to the Elders past and present, and also to remind us, in a health audience especially, that the disadvantage suffered by Indigenous people is such that their life expectancy is about ten years shorter than the life expectancy of non-Indigenous people. So when we hear those acknowledgements of country we should always bear in mind that it's not just a rote thing, but it's actually a commitment of ours to do something about it. As James said, we're talking about a few reports and so I'm going to talk about some of the background, and some of it has some statistics in it, and also some of the strategies about payment and place-type solutions that have been put forward. So we're talking about two reports that we've released this year, one is *Chronic failure* and the other is the *Perils of place* report, and both of those are available on the Grattan website.

Chronic disease can be looked at in any number of ways and one of them is that it's going to cost the economy a lot more in the future than it does now. So what we see on this slide is how much money is spent on particular chronic diseases starting with cardiovascular disease, and the orange bar is how much we spend now roughly in the millions or billions of dollars and what we will be spending in 30 years' time. So across all the diagnostic categories here the three big ones are all to do with chronic disease and you can see the significant growth that's going to occur in what we spend. So what we have to be thinking about is, is it possible to change those trends, to change that pattern of future expenditure? We spend a lot now on primary care, in fact about $7 billion or so is spent on MBS expenditure. The vast majority is spent on fee-for-service payments to general practitioners with a little bit of money, that adds up actually to quite a lot, in terms of chronic disease co-ordination payments, mental health payments and health assessments, and what are called performance incentive payments, practice incentive payments and service incentive payments. This is looking at it a different way, at those little bits of money that add up to quite a lot. You can see that because of the data we still have the Medicare Locals here, but you can see there's quite a bit of money which is already spent on specific payments for chronic disease.

In our paper *Chronic failure* we suggested that those payments ought to be redirected because they don't seem to be doing the things that we would be hoping they would do in terms of delivery. In our paper *Chronic failure* we used data for Medical Director, which is a practice software that most GPs use. This is from a sample of GPs and the data has been cleaned up somewhat, but you can see that in terms of the percentage of people with diabetes who had particular values recorded in the software, only 60% of the people with diabetes had glucose recorded, a smaller proportion had BMI and blood pressure, if you had all three recorded it was only 15%, and of those who had the data recorded, not all of them were within the normal ranges. So this is a sign that we need to be doing better on either recording or on delivery or both. Importantly, if you look at what GPs say they do, if you look at, say,

the community prevalence of smoking, about 20% of the population still smoke and of the roughly 20% of the people who present to GPs only 0.6% of them actually had smoking cessation advice recorded in their record. The same sort of pattern of quite significant difference between the community prevalence of an issue, and the recording of something by the GP to do something about it is there with significant differences.

So obviously if you're on about trying to change behaviour you've got a limited number of levers that you can use, of interventions that you can use, and some of these are bottom-up or from the community and some of them are top-down. Of the top-down interventions, one of the ones that is used a lot in the primary care sector is to talk about it. This was particularly the case with the Medicare Locals where the ministers went around saying Medicare Locals were going to do everything and fix the whole healthcare system. So there was big talk on what was going to help things, also the Medicare Locals themselves, and Primary Healthcare Networks (PHNs) were again seen as a strategy for trying to change the way primary care worked in this country. The creation of what are called meso-level organisations, mid-level organisations between the government working at the state or national level and primary care practices working at the local level. So those meso-level organisations were going to fix the whole problem and, of course, there's this cartoon which basically has two scientists standing there at a blackboard and you've got equations over here on the left, equations over here on the right, then a miracle occurs and one says, "I think you should be a bit more explicit here in step two". Well that's the story about PHNs and also about Medicare Locals: they were going to be the miracle that was going to fix the big problems on either side of them. Here you have a third level which is financial incentives and the issue is fee-for-service versus capitation or annual payments. We also have provision possibly of new services, also provision of feedback, collaborative, data-sharing and so on, also issues about community education and so on. The issue about this is what I'm trying to say with this slide is there are already multiple interventions playing on different sorts of ways of trying to change practice, not all of them are co-ordinated and not all of them have been put in place long enough to actually effect change.

So in our report *Chronic care* here's a long list of things that need to be done. You need to have regional health systems like the meso-level organisations, you need to actually have a performance framework, and you need to have care pathways so there's clarity about what needs to be done and how primary care and acute care need to interact. But if you think about it, two of the very important components of that long list are alignment of financial incentives. So instead of rewarding individual separate visits and individual separate interactions between a patient and a GP, you reward continuity of care, you reward looking after someone adequately for a 12 month or a three month or a six month period and have some sort of quality and performance framework that goes with it. Secondly, that because the change we're talking about is quite significant and, indeed, is so great you need to actually plan the implementation over a long period of time and phase up into that implementation. So what you need to do to change general practice, and this is another slide from the report, is you need all of these things to be working on changing the way primary care works. The very important message we're trying to say here is there's no quick fix. If it was a simple problem to fix it would have been fixed a long time ago. So what we need to do is a host of interventions that all ought to be working in the same direction, we ought to have a clear strategic direction for achieving them, and we don't have that at the moment.

