cohealth

position statement

A model of comprehensive primary health for 21st century Australia

cohealth sees a comprehensive primary health care model as providing primary health care that is accessible, integrated, multidisciplinary, coordinated, person-centred and goal-directed. The model uses risk stratification to identify groups with different levels of risk, and tailors service responses to their different needs. The model recognizes that a range of social factors in addition to clinical features contribute to risk of poor health outcomes, and prioritises groups at highest risk using an enrolment approach. The model includes primary prevention and health promotion and is focused on outcomes at both the individual and population levels

The limitations and challenges of Australia's primary health care system are now well recognised[1-4] and include:

- A system designed for one-off episodes of care rather than ongoing care for chronic conditions
- Insufficient coordination of care for people with chronic and complex support needs
- Lack of focus on prevention
- Lack of person-centredness
- Persistence of the inverse care law, with populations most in need of health care services the least likely to receive them

A comprehensive primary health care model is needed which addresses the above issues. Such a model is consistent with international best practice, and will position the Australian health system to meet the current and emerging primary health care needs of the population.

A comprehensive primary health care model will improve health outcomes by addressing health inequalities. Social disadvantage is a leading modifiable risk factor for poor health outcomes. [5]

The poor health outcomes experienced by disadvantaged communities are further associated with high social and economic costs, including: lower satisfaction with life; lower levels of employment; lower income; and higher burden on government through welfare support as well as health system costs.[6] Furthermore, higher spending on social care and public health is associated with subsequent improvements in health outcomes.[7]

A comprehensive primary health care model which focuses on the most disadvantaged populations has the greatest potential for gains in health status and quality of life, and reduction in avoidable health system and other costs.

cohealth's vision for a comprehensive primary health care model includes the following elements:

Target groups

- Risk stratification: populations are categorised by levels of risk.[8] This approach can improve the effectiveness and sustainability of the health system.[9] Risk is calculated based on the diagnosis of one or more health conditions and other clinical variables (e.g., medication use, history of hospital admissions, behavioural risk factors such as smoking). It also takes into account other "complexity variables" known to impact on risk of poor health outcomes, including cultural and linguistic diversity, and social disadvantage.[10] This points to a focus on identified priority cohorts, such as: those who are homeless or at risk of homelessness; refugees and asylum seekers; people recently released from prison,; and Aboriginal and Torres Strait Islander peoples.

  At present there is no consensus on the best tool for risk stratification in Australian primary care settings.[11] Identified key considerations in the use of risk stratification include: embedding them within broader care integration strategies, working with service providers before and during implementation; and ensuring sufficient and organizational capacity system (information technology; data management etc).[11]

- Enrolment: Individuals in the highest risk group (people with complex support needs) are enrolled with an identified primary health service, which then has responsibility for looking after their primary health care needs. Enrolment is a key feature of the primary health system for may comparable countries.[12]

Service models

- Primary health services are responsible for integrated, multidisciplinary, coordinated services for enrolled and non-enrolled individuals. The 'Health Care Home' (HCH) is internationally recognised as an effective service model, and has now been recommended for trial in Australia.[1]

- Primary health services are locally based, 'human scale', accessible services which vulnerable groups experience as appropriate and acceptable.

- Primary health services use a person-centred approach which includes:
    - a focus on client rights and responsibilities
    - a goal-directed approach to care planning which takes into account individual's preferences and priorities for their own health and wellbeing
    - consideration of the social and cultural influences on the health of individuals and populations .

Funding

- Funding for primary health services is a blended model, including capitation payments for enrolled individuals and fee for service payments for primary medical care for non-enrolled individuals. Australia is one of the few high income countries of the world to have no capitation element as part of primary health care financing.[7]

- Funding for primary health services includes a dedicated, ongoing funding stream for health promotion and primary prevention to address the primary contributing factors to poor health in the social and environmental arenas.

- Funding models may include pay for performance elements to incentivize high quality of care and improved health outcomes, and should incorporate measures of experience of care. Funding is also required to ensure that primary health services have the capacity to monitor and report on health outcomes at the individual and population levels.

- Capitation payments are adjusted to reflect the factors which contribute to the level of resourcing required to meet health care needs.

Quality and outcomes

- The Commonwealth Government is responsible for system quality and funding. This includes building risk stratification models, setting performance standards, and monitoring quality. Responsibility at the Commonwealth level ensures equity of arrangements across Australia.

