Integration on the ground - NSW community health, primary care and beyond

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Abstract
[extract] 'Right care' in the 'right place'

- Integrated service delivery is "the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money"

Keywords
nsw, community, ground, health, integration, primary, care, beyond

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Integrated Care Forum

Wednesday 26th March 2014
Stamford Plaza, Sydney Airport

Integration on the ground –
NSW community health, primary care and beyond
‘Right care' in the 'right place'

Integrated service delivery is “the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money”


The jury is in...

‘Robust evidence shows that patient care delivered with a primary care orientation is associated with more effective, equitable, and efficient health services. Countries more oriented to primary care have residents in better health at lower costs...’

Integration ingredients

◆ Structural
  – Commonwealth / State; public / private / NGO; hospital / community etc
◆ Policy
  – Health / aged care / disability
  – Health subsets – acute / subacute / primary / mental etc
◆ Funding
  – Funding / purchasing / commissioning / paying / subsidising etc
  – Population need (capitation) / service activity / outcomes
◆ Transactional
  – Eg, IT platforms and systems, electronic medical records
◆ Cultural

Structural integration

A reality check
The starting point for our western health care system

New South Wales became a (penal) colony in 1788, followed progressively by the other Australian States. Australia didn’t become a country until 1901

A federation

- Commonwealth (national) government
- 6 State (previously colony) and 2 Territory governments
- Constitution (1901) - health is the responsibility of the States
  - Except quarantine matters
- Amended in 1946
  - To allow Commonwealth to provide health benefits and services to returned soldiers
- Commonwealth didn’t have a role in health care until 1972 (Medibank)
  - Except for war veterans
- States and territories own all public health facilities and infrastructure
Public hospital funding

- Commonwealth originally agreed to contribute 50% of public hospital funding in 1972 (with inception of Medibank)
- 5 year Commonwealth-State agreements from 1983 until 2013
  - But Commonwealth reduced its funding contribution in real terms, especially from the 2003 agreement
- With election of Rudd government in 2007, states and territories wanted a return to 50:50 funding
  - they got ‘national health reform’ instead
- Commonwealth share (38%) now Activity Based Funding

Public health financing in 2014

- Australian health financing (‘Medicare’)
  - Commonwealth funded health care
    - CMEB
    - Costs of private medical and related services
      - Seemingly capped
    - Medical and diagnostic costs of privately insured hospital care
      - Seemingly capped
  - Other Commonwealth PBS, DVA, aged care etc
  - Payments to States and LHNs
    - Activity Based Funding
    - Block funding
      - Capped by state ability to pay its (majority) share
      - Capped
    - National Partnership and incentive payments?
      - Capped
National Health Reform Agreement (NHRA)

Signed by COAG 31 July 2011

Brave new world

- Health system splits into 5
  - Hospitals - State responsibility
    - Commonwealth now contributes its share on an activity basis
  - Private sector primary care - Commonwealth responsibility
  - “Aged care” including Home and Community Care (HACC) for people > 64 years - Commonwealth responsibility
    - except Victoria and Western Australia
  - Disability services - State responsibility
    - All disability, HACC and residential care for people < 65 years
    - But NDIS has superseded this
  - Community health, population health and public health - State responsibility
Medicare Locals – parallel universe

◆ Service delivery
  – Health promotion and prevention programs
◆ Networking and coordination
  – Facilitate services for people with chronic conditions as per care plans prepared by GPs
  – Work with LHNs to identify service pathways, transitions out of hospital & into aged care
◆ Population level planning and selective commissioning
  – Identify service gaps & better target services to respond to these gaps
  – “Act as fund-holder and purchaser of services in areas of market failure and where patient needs are not being met”

NDIS – parallel universe

◆ Long-term care and support to people who have lifelong disabilities
◆ Not a health scheme
  – Health care is a specific exclusion under the legislation
◆ But boundary between health and NDIS leaves plenty of room for conflict, cost-shifting and misunderstanding:
  – Eg, therapy for maintenance purposes is eligible for NDIS funding. Therapy for functional improvement is not
Incentives for NSW

- The (short-term) incentive for NSW is to close whatever it can (except public health & hospitals) on the basis that:
  - The Commonwealth can fund / subsidise private medical and allied health services, aged care, the NDIS etc
  - Private insurers & consumers can pay for the rest
- How risky is it for NSW to leave hospital demand management to other parties?
- Other unintended consequences?
  - Children at risk, justice / corrections / police, public health issues, education, public housing etc
- How can NSW better manage this risk?