Moving on to one of our other reports is this issue of if primary care is working well maybe it will reduce the number of admissions to hospital and, in particular, what are called either potentially

preventable hospitalisations or ambulatory care-sensitive conditions. Very frequently you hear politicians going around talking as if we could prevent all of those and you will see the rhetoric like "there are 6% of all hospitalisations which are ambulatory care-sensitive care conditions or potentially preventable hospitalisations". If we use asthma as an example, and this is national data, you'll see that there are many admissions which are same-day, some which are overnight, and some of which actually are 29-day admissions for asthma. Now it is unlikely that primary care interventions in the last few months would have stopped a 29-day admission for asthma, so not all of these clearly are preventable with good primary care. Some of them might have been preventable with good public health interventions five years ago. So when we think about what are the savings from good primary care interventions it is not a simple matter of just adding up all these asthma admissions, for example, and say they're all preventable, because they are not.

So that's sort of a sketch of the problem. I now want to talk about two sketches of solutions. One is to say we know that people who are poor have more admissions to hospital for potentially preventable hospitalisations, let's just fix that problem, and another one is let's just fix the payment. So that's where we started from and this is an American journalist who, amongst other things, said, "Explanations exist; they existed for all time; there is always a well-known solution to every human problem - neat, plausible and wrong". Well that's what we found in both of these reports. He was a called H L Mencken and he was trying to explain why sometimes you're able to write very innovatively and sometimes you're not and peculiarly, of course, he found it was all to do with bowel obstruction, so when people use that quote think about that. Anyway, so what we did was for both Queensland and Victoria we looked at admissions to hospital for these potentially preventable hospitalisations and, based on where people live and wherever they went to hospital, and could you predict them or how consistent were they? What this graph shows is if a postcode, in the case of Victoria, had a high rate of admission to hospital for potentially preventable conditions there was only a 50% chance that they'd still have a high rate next year. So there's a lot of volatility in those postcodes about whether they had a high rate of admission to hospital for potentially preventable hospitalisations, and by a high rate we mean 50% above the state average, and the same sort of pattern applies in Queensland.

If you look at that graph you can see it's only after about three or four years that you get stability in that graph, that is it's only after an area has had high rates for a few years that you can think, "Yes, they'll be high next year". The importance of that is that if you were going to intervene to do something about those high rates of admission, if you choose your areas based on one year of admissions you've got a high rate of being successful simply because of random variation, so you can put up your flag and say, "We actually did wonderful things and half of the areas are no longer high rates of potentially preventable hospitalisations". The interesting thing about that is the advice the Commonwealth Government gives to the PHNs is all about one year of data. So if they follow the Commonwealth's advice about how to set priorities they are doing absolutely the wrong thing. This is the map of where people were, the areas that have higher rates of admission for ten years in a row. So these are no longer random variations, these are every year for ten years more than 50% above the state average. You can see many places with quite high rates across Queensland, but here in Victoria that's Broadmeadows, Frankston and other areas here, one of these areas is Colac for dental care. There are high rates of admission to hospital for dental disease and, interestingly, Colac didn't have fluoridation for much of that period. So some of these are public health reasons for why they've ended up with high rates and this is one downwind from the Latrobe Valley. So you've got a series of places where there are entrenched and high rates of admissions for a long period of time.

Another thing we looked at was to what extent was it the same person coming back to hospital every day, were readmissions a problem or not? In this graph every separate bar is a separate person and what you can see is in the case of Broadmeadows, for example, about 20 to 30 people here represent a third of all admissions from Broadmeadows and Corio. So if I were looking at these areas a lot of the problem is to do with readmissions, but down here, in these places, there are almost no readmissions and so it's not a readmission problem. So what we're saying here is that different places have different problems and so you cannot have a one-size-fits-all solution to these sorts of issues. The response has to be a locally-driven, locally-developed response to dealing with these very, very high rates of admissions. This slide is an interesting one, we started this process thinking that all of the ambulatory care-sensitive conditions, all the places with high rates were going to be low socioeconomic status areas and that all the low socioeconomic status areas will have high rates. Well, as it turns out yes, if you're a low socioeconomic status area more of those are in fact areas with high rates of admission to hospital for potentially preventable hospitalisations, but there are a few high socioeconomic status areas with high rates. But also, interestingly, there are some postcodes which are low socioeconomic status which didn't turn up in any of those ten years. Sunshine is down here and Broadmeadows is up here, so what is happening in Sunshine and what is not happening in Broadmeadows is really quite an interesting question.

