

Queensland Health
Community Health Services Reform Project

Literature review July 2007

Smart Health:
Reforming community health services in Queensland



Queensland
Government
Queensland Health

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1. Executive Summary

This paper is one of the pieces of work commissioned by the Project Management Committee (PMC) of the Community Health Services Reform Project. The PMC requested a review of international, national and state/territory initiatives and evidence in relation to new models of community health care, including community controlled health organisations in delivering services for the Aboriginal and Torres Strait Islander population. This paper will be used to inform the Options Paper and the Final Report.

The health system reviews, reforms and new models of care, in Australia and internationally, are following a similar trajectory.

- Each health system review and subsequent recommendations have similar themes and identified almost identical principles of care.
- Each review has highlighted the need for their health system to become more patient-centred and to have equity of access, regardless of where people live, their socio-economic circumstances or the time they require care.
- The reviews identify the need for health systems to improve continuity of care across and within primary, secondary and tertiary health services and across the health continuum.
- There is a move to focus health care on early intervention, prevention and promotion rather than diagnosis and treatment.
- An admission to hospital is increasingly seen as a short, episodic event within the wider context of the health care continuum.

Each model outlined in this paper is responding to similar supply and demand forces, such as:

- an increasing and ageing population;
- increasing cost of new health care technology and increased overall expenditure on health;
- increasing prevalence of preventable chronic disease;
- increasing disparity between the health of Indigenous and non-Indigenous people (particularly in Australia);
- a desire to reduce avoidable hospital admissions; and
- a move to provide safe and high quality health care away from a hospital setting.

A key issue for government-funded community and primary health care is the definition of their core business. The need to identify the range of health care services (including essential services) provided for defined populations has been highlighted in all reviews, as a recognition that government-funded health systems cannot be all things to all people and that there are many key non-government and private health providers within the health system that need to work together to provide health care.

There is pressure for the workforce to adapt in the face of decreasing numbers of skilled professionals and changing models of care. There is also an increased emphasis on the use of multidisciplinary teams to respond to the new focus on patient-centred care, to ensure an integrated health care system and smooth journey for patients through the health system.

The literature review is limited by the need for a broad sweep of health care reforms and models of care and also by the tight timeframes of the project.

1. Background

1.1 Scope of the paper

The Literature Review is one of the pieces of work commissioned by the Project Management Group of the Community Health Services Reform Project. They requested a review of international, national and state/territory initiatives and evidence in relation to new models of community health care, including community controlled health organisations in delivering services for the Aboriginal and Torres Strait Islander population. This paper will be used to inform the Options Paper and the Final Report.

1.2 Methodology

- A review of Queensland Health documents, including the *Queensland Health Action Plan - Building a better health service for Queensland*, the *Queensland Health System Review. Final Report* (Forster Review), the *Queensland Statewide Health Service Plan 2007-2012*, the *Queensland Health Hubs & Precincts Service Development Framework* and a scan of Queensland Health Program area policies;
- Policy scan of all Australian State and Territory health jurisdictions;
- Scan of Commonwealth Department of Health and Ageing policies and funding programs;
- Searches of Australian and International Health Policy Research Institutes/Centre reports;
- Review of United Kingdom, New Zealand and Canada health reforms, policies and models of care;
- Medline and ScienceDirect searches- <1997-2007>: community health, primary health care, primary care, secondary care, health outcomes, models of care, performance indicators.
- Cochrane collaboration search: community health, primary health care, primary care, secondary care, health outcomes, models of care, community health performance indicators.
- Internet/ desktop search, such as Google Scholar and general web search.

1.3 Limitations

The literature review was undertaken in the first three months of a nine-month project. The scope of the review is not exhaustive and is limited by the nature of the timeframes of the project.

2. International models

2.1 United Kingdom (England)

Reform

The UK Labour Government has been implementing health care reform since its election in 1997. Since the release of the Department of Health's *NHS 10-Year Plan* in 2000 and the *Wanless Report* in 2002, the National Health Service (NHS) has undergone a period of rapid change. The new Labour Prime Minister, Gordon Brown has just announced another stage of reform, the *NHS Next Stage Review*, which states they will build on the progress made in delivering the NHS plan and the Government's reform agenda and identify the way forward for the NHS to be clinically-driven, patient-centred and responsive to the needs local communities.