- Performance frameworks should include both the individual level (quality of care and health outcomes), and the population level (focus on prevention and addressing the; focus on health inequalities).

The key principles of the model are:

Principle	Description	Implications
Equity of access	The principle of universal access which underpins Medicare and which has strong and wide support across the Australian community must be maintained. Furthermore, investment should focus on reducing the gap for those with the poorest health outcomes.	Funding arrangements must not adversely impact on low income groups or other groups who experience barriers to accessing care. System performance monitoring must support parity of access between regions.
Coordinated care	Care should be appropriate to, and driven by, the needs of the person rather than fragmented and piecemeal as a result of different funding streams, eligibility requirements, or caps.	The necessary enablers must be in place, such as shared information systems, and dedicated roles and resources for coordination and navigation. Multi-disciplinary teams should be the core of the system.
Efficient care	Care should be delivered by those providers, in those settings and through those modes that are the most efficient while maintaining high quality service and high levels of client satisfaction/ experience.	Health professionals should work to the top of their scope of practice within multi-disciplinary teams. The settings and modes which are most convenient and accessible to clients should be used, leveraging off new technologies and supporting client preferences.
Person-centred	Care should be aligned to individual needs and preferences with meaningful health goals set by the client. Care should 'wrap around' the person as appropriate to their needs rather than requiring individuals to navigate a fragmented system. Care should take into account the social and cultural influences on health.	Mechanisms to understand people's experiences and preferences must be embedded in the system. Ideally these should be linked to funding mechanisms. Goal-directed approaches should be used. Services should be culturally appropriate and safe.
Prevention-focused	The largest contributors to the burden of disease are preventable risk factors. These hold the key to long term containment and even reduction of demand for more intensive and more expensive health interventions.	Funding arrangements must incentivize keeping people well through primary prevention that addresses the foundation social, environmental, and cultural determinants of health. Pressures on meeting demand for acute services must not overshadow the importance of investment in prevention.

Community health services are ideally positioned to trial a comprehensive primary health care model

cohealth welcomes the proposed trial of Health Care Homes.[1] Community health services (CHSs) such as cohealth are ideally positioned to participate in this trial for a number of reasons.

First, they already have many of the key elements of the Health Care Home model in place, such as care coordination mechanisms, goal-directed approaches, and multidisciplinary teams. CHSs, which have a particularly strong presence in Victoria, provide an integrated platform of primary health services including general practice, nursing, allied health, oral health, mental health and other services. To coordinate care, cohealth for example uses mechanisms such as interprofessional collaborative practice teams,[13] employment of dedicated care coordinators, and collaborative arrangements with acute services including outreach specialist clinics. cohealth has also made significant investment in building staff capability in goal-directed care planning. In addition to implementing the person-centred Collaborative Recovery Model in our community mental health support services,[14] over 300 of our staff have completed training in goal-directed care planning and we are now embedding this across our services.[15]

Second, CHSs are specifically designed to focus on disadvantaged people and communities, such as those who are homeless or at risk of homelessness; refugees and asylum seekers; and Aboriginal and Torres Strait Islander peoples.[16] CHSs have extensive experience in evidence-based approaches to providing accessible and appropriate services for these groups (e.g., through the use of priority access, drop in clinics, inclusive accessible sites, assertive outreach, and rights-based practice). They also have well-established relationships with vulnerable communities, and expertise in primary prevention and health promotion programs that use participatory, codesign approaches tailored to specific communities. Given that vulnerable communities have the highest levels of need, they are a primary target for the Health Care Homes trial, which is designed to focus on those with complex support needs.

In short, Victorian CHSs, and similarly, Aboriginal Community Controlled Health Services, are already delivering evidence-based, high quality, integrated, person-centred care to vulnerable populations. These approaches arise from the rights-based, equity-focused principles on which these organisations are founded, and rely on the organisations carrying substantial costs over and above what is covered by existing government funding. Such subsidisation is rarely found in the (dominant) for-profit providers in the primary health sector, and is increasingly unsustainable. The proposed model overall, and the Health Care Homes trial in particular, would provide sufficient resourcing for Victorian community health services to systematically and effectively deliver the model of care in which they have built expertise over the preceding decades.

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