Moving on to risk and reward, that graph is for people who have at least one chronic condition and 20% of patients account for 50% of all GP consultations, so they're very significant users of a GP practice. So what the general conversation now is about is we've got to think about paying differently, rather than paying on the basis of fee-per-service, which has some strengths, it does lead to better accountability to the patient and so on, but it also has some weaknesses. So what we've got to think about is we ought to have a system which tries to get the benefits of both of those things, a fee-for-service and of capitational annual payments or continuity of care-type payments. Both of those systems of payment have strengths and both of those systems of payment have weaknesses and, as I said, what you've got to do is try to minimise the weaknesses. So there's now a lot of discussion about moving towards capitation payments for general practice, so you pay the general practice a sum to look after the patient for a whole year. One of the problems in designing the policy for this is you have to actually identify the patient population - in the Commonwealth trial that they're talking about for primary healthcare homes it's people have to have two chronic conditions - and you have to work out what services are included in the capitation payment. Is it just the general practice consultations? Is it pharmaceuticals and diagnostics? Is it home care services? Is it hospitalisations? So you have a number of choices about what you bundle into that payment.

You also have to actually have good enough data to design a payment, because you want to pay the general practice more for looking after more complex patients than for looking after less complex patients. We tried to look at this, so we took our data and we had about 60,000, I think, consultations, and for the whole dataset, which were people with one or more chronic conditions, they averaged at 7.8 consultations in a year. Using statistical techniques you can split that. The people under 70 had on average 6.4 consultations and people over 70 had on average 11 consultations, and if they had one condition they'd have on average 5.9 consultations, if they had more than two they'd have on average 14 consultations. This is the way you develop a classification system in the hospital scene, called diagnosis-related groups, and so you can do exactly the same with general practice consultations. In fact, you end up with quite different distributions. So this is the graph of this one, people under 70 with only one chronic condition, and the average here is 5.9 consultations in a year, you can see there's pretty much of a tail but it's skewed in that way. This is the graph for people over

70 with two or more chronic conditions and 14 consultations is the mean and, again, you see quite a different distribution. So you can see why the statistical programs split it in that way. On the other hand, when you put them together on the same graph you see there's a huge overlap in those two graphs and, in fact, going back to this tree here, it only explains 13% of the variation in the number of consultations, which in our view is not enough to be used as payment, so you have to have better explanatory power.

What's important is the data we used in this analysis is more than the data the Commonwealth has available to it. It doesn't have diagnosis, which we had in this dataset. So what we're saying is there's a lot of work that needs to be done in actually developing the payment and we think it's a bit too early to actually talk about it, so we don't think that condition is met. Certainly we don't have good performance indicators in general practice and certainly we don't think the capacity of practices to manage in this new system is there at the moment. So unfortunately our view is that we've got to be wary of jumping on bandwagons about what is the right thing to do and the evidence base for all of what needs to be done is very weak, so you have to proceed with a lot of caution. And, as we said before, obviously there's always a well-known solution to every human problem – neat, plausible and wrong. Thanks very much.

ANNE CONGLETON: Good evening everyone. I would like to start today by acknowledging the traditional owners of the land that we meet on today, the Wurundjeri people, and their neighbours, the Bunurong people, of the Kulin Nations and pay my respects to Elders past and present and any Elders of other communities who may be with us tonight. Thank you very much for the invitation to join tonight's panel. I just wanted to acknowledge the work of the Grattan Institute in producing the report and to shine a light on an area of significance not just from a health policy point of view, but more broadly from a social and economic policy point of view as well. I'm going to talk a little bit about what we see in the Department in the data that Stephen has presented, what our thinking is in terms of how we address the issues that presents, and also some reflections and observations on that.

So starting from the Department of Health and Human Services point of view, at the outset improving our understanding of the reasons behind the geographic variation in health and wellbeing is really important to the Department. People are probably aware of the Public Health and Wellbeing Plan which has as its vision of a Victoria that is free of the avoidable burden of disease and injury so that all Victorians can enjoy the highest attainable standards of health, wellbeing and participation at every age. So for us to achieve that then we must tackle where inequality exists. The Department as well has undertaken some work a bit similar to what Grattan's work has presented and we'll be doing some further analysis, picking up on the Grattan work. So we've heard from Stephen about the areas, the geographic hotspots, as we call them, where rates of potentially preventable hospitalisations are persistently high. As we heard from Stephen, the report found that disadvantaged areas and, in fact, some figures that have been presented showed they were 2.5 times more likely to be hotspots than all areas on average and they require tackling on a number of fronts, and we think about areas of disadvantage. It is though I think important for us as we do that further analysis to also look at, as Stephen's just mentioned, the fact that not all areas of low socioeconomic status areas were hotspots, so what is happening in Sunshine, as Stephen mentioned, I think will be equally important.

Some of the findings that have come through the work and the analysis that the Department has done, and again there are a lot of connections with the Grattan work, is the potentially preventable hospitalisations are strongly associated with access barriers, what that means is that the higher the

access barriers, the higher the rates of admissions of potentially preventable hospitalisations. We also heard about the correlation with socioeconomic status, there is also a significant link with poor self-rated health as well as there is a correlation in rural areas. So just thinking about that data and then thinking about the Department's role and direction there are four strategic drivers that will be sitting in our strategic plan of this current financial year. Our efforts are really going to be focused, and remembering again that we're the Department of Health and Human Services, on person-centred services and care, local solutions, earlier and more connected support, and advancing quality, safety and innovation. There are a number of elements that sit across those four that we need to bring together to address the challenges that have been articulated through the Grattan report and the opportunities that a place-based approach presents.