Vision

The Department of Health's vision has been to have a health system designed around the needs of the patient, to increase equitable access to and affordability of health care (NHS Plan, 2000). There is an emphasis on prevention, primary care, self-care, the quality of care and an increased focus of the health system on the provision and management of health care by the primary care sector.

Drivers for reform

The drivers for change have included an ageing population, rising rates of obesity and other chronic diseases, and changing consumer expectations. Drivers have also included changes to the way health care is delivered such as advances in high cost medical technology, promotion of integrated care and management of chronic disease.

There has also been an increase in day procedures and a consequent reduction on the need for hospital beds. Consumer expectations have changed, with an increasing demand for access to local health service after hours. The five key elements of the NHS Plan reforms have been the introduction of performance targets, patient choice, funding associated with patient choice, new forms of providers (such as NHS Foundation Trusts and Independent Sector Treatment Centres) and an emphasis on self-management by people living with chronic disease.

The focus of funding

Since the introduction of the NHS Plan in 2000 there has been a major injection of funding in order to bring the NHS health spending up to the European Union average (NHS, 2007a). Expenditure on public health has increased from 5.6 per cent of GDP in 2000-01 to 7.3 per cent of GDP in 2006 (now 17 per cent of public expenditure).

Although the initial focus of the injection of funding was on building the capacity of the health system to reduce waiting lists, improving the care of people with cancer and heart disease and to reducing the NHS deficit by reforming spending there is now a focus on improving the experience of the patient within the health system. The original focus involved employing more doctors and nurses, building infrastructure, changing the governance model and changing the focus of decision making from the Department of Health to local health service providers, particularly General Practitioners (GPs) and their practice teams. The focus has now shifted to the provision of integrated patient-centred care. There has been a move away from a diagnostic and treatment focus to a model of care based on predicting and preventing illness to become more patient-centred and to be primary-care based

The Department of Health's White Paper, *Our Health, Our Care, Our Say* (2006) continued the reforms of the NHS Plan (2002) with a further move towards GP-based primary care.

The development of Primary Care Trusts in 1999 placed general practice as the key players in the NHS (McDonald et al 2006) and the development of GPs as fund-holders and purchasers (or 'commissioners') of health services for their patients allowed GPs to develop more local responses to health care.

Structure of the primary care sector

The NHS is moving toward becoming a locally lead and locally driven service, with GPs being seen as the central service provider of the health system.

GPs and their practice teams

GPs and their practice teams are both providers and purchasers of care. Through the introduction of Practice-Based Commissioning (PBC) in 2004, GP practices now receive 'indicative' budgets from Primary Care Trusts, which allows them to provide innovative care, develop local care pathways and purchase necessary secondary care for their patients. Practices are able to retain at least 70 per cent of any savings achieved by directly commissioning services and to reinvest the savings into premises, capital infrastructure (including diagnostic equipment) and to develop services on-site. GPs must reinvest savings back into their practices, by either developing or providing specialist care, diagnostics, equipment or staff (Lewis et al 2007, NHS 2006).

GP practices are expected to improve patient's access to other healthcare professionals and for larger practices to consider safe pathways for patients to see specialists in-house. As part of the focus of the NHS system on preventive and community-based care, GPs are also expected to actively encourage self-managed care for people with chronic disease.

Through PBC and being able to choose local services to provide care, GPs are referring fewer patients to hospitals for outpatient appointments. By late 2006, GP referrals to hospitals had decreased by 25-33 per cent. Services have been redesigned according to local needs (GNN, 2007).

Primary Care Trusts

Primary Care Trusts (PCTs) are free-standing statutory NHS bodies with responsibility for delivering health care and health improvements to their local areas. Primary Care Trusts provide the strategic frameworks and business support models for delivery of health care for General Practitioners and their practice teams (Nicholson, 2007). There are currently 152 PCTs in England, covering approximately 8,000 GP practices (GNN, 2007). PCTs currently receive approximately 80 per cent of the NHS budget, which they receive directly from the Department of Health (Gubb, 2006).

PCTs are responsible for understanding the local health needs and for developing commissioning strategies to ensure appropriate services and pathways of care are available locally. PCTs work in partnership with GP practices, Local Authorities and other care providers.