Future of community health?

**Child, family & youth health**
- Child and family
- Physical Abuse and Neglect of Children (PANOC)
- Youth health
- Sexual assault
- Sexual health
- Womens health

**Community & priority populations**
- Intake and initial assessment
- Counselling and psychosocial services
- Health promotion
- Aboriginal health
- Multicultural health

**Mental health, drug & alcohol**
- Mental health
- Drug and alcohol

**Rehabilitation, aged care & chronic disease**
- Aged and extended care
- Community nursing and domiciliary care
- Community rehabilitation
- Hospital demand management
- Multidisciplinary chronic disease management
- Palliative care

**Oral Health**
Conclusions on structure

◆ Health care in Australia will not be structurally integrated in the foreseeable future:
  - Commonwealth and state will continue to split / share responsibilities for health
  - Health / aged / disability will continue to be structurally separate
  - Primary care, mental health, acute care etc will continue as separate streams
  - Public, private and NGO provision will continue

◆ Community health is at the cross-roads
◆ We need to improve integration regardless

A cook book of integration ingredients

◆ Policy
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◆ Cultural
Laws we need to learn and apply in the next decade and beyond

Starting with the Leutz Laws of Integration

Leutz Law’s of Integration

1. You can integrate some of the services for all the people, and all the services for some of the people, but you can’t integrate all of the services for all of the people
2. Integration costs before it pays
3. Your integration is my fragmentation
4. You can’t integrate a square peg and a round hole
5. The one who integrates calls the tune
6. All integration is local
**Leutz laws 1 and 3**

- You can integrate some of the services for all the people, and all the services for some of the people, but you can't integrate all of the services for all of the people
- Your integration is my fragmentation

- Not all patients need/want their care to be integrated:
  - Self-navigation (healthy, literate, episodic contact)
  - Guided navigation (at risk or with acute conditions needing multimodality care or chronic and complex)
  - Case management (unable to make informed choices)

- Priorities for integration are those with chronic conditions and those who are at risk

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**Different strategies needed at different points across the continuum**

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Leutz Laws 5 and 6

5. The one who integrates calls the tune

6. All integration is local
   – implementation is always local and has to fit the context
   – as a corollary, larger policies should facilitate, rather than dictate, the structure and pace of local action

◆ Both of these can’t be (completely) right

Gate-keeping laws - the need for smarter funding and payment models

◆ Primary care providers cannot be successful gatekeepers of systems they are not part of
   – ‘strong gatekeeping is not characteristic of fee for service arrangements’ (Gervas, Fernandez and Starfield 1994)

◆ Smart funding and payment models are required to create the right incentives
There is no point waiting for structural integration

- **Policy**
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- **Cultural**

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**Four priorities**

1. Maintain and extend commitment to decentralisation
2. Favour capitation and needs-based funding over fee for service and activity based funding
   - Use the international evidence to develop smart blended and mixed payment models
3. Optimise use of IT and promote information sharing
   - ‘collect once, use often’
4. Support a well organised and resourced primary and community care sector
Key evidence to measure success

◆ Peripheries of Excellence (Julian Tudor-Hart 1997)
  – not just Centres of Excellence
◆ Linked up providers
◆ Smooth patient journeys
◆ Decision-making (both policy and practice)
  routinely informed by evidence
◆ A health system we can afford to pay for

References

◆ Gerves, Fernandez and Starfield Primary Care, Financing and Gatekeeping in Western Europe Family Practice. 1994; 11: 307-317
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Access to specialist services is a large and growing gap, where would this fit in your model?
Different strategies needed at different points across the continuum

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