Many of you would be very well familiar with the Latrobe Valley and also the government's response to the Hazelwood Mine Fire Inquiry. So the Latrobe Valley, we saw some of the statistics in terms of the health and wellbeing of the community and there is a focused response that has been announced through the government's response to the Hazelwood Mine Fire Inquiry that is really going to give us the opportunity to have really focused effort and intervention in the Latrobe Valley. Our starting point with that is - and this is something that has to be a feature of any place-based approach - that it really needs to be driven from community to marshal the local knowledge, leadership, ideas, expertise and resources, and for us in the Healthy and Strong Latrobe that will be through the creation of the Latrobe Health Assembly, which has kicked off today with a taskforce. Also I think as part of this, and again not just thinking about it from a strict health point of view but thinking about it from a broader point of view, we need to tackle the issues across a number of areas. So we just don't have a lens on health and hospital admissions, but we also know in places like Latrobe the importance of education, of jobs, and we know that there are issues around child protection, so thinking about things from a holistic point of view is really critical. So it is requiring agencies, community service organisations, government departments, across local government, State Government and the Commonwealth Government and with our PHNs to work together, and that is an important prerequisite.

It's really important to also then think about what is the local intel, what do we need to change at a local level, and where might there need to be some interventions that really sit at that whole-of-population point of view and whole-of-state point of view? Investing in prevention and early intervention is really important as well as we've heard about interventions in the primary care space, and recognising that investment in additional services is also part of the picture. Another important frame to place-based approaches is being really clear on setting the outcomes that we're trying to achieve collectively and to track those and also to report on our progress. I really believe that place-based interventions tailored to local communities are the keys to addressing the issues that we've seen that have been highlighted by the Grattan report and this approach will also facilitate a focus on particular population groups. When we're looking at a place there is capacity then to think about who is in that place and we recognise that not just for some places, but even for some population groups their health outcomes are not as great as the state average. So the chance for us to be thinking about that, whether it's around Aboriginal people and communities or refugees, it offers us that opportunity to really drill in and understand what interventions work for population groups as well. But I think, as Stephen mentioned, we can't take a cookie-cutter approach to this, that the barriers and issues may be different in different places and for different people.

We've been doing a lot of work with Aboriginal communities as part of the development of a new Aboriginal health, wellbeing and safety strategic plan for the Department and there is a lot that

Aboriginal people are telling us about what is it that they need and want to see in terms of our responses. They talk about holistic approaches that consider the cultural and social determinants of health; they talk about the importance of cultural capability of organisations; they talk about some of the barriers that they confront and that is around barriers of stigma, discrimination and racism. These are critical barriers to access to good health and good human services and that those things need to be averted and to be tackled. So I think it is a reminder that in place and local solutions we need to listen really carefully to what communities are telling us that they need. So it will be important that we learn through our local place approaches, that we adapt and, as we learn things, that we can apply those things, but how we then use that information to inform other responses in other places and our policies more broadly. So critical to this will be rigorous evaluation on the interventions, so recognising that, particularly as we approach what we're doing with the local community down in Latrobe, what are those things that are yielding best outcomes, rather than it all being mixed together? So being able to differentiate will be really important so we can see what works and what we can apply to different places and what, in fact, is quite unique to that place.

The approach I think will continue to provide challenges, as it is already, to us as an organisation to think about how we work. So we can think about doing things in a different way, but there are challenges for organisations to think about how we connect with communities and how we lead centrally but on the ground, which is really quite critical. So I think that any approach from a place-based point of view really does require our enduring leadership persistence and, I think as Stephen point out, that to get change and shift in places where there are those hotspots it is going to take time, so continued focus and energy over a long period is quite critical. I'm really excited by the opportunity that is presented by our work with the Latrobe community, I think that there is much for us to be learning from the community as bureaucrats and I think there's a real chance for us to make a difference in that community, and not just in that community but in other communities as well. I'm certainly happy to take questions or comments and to explore this in a bit more detail when we have the panel session. That's it from me.

JANE GUNN: Thank you. I'm going to take a slight diversion now and just talk about getting primary care from the general practice perspective, so from place back to the general practice, but I'd like to start by acknowledging the traditional owners of the land upon which we meet, their Elders past and present, the Wurundjeri people, and make note that we can learn a lot from the way that Aboriginal health services have actually tackled some of these problems around the country, and we can perhaps take that up during the discussion. I'm sure some of you have been on the road to the Medicare Local journey and will it have a happy ending, Melissa Sweet wrote some years ago. Well, the happy ending has been the development of PHNs and now, of course, the focus is on PHNs and whether or not they will deliver. As James said, I'm on a Board of Directors of the Eastern Melbourne PHN, but anything I say here tonight is not representative of that organisation, they're my own opinions.