Most Primary Care Trusts also directly provide community health services and across England, PCTs employ about 250,000 staff directly, including district and community nurses, community midwives, health visitors, speech and language therapists and physiotherapists. PCTs integrate family health services and community health care within one organisational structure.

The NHS has also introduced competition and collaboration into the health system to encourage innovation with the introduction of independent treatment centres and non-NHS owned and operated PCTs.

Patient-centred care

The key initiatives that have supported patient centred care have included the introduction of *NHS Direct*, a 24-hr health advice line, and *Choose and Book*, the ability to book specialist appointments on line or by phone, at time that is convenient to the patient. The patient usually has a choice of four providers to choose from, which might include an NHS Trust, an NHS Foundation Trust or an Independent Sector Treatment Centre (NHS 2007b).

Governance

Strategic Health Authorities (SHAs) monitor the performance and standards of the PCTs. There are currently 10 SHAs in England. The NHS Leadership Team is responsible for setting the role, rules and priorities of the health system. The NHS Boards hold the Executive of the PCTs to account to the NHS and the local community (NHS, 2007).

Workforce changes

Community Matrons (CMs) were introduced in 2006 and by March 2007 there were 3000 placed across England. CMs undertake a nursing case management role working with the frail elderly in order to decrease the number of emergency hospital visits and to prevent premature death. They provide 1:1 support to the most vulnerable patients and ensure health care services are integrated and complementary. CMs have an average caseload of 50 to 80 patients. An evaluation of a pilot program that involved nine Primary Care Trusts showed whilst CMS were not shown to directly reduce hospital admissions they did increase access to an additional range of services and thereby improved the quality of life of the frail elderly (McDonald et al, 2006).

Evaluation

In undertaking a systematic review of primary health care models, McDonald et al (2006) stated that as the models of care in the UK were only recently introduced they were unable to find any literature evaluating them at this time.

2.2 New Zealand

Reform

The organisation of health and disability support services in New Zealand has undergone a number of reforms over the last decade and a half. In 1993 a quasi-market model ('purchaser/provider' model) was introduced, involving increased contracting and competition (McDonald, 2006). Since 2000 and the release of the *New Zealand Health Strategy*, there has been a move to a more community-oriented model. The current system, implemented through the *New Zealand Public Health and Disability Act 2000*, allowed for the creation of District Health Boards (DHB) designed to move New Zealand to a population based health system. The *Primary Health Care Strategy (2002)* and the *He Korowai Oranga- Māori Health Strategy (2002)* aimed to reduce health inequalities in New Zealand and to improve the overall health outcomes of the whole population.

Vision

The New Zealand Health Strategy (2000) is based on seven principles, which are meant to be applied across the health sector and be demonstrated in all strategies and developments. The principles are:

- Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi;
- Good health and wellbeing for all New Zealanders throughout their lives; (*promotion, prevention, early intervention, continuum of care*)
- An improvement in health outcomes of those currently disadvantaged; (*equity*)
- Collaborative health promotion and disease and injury prevention by all sectors; (*promotion, prevention, early intervention, partnerships and collaboration*)
- Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay; (*equity, access*)
- A high-performing system in which people have confidence; (*quality*)
- Active involvement of consumers and communities at all levels (*partnerships, patient-centred care*).

Drivers for reform

Although the contracting system introduced in 1993 resulted in increased accountability for primary health care providers and collaboration between sectors, the purchaser/provider model ultimately proved to be very unpopular (McDonald, 2004). Due to the dissatisfaction with the market-driven model of health care, the Government changed to a new model of care, focussed more on health care that was developed, governed and provided locally. In the *New Zealand Health Strategy (2000)*, the Government stated it believed improvements in health and consumer satisfaction with the health system were being hampered because of a commercially-focussed health care system and consequently increased community and consumer participation, as well as delegated responsibility for the provision of health care closer to the consumers via the establishment of regional District Health Boards and local Primary Health Organisations.

New Zealand was also found to be behind other OECD countries in terms of the health outcomes of the Māori and Pacific peoples communities with the average life expectancy for Maori New Zealanders being 9 years less than for other New Zealanders (Hefford, 2004). In order to address health inequities, the Government aimed to provide a health care system that targeted Māori and Pacific people's health. *He Korowai Oranga – the Māori Health*

Strategy (2002) was developed to address health inequities and is based on three principles - Partnership, Participation and Protection.