I'd like to think that the involvement of general practice is key to the reform and certainly one of the elements of the revised version of meso-level primary care organisations, now called PHNs, is an attempt or a recommendation that they engage with general practice. This was seen to be an area where Medicare Locals didn't do well. I think that is a generalisation and maybe not evidence-based, but certainly now it's explicit that general practice is key to reform. So what is general practice? I've been involved for 25 years in primary care research at the University of Melbourne and it always occurs to me that people are a little bit reluctant to engage general practice in really getting into the

nuts and bolts of reform and almost try to work every way around it, rather than tackling it, and I'd like to bring that to our attention tonight. General practice has changed dramatically over the last 50 years, but in recent times it's gone from solo practices to group practices and the number of practices has reduced. At the same time, we've seen the number of GPs increase slightly, although there's only about 18,000 full-time equivalent GPs across the nation. There are some things that we have to think about at the professional level. There are increasing pay gaps between GPs and specialists in our healthcare system and this has made general practice not necessarily the career destination that we'd like it to be if we're going to tackle these important problems. We're increasingly relying on overseas-trained doctors to come often to our places of work for shortage and do the jobs that a lot of the locally-trained doctors don't want to do and there is increasing corporatisation of around about 50%, the figures are hard to get. This is a context that we must be really aware of if we're going to try and reform the healthcare system.

When we ask is general practice all the same? Well no, it's not. Across those 7,000 to 10,000 practices they vary enormously. Some things are very similar though. There is no patient registration, so no practice is really absolutely certain of who their population is. Most operate on 10 to 15 minute appointments, they use electronic medical records but they're not that intelligent, and I'll come back to that later, and a lot of the data Stephen presented came from those unintelligent medical records. The decision support that we work with as GPs every day is very poor, there's no routinely collected outcome data, and we don't agree on how to code anything into our medical record systems even within our own practices, not because we find it hard to agree, we just haven't agreed and it's not easy to do. The corporate governance, the way that our practices are run varies enormously, from highly organised corporate organisations down to still family-owned businesses. Clinical governance is an area that is very unexplored in the general practice setting and the infrastructure varies enormously, both in premises and information technology. In the staffing you'll see pretty similar things, there are GPs in general practices and lots of nurses and these have been increasing in recent years, and you will see, depending on where you go, various levels of team organisation, from highly advanced practices to very low-key. That's general practice today.

I just want to remind us of the ecology of medical care because this is very important as we try and tackle the problems that Stephen's reports have identified. Most people living in the community will be well, about 750 of us will have a grumble in the previous month of an injury or illness and out of that group around 250 will go and visit a primary care doctor. Of that, around nine will end up hospital, about five will be referred to a specialist, and one will end up in a big academic institution, like the Royal Melbourne or Monash Medial Centre. A lot of our focus goes onto the one person in these very big tertiary hospitals often for good reason, but for the GP working out there in general practice, their focus is very much on the community that they see, those 250 people that walk through their consulting room each month, so this is a context that we have to be very aware of. So what are we trying to change it to, what does strong, effective primary care look like? One of the challenges is that there are lots of models around the world, but what are we going to do, what's our plan for Australia? This is something that is not clear. There is no blueprint for what we're trying to achieve as general practice. So I'm going to put forward to you that I think there are four essential functions of primary care that we need to think about, and I'm sure there are many other things to put into the mix, but just for the discussion tonight.

I think that it really is about entering into the world of the GP and using that little "enter" pneumonic, it's about evidence. The practices have to have the capacity to access, use and improve upon

evidence for every one of the consultations. They have to have the tools to navigate around the healthcare system and to track people's way through. There's the essential capability of engendering trust. If our community is not at the heart of this healthcare, if the patient is not central to what happens, this whole endeavour will become undone. Trust is essential. And primary care has to have the function of reflection and it has to have a culture of reflecting on what it does at every level. I think these four elements are key. I think that they can be grouped into the aspects of what you'll read about in all the literature, and I haven't bothered to reference any of it but if you go and look at primary care reform you'll find all of these elements, but we are really lacking in the medical record systems that we have in primary care in the way that they're intelligent, the way that they should be helping us do our work. We really need to have patient registration so that we can help people navigate around the healthcare system. We need to be able to have excellent information flow in all directions and people accessing care need to know what's happening for them, to them and with them, and that's so important as we redesign the healthcare system. Trust is also so important around the way that people are communicated with, the way that those encounters happen. We cannot ignore the fact that in healthcare still we want it to be a personalised experience. And reflection, the annual team profiling, the way that we fund the continuous quality improvement, these aspects are all things that we need to do.

I would put to you that most of the things up there on the PowerPoint slide exist at least in embryonic form in our system here in Australia and we do have foundations upon which to build, but I think that we're at risk of not building on them at all and trying something completely different. Are the general practices ready for this transformation? This is the Commonwealth Fund data which I'll just finish up on and you'll see that Australia's in the middle here, this is from 2015, last December - we could argue about the methods used for the Commonwealth Fund, but nevertheless. Around about half of the GPs responding to this survey are ready for fundamental change, so one in two. That's great. I think that means the soil is fertile for change, but is it that simple? No. Here's one example why it's really hard to make the changes Stephen is talking about. We have been early adopters of electronic medical records in Australia as GPs, we're well head of our hospital colleagues, we've been using them for more than 20 years and we're right up at the top of the world in our use and it's consistent. If you ask the GPs whether or not they think they're good records you find 80% of them think they're very satisfied or satisfied with the electronic medical record. Well I just think we're too easily pleased because I think they are not doing the job well enough for intelligent healthcare in this technological age. But if the GPs think they're great, then how are we going to convince them that they need to do things so differently, and therein lies the challenge.

I want to end with one of my favourite diagrams for medical student lectures - this is how boring they are these days. This diagram to me sort of says it all. This is where we have to have change happening. The individual GP patient, I think the patient or the person is at the heart of healthcare and they have to be the focus on which this system reform evolves. They have consultations with the GP every day in the consulting room and out of the consulting room more and more, email contact, phones, telemedicine, e-mental health, all of those things. But one of the things I've seen over 20+ years of watching what's happening in reform, often all of the activity happens above that line and very little gets down to actually tackle the problem across the 7,000 practices that are the functional units of the primary healthcare system in this country. That is challenge for PHNs. They must enter into what's happening in that practice. It cannot be done totally from above. The levers that you might use are interesting, but the activity that changes has to happen inside those walls or else we'll still be here in another decade talking about exactly the same problem. Thank you.

JAMES BUTTON: Thank you Stephen, Anne and Jane for three terrific presentations. Just before we go to questions from the audience, I wonder if Anne and Jane you could try to pull this together. Stephen is working towards place-based approaches for those areas that really have high rates of potentially preventable hospitalisations and he's looking in this final report, which is not yet released, on the possibility of what they call a capitation model versus a fee-for-service model, a capitation model being payment for one patient over a period of time and, of course, there are different challenges with that. I wonder if you could both reflect on those two aspects specifically of Stephen and Grattan's work: are they the right way to go and what specifically would you like to see Grattan focusing on in those areas?

ANNE CONGLETON: Gee, that's a doozy! I suppose for me, coming back to I think primary care is obviously a key part of addressing those issues, but they can't do it alone. I think that for primary care to work effectively, and just reflecting on the slide that Jane presented in terms of what's important from a GP perspective, to get traction it's really got to be about the relationship that the GP has with the person. So I suppose when we think about whether it's funding, is it a quick fly-through or is there that chance to see what that person is coming up with now, but also then having that relationship and trust to think about what other things that person may need and whether that helps the churn or the comeback. So just thinking about then the capacity to think about the relationship and having an element of that that goes beyond just what they're there for at that point in time.

JANE GUNN: I'd probably think that the way to look at the areas that have shown up as the very big hotspots, one of the things that would be a good starting point is to actually look at the practices within that hotspot. Because we don't have people registered necessarily with the practice in the hotspot I think there's still a lot of alignment between where people live and where they seek medical care, although we should be able to answer that very precisely and look at where the people are that are having those frequent admissions. There should be good communication between the hospital and the practice and a practice should know whether it's got a higher number than average of that. In the same way that Stephen's done the report for the country, practices have to think about that at their own level and being able to do that means you've got to have the reliable data systems and collection methods and everything to be able to even look at it, to even guess at it. I'm jealous of other countries because they do have this often in place already so it is possible.

JAMES BUTTON: Thank you. Okay, let's have some questions.

AUDIENCE: I'm very interested in the readmissions data and I'm just wondering if there's any data about early discharge and insufficient support in the home when people are discharged from hospital, because I see both of them are really two sides of the same coin?

STEPHEN DUCKETT: We didn't look at that, we didn't look at the factors associated with the readmission, whether it was length of stay related or not. There has been one study of that kind in Australia and it came up with quite mixed results, in some cases shorter length of stay was associated with higher rates of readmissions and in some cases it wasn't. At the Council of Australian Governments meeting on the 1st April of this year the heads of government, the Prime Minister, the Premiers and the Chief Ministers agreed that there would be financial incentives incorporated into the hospital funding arrangements associated with readmission rates to come into effect on 1st July 2017. But we didn't look at that issue in that report.

AUDIENCE: Just a quick question about the hotspots, obviously you said there was socioeconomic correlation, but was there any correlation with the number of practices in the area?

STEPHEN DUCKETT: Yes, we wanted to do that and we got two datasets from the Commonwealth Department of Health, one had age and sex in it and one had geography. So we couldn't do an age/sex standardised rate because we had two separate datasets, we couldn't do the analysis.

AUDIENCE: To what degree do you think the demarcation issues between Commonwealth and State funding play into some of these issues and can you see PHNs as a means of actually maybe better integrating funding or is maybe reform just dead?