Structure of the primary care sector

Primary health care

Primary health care is designed to be delivered to New Zealanders according to the *Primary Health Care Strategy* (2002) and is now a central focus of the New Zealand health care system. It covers a broad range of out-of-hospital services, both public and privately funded. The focus on primary health care aims to improve the health of the people in communities by working with them through health improvement and preventative services, such as health education and counselling, disease prevention and screening. Primary health care includes first level services such as general practice services, mobile nursing services and community health services targeted especially for certain conditions, for example maternity, family planning and sexual health services, mental health services and dentistry, or those using particular therapies such as physiotherapy, chiropractic and osteopathy services. Chronic diseases, such as diabetes are seen to be best managed by primary health care services through prevention and early intervention. A key part of the *Primary Health Care Strategy* (2002) has been the creation of Primary Health Organisations (PHOs).

Primary Health Organisations

Primary Health Organisations (PHOs) are the local health service structures that deliver and co-ordinate primary health care services to an enrolled population. PHOs are made up of medical clinics, GP practices, family health centres and involve multidisciplinary teams, such as doctors, nurses and other health professionals (such as Maori health workers, health promotion workers, dieticians, pharmacists, physiotherapists, psychologists and midwives). PHOs are based in the community and patients enrol with a PHO of their choice. PHOs vary widely in size and structure and are not-for-profit. The first PHOs were established in July 2002 and there are now 81 PHOs in New Zealand covering approximately 3.9 million (of 4.1 million) New Zealanders (Statistics New Zealand, 2007).

The aim of PHOs is to ensure: a greater emphasis on population health, health promotion and preventative care; community involvement; involvement of a range of health professionals, with multidisciplinary approaches to decision making; improvements in accessibility, affordability and appropriateness of services; improvements in co-ordination and continuity of care; and the provision and funding of services according to the population's needs. PHOs aim to make primary (non-hospital) health care more affordable, accessible and more accessible suited to the needs of enrolled members and their family or whānau (Te Tai Tokerau PHO, 2007).

Primary Health Organisations are allocated funding from the government to subsidise a range of health services. PHOs are funded via District Health Boards for the provision of a set of essential primary health care services. The funding is based on the number and characteristics (eg, age, sex, ethnicity) of people enrolled with their service. Funding pays for provision of care and treatment, preventative health care and outreach programs to disadvantaged or isolated populations. The policy has been successful, with over half the New Zealand population enrolling in new Primary Health Organisations within 15 months and over 400,000 people (half of them in vulnerable groups) gaining improved access to primary care subsidies (Hefford, 2004).

District Health Boards

District Health Boards (DHBs) are responsible for providing or funding the provision of health care services for the population of a designated geographical area. DHBs were established in 2001, after the release of the *New Zealand Health Strategy* (2000) and there have been 21 DHBs established in New Zealand to date.

The DHBs statutory objectives include improving, promoting and protecting the health of their local communities. They are charged with promoting the integration of health services, particularly primary and secondary health care as well as working to reduce the health disparities of the Maori population by improving their health outcomes. DHBs are expected to show a sense of social responsibility, to foster community participation in health improvement, and to uphold the ethical and quality standards commonly expected of providers of services and public sector organisations.

For example, Auckland DHB is funded on a population-based funding formula that is based on where people were living on census night. Auckland DHB has a total revenue of approximately \$1.3 billion per year and funding of \$754 million for the Auckland DHB population. Auckland DHB owns a provider arm which is made up of the Auckland City Hospital and the Greenlane Clinical Centre and their related community-based services. Greenlane provides community, ambulatory and mental health services as well as children's and young people's services.

Funding - primary health care budget

The funding for primary health care is based on the population that the PHO services. Funding is provided to District Health Boards, who then resource Primary Health Organisations in their regions.

Total funding comprises funding for capitation based subsidies and other initiatives (not funded on a capitation basis, such as Performance Payments and Care Plus). Capitation Based Funding is 'demand driven', in that the funding is tied to the volume of enrolled patients on a PHO's register and is highly sensitive to the demographic characteristics of enrolled population as different demographic categories, such as age and ethnicity, are paid different capitation based subsidy rates. The introduction of capitation funding in 2001 was seen as a key policy tool for achieving the *Primary Health Care Strategy* objectives of improving health outcomes and reducing health disparities.

PHOs get a set amount of funding to subsidise health services for their enrolled populations, including funding to subsidise the costs of doctors visits and pharmaceutical charges; to conduct health promotion programmes and to provide new services or improved access to reduce health inequalities among high-need groups. PHOs are funded under two different models – Access and Interim. 'Access' funded PHOs and practices have high proportions of low-income, Maori and Pacific peoples - groups that have traditionally had poorer health outcomes than the rest of the population.

PHOs are also eligible to receive Performance Payments as they improve their performance on clinical, process/capacity and financial indicator targets. For the majority of indicators the closer the PHO moves towards its target the greater the proportion of the payment they will receive (MoH, 2006). The initial focus was on improving clinical indicators, with 60 per cent of performance payments available for meeting targets based on national priority initiatives and therapeutic areas to support best practice, population health initiatives and overcoming barriers to access for specific population groups (MoH, 2007d)

PHOs and practices that charge very low fees to patients are also entitled to a "Very Low Cost Access" subsidy in order to support, encourage and reward PHOs and their practices to forgo charging patient fees so they can reduce health inequalities by providing very low cost access to primary health care. On 1 July 2007, increased *Primary Health Care Strategy* funding for 25 to 44 year olds was rolled out to PHOs.

Governance

The governance requirements for DHBs and PHOs are set out in the minimum requirements documents released by the Minister of Health in 2001. These minimum requirements cover community, consumer and practitioner/provider involvement in governance arrangements. PHOs were expected to establish their own governance arrangements, suited to the local population. After concerns were raised in 2005 about the inadequacy of consumer participation, the Ministry of Health conducted a stock take of PHO governance documents. Thirty-three PHOs were registered under the Companies Act 1993, 36 registered under the Charitable Trusts Act 1957 and 5 registered under the Incorporated Societies Act 1908. The stock take found variable arrangements for ensuring consumer participation, with 18 of the PHOs surveyed having no provisions in their constitutions for their governance structure to include community, consumer, Maori, or health service provider representation. The Ministry refer it to the DHB to continue to investigate the issue and to report back to the Ministry.

Performance Management

Primary Health Organisations

In 2001, the Minister of Health released a set of minimum requirements that guide the establishment and operation and set out standards that PHOs must meet. PHOs have clinical, process/capacity and financial indicators that they must achieve which includes a requirement they will give communities, iwi¹ and enrolled people the opportunity to have their say about the services provided. Primary Health Organisations are accountable to District Health Boards (MoH, 2005) who are contractually responsible for performance and who monitor performance through the PHO Performance Management Program

The PHOs guidelines state that at a minimum, services will include approaches directed towards improving and maintaining the health of the population, as well as first-line services to restore people's health when they are unwell. They are required to involve their communities in their governing processes and must demonstrate they are responsive to communities' priorities and needs. They must also show that all their providers and practitioners can influence the organisation's decision-making, rather than one group being dominant. PHO must be not-for-profit bodies and are required to be fully and openly accountable for all public funds that they receive. While primary health care practitioners will be encouraged to join Primary Health Organisations, membership is voluntary.

The Ministry for Health's 'PHO Performance Programme' aims to improve the health of enrolled populations and reduce disparities in health outcomes through supporting clinical governance and continuous quality improvement processes within PHOs. The Programme was designed by primary health care representatives, DHBs and the Ministry.

District Health Boards

The activities of District Health Boards are guided by two overarching strategies for the health and disability sector, the *New Zealand Health Strategy* (2000) and the *New Zealand Disability Strategy* (2001). The statutory objectives of DHBs are outlined in the *New Zealand Public Health and Disability Act 2000*.

¹ Iwi - Tribe or grouping of people, usually with a common ancestor. They are the largest everyday social units in Māori society

2.3 Canada

Structure of the Canadian health system

Like Australia, Canada has a federal system of government, with health care being the responsibility of both the federal government and the provinces (states) and territories. The federal government, the ten provinces, and the three territories play a role in the health care system in Canada. The federal government is responsible for setting and administering national principles for the health care system through the *Canada Health Act* (1948); assisting in the funding of provincial/territorial health care services through cash and tax transfers; delivering health care services to specific groups (e.g. First Nations and Inuit and veterans), and providing other health-related functions such as public health and health protection programs and health research.