STEPHEN DUCKETT: You're such an optimist! I'm actually more of a Pollyanna on these sorts of things and my view is that PHNs are the only game in town so we've got to use them. Also, even though the Commonwealth Government treats them as creatures of the Commonwealth Department, they are in fact independent incorporated entities and so my hope is that over time they'll be regarded as a neutral space which both the Commonwealth Government and the State Government can use. That will require the Commonwealth Government to liaise with them and hold them accountable more for outcomes than for inputs and they're very micromanaged still at the moment, is my view. So if we want to use them as a neutral space between the Commonwealth and the State, the Commonwealth has got to change its behaviour but the State has also got to say that yes, these things were stimulated by the Commonwealth, but we can use them too, and, as I said, my view is they are the only game in town.

One of the good things about the hospital funding arrangements is the Commonwealth is on the hook to pay for 45% of the costs of increasing hospital activity. So it's in the Commonwealth's interest to try and develop the primary care system to reduce the growth in hospital demand, so they have a financial incentive too in terms of trying to moderate hospital growth. So I think financial incentives are working in the right direction and that should mean that the Commonwealth is interested in doing the same things as the State is doing. So even though we've got quite a complex system, the financial incentives are working in the right directions.

JAMES BUTTON: Just before we take another question from the floor we've got questions that have been submitted to us as well. Jane, this one is for you, do you think the PHNs have the necessary professional leadership both centrally and at the local level to tackle the problems?

JANE GUNN: That's a very good question I think. I'd probably respond by saying that one of the things that's lacking and what's going to help in terms of leadership for the reform that we need is a clear idea of where we want primary care to head and the sort of primary care setting that we're trying to develop. In particular, I think we need to look at that in terms of what sort of practice do we want to be available at our local level and across the country so that we have a clear idea of the type of primary care, and obviously it's not going to be one-size-fits-all, it's got to meet the needs of the local community, but having clarity on that would be very good. I think there is a place for national leadership around some very important areas and in particular I would put that around electronic medical records data and decision support. That's the kind of thing that's expensive to do well, it's hard to do well, and there's no point doing that at every individual PHN level, it's just too difficult; even to do it at a national level is hard. So I think leadership around that is very important and around outcomes and indicators at the high level, although every PHN will need to develop things for

themselves that are very relevant for their own context at a local level. So I think leadership is important beyond the individual PHNs that exist, and that bit is not clear currently.

JAMES BUTTON: Thank you Jane.

AUDIENCE: My question relates to Stephen's presentation, which I thought was very good. You had a particular graphic there which showed the hotspots spread across the different SES areas in Victoria and Queensland and they showed hotspots, warm sports and cold spots across each of those SES areas. My concern is it's all very easy to concentrate on the hotspots. What's translatable from a warm spot or a cold spot to a hotspot? Why is it that hotspots remain hotspots for considerable periods of time? What lessons can we learn and what additional work needs to be done to establish those transferable learnings from a cold spot to a hotspot?

STEPHEN DUCKETT: That was one of the two really interesting things that we found. We thought right from the start it's all going to be socioeconomic status and all socioeconomic status is going to be the same, but it's not and it's this Sunshine versus Broadmeadows issue that really is interesting. To my experience, having worked a little bit in both of those areas, the social determinants of health, if you like that phrase, the socioeconomic factors that would lead to elevated rates of potentially preventable hospitalisation are very similar and yet they're not. There are a lot of areas of this kind, so the question you raise we couldn't analyse from where we stood, we didn't have the data to do it, but our conclusion was there are local factors, what is it locally, is it that there are more GPs in one or not? As I said, we couldn't look at that. So no, we don't know the answer to that, but you're absolutely right, it's one of the critical questions because they're only ten kilometres apart; we should be able to learn from one to the other.

AUDIENCE: Forgive me if I'm misinterpreted the data that was put up, but it seems to me that there's a huge amount of money that's going to treat chronic disease management. I'm interested in how we can improve that and how we can actually focus in on something that can change without waiting for the miracle to occur. So I'm interested particularly in Jane and Stephen's points of view about how in fact you can do something to enable this incredibly high amount of money that we spend with at best poor outcomes being demonstrated and at worst very poor outcomes.

JANE GUNN: I think there are high level and low level things you can do, high lens and low lens. I'll leave the high lens for Stephen and I'll take a low lens anecdote. An example from my own clinic, a woman I saw this morning, she's a single parent with diabetes. I've known her for 20 years, I've seen her child grow up, and I've been with her throughout the struggles to get her health in order. She has tried hard against all sorts of odds, but recently one of the really difficult things has been being able to get her into a supported environment where she would be able to do some physical exercise that's really needed and which she's needed for 20 years. Finally she has been able to get this really coached physical exercise. Because through the care plan she'd get five of those a year, that's nothing, I mean, it was just gone before she'd even started and she had to split them up between the dietician and the exercise physiologist. So she's finally made a huge commitment from money she doesn't have to spend it on an exercise physiologist and she's actually making gains for the first time in those 20 years. Now I think the chronic disease management is as tailored as that, it's as tailored as understanding what each individual needs and then the financing system, being able to allow the primary care practice to deliver that somehow.

If I could have given her an exercise physiologist 20 years ago to coach her once a week I would have given it to her then, but it was impossible to get and so she's had these little sprinkles of intervention over 20 years where she's got bits and pieces of programs and projects and things that have been funded from various community health centres or a bit of State Government or a bit of the chronic disease management plan. I think what we've done is spread too much too thinly across the system. Too many people have chronic disease management plans and all of the things that they probably don't need because they're not at high risk, like this woman is. She needs 26 visits or 52 with an exercise physiologist for a few years and then she could conquer her diabetes. That's the low level example.

STEPHEN DUCKETT: Just following up on Jane's comments, there's about a billion dollars spent on chronic disease management items and the like and general practice gets the same amount for a person with well-controlled diabetes, so no real problems, to a person like Jane was describing. So we've got to do some sort of tailoring and focus or risk adjustment, to use the technical terms, and that is actually quite complex and we haven't started that process. As I showed in our work that we've just started to do, we don't have the data to do it well enough at the moment. Another anecdote of the same kind is that I was in London a few years ago now and I was looking at care path software. The particular care path software I looked at the GP could use the care path to refer people off to an exercise physiologist, but they also had tailored it so that they could refer it to a local exercise group or a local walking group that the local council had organised and the data for that was in the care management software. So it was not putting them off to a health professional, but putting them off to local community support services which were a) group activities and b) locally available.

Going back to the high level or the broader system changes, yes we need to change the way we think about payment for general practice. At the moment every problem has a fee-for-service solution. The way we've evolved our payment system has been to graft on and graft on and graft on and each time it is making the fee-for-service system a bit more complicated and adding a few more items, rather than stepping back and saying what is the right thing to do and how can we do it? One of the problems with the Commonwealth Healthcare Homes trials is that a) they're very small with a very few number of general practice, but b) they haven't stepped back. As Jane said in her presentation, what is the overall vision, where are we trying to get to and articulate what it is and how do we know that what we're doing here is part of the way to get to that? It is going to take a long time because it is a big system we're trying to shift and the evidence base isn't as strong as we'd like it to be. So it is using what we've got and using it better but it also, as Jane said, needs to be setting a vision that is very clear.

ANNE CONGLETON: As I'm listening to Jane and Stephen what goes through my mind is reflecting on the disability services system through the development of individual support packages in Victoria and then the National Disability Insurance Scheme. So we're focusing on what the outcomes are for people and providing a tailored package of support to people and that can be a variety of things, so there is quite a bit of flexibility in what that can be deployed to, but very much at the centre it really elevates the person to be driving what it is that they need, so whether there are some learnings from that we can take into other funding models. I think the other thing is just thinking about the future, I think it is about then the investment in prevention. When we think that I think two-thirds of Australians are obese or overweight, so there are a number of risk factors that I think we've got to pay attention to.

AUDIENCE: I just want to know, is it really possible, if you have 7,000 individual GP practices all established in different ways, to actually move towards a new system if you don't have capitation or if you don't have a different way of managing data?

JANE GUNN: I think it's possible with the 7,000 practices. I'm not sure if that's how many we really need, but I think it's a good enough number. I think having healthcare close to your home is probably what most Australians would like to know was going to be there, so I think that's probably okay. I do think that the technological issues are beginning to be solved, but they're going to take a long time. I think that engaging the practices in the endeavour is going to require a different funding model and I think that often GPs might necessarily think that will mean it will be a funding model that means I can't run my practice, because a lot of them now are running on very close figures, others are probably making a lot of money out of the Medicare items that maybe aren't evidence-based. I think we have to sort that out, there is a lot of variation, and a new funding model is required to do it.

STEPHEN DUCKETT: I'm an economist, so it won't surprise you to know that I think if the financial incentives aren't going in the right direction you're not going to get the right answers. Half of the practices are big corporate entities, the majority of those are listed on the stock exchange, and the majority of the remaining half are small businesses. So financial incentives will change the way they operate, so that is absolutely core, getting the financial incentives right. Jane also said there are some other things. There are three big providers of practice software and there is no consistency about how you record things at all, each GP almost has their own idiosyncratic way of doing things, sometimes there is standardisation within a practice's software but sometimes there's not. One of the things the government ought to say, after consultation with GPs, is, "You can record however you like, but it's all going to be mapped to this standard system that we're going to apply".

Other countries have done it. The United States, for example, the home of free enterprise, the doctor's themselves have to record the ICD10 codes on the billing for Medicare and then say what this intervention was and which diagnosis the intervention relates to. So that's the home of free enterprise and anti-red tape and mad Donald Trump, but we ought to be able to have some sort of systematic collection. For every discharge from every hospital in the country, we know the diagnosis, we know the procedures, and we know what happened. We've got almost nothing on general practice when, if it's going to be the foundation for the health system, we ought to know what's going on, rather than what they just did.

JAMES BUTTON: Let's thank our panel, Stephen Duckett, Jane Gunn and Anne Congleton for a wonderful discussion. Thank you to the State Library, Sarah we really value this relationship with you in the *Policy Pitch* series and we hope it lasts a long time. Thank you all for coming tonight, such a large and attentive audience, it's been great. See you next time.

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