Canada has a Medicare system which provides access to universal, comprehensive coverage for medically necessary hospital and physician services. Hospital and physician services are administered and delivered by the provincial and territorial (i.e. state or regional) governments, and are provided free of charge. The provincial and territorial governments fund health care services with assistance from the federal (i.e., national) government. The responsibility for First Nations people and Inuit health services is shared by the federal, provincial and territorial governments and Aboriginal organisations. The responsibility for public health is also shared (Health Canada, 2007).

The Canadian Government sees primary health care as central to the health care system (McDonald, 2004). In Canada primary health care involves providing services with a focus on prevention and support for management by multidisciplinary teams to individuals, families, communities and populations and follow-up if health problems occur.

Canadians do not pay directly for insured services and insured services do not include deductibles, co-payments, or dollar limits on coverage. The *Canada Health Act* (1948) establishes criteria and the conditions that govern the federal contribution to health care under the Canada Health Transfer (CHT) (see funding below), with Health cards (also called Care Cards), being a Provincial responsibility.

Vision

Health Canada's stated vision is to be "committed to improving the lives of all of Canada's people" and to making Canada's population among the healthiest in the world "as measured by longevity, lifestyle and effective use of the public health care system" (Health Canada, 2007). The *Canada Health Act* (1948) is Canada's federal health insurance legislation and establishes the criteria and conditions related to insured health care services. The conditions (or principles) include comprehensiveness, universality, portability, accessibility and public administration.

Reform

In 2000, the Government of Canada established an \$800 million, five-year Primary Health Care Transition Fund (PHCTF) to support the implementation of large-scale Primary Health Care renewal initiatives which would improve access, accountability and integration of services (McDonald et al, 2004). The PHCTF was seen an important federal mechanism for enhancing primary health care reform across Canada and a key federal lever for the renewal of Canada's health care system overall (Health Canada, 2005a) The Fund was established to: increase the number of primary health care organizations to provide a prescribed set of comprehensive services to the populations they serve; increase the emphasis on health promotion, disease and injury prevention, and chronic diseases management; expand 24-hours-a-day, 7-days-a-week access to essential services; establish multi-disciplinary provider teams within these primary health care organizations; and to facilitate coordination

and integration with health services available elsewhere, such as hospitals (Health Canada, 2005a). There are three national strategies under the PHCTF: the National Strategy on Collaborative Care, the National Primary Health Care Awareness Strategy, and the National Evaluation Strategy.

Central to primary health care renewal in Canada has been the implementation of various collaborative care models across Canada. The National Strategy on Collaborative Care was created to complement and reinforce a move to a more collaborative approach to health care. The Strategy supported national initiatives aimed at addressing the barriers to health care and facilitating approaches to collaborative care within the primary health care sector. Collaborative care ensures coordination and continuity of care across primary health care providers to meet the needs of the patient, usually through a team approach. The Primary Health Care Transition Fund played a significant role in supporting the provinces and territories' shift toward a more collaborative approach to care through the Provincial-Territorial and Multi-Jurisdictional spending. According to McDonald et al (2004), Romanow (see below) believed the PHCFT had not been successful in reforming the health system and suggested that funding and accountability obstacles needed to be addressed.

In 2001, the Prime Minister identified the need to ensure the long term sustainability of a universally accessible, publicly-funded health care system and therefore commissioned a review into the Canadian public health system and associated funding models. In April 2001, the Prime Minister established the *Commission on the Future of Health Care in Canada* and Roy J Romanow, QC led a major review into long term sustainability of Canada's public health care system (Romanow, 2002). A Research Program ran in conjunction with the review, to ensure recommendations were evidence-based. In November 2002, Romanow released *Building on Values: The Future of Health Care in Canada – Final Report*, which made 47 recommendations 'to reform and renew' the Canadian public health system. The recommendations validated the central role of primary health care (PHC) in the Canadian health system (McDonald, 2004).

In 2003, an *Accord on Health Care Renewal* resulted from a meeting of First Ministers. The Accord was developed as an action plan to improve timely access to quality care for all Canadians. The Accord reflected the recommendations of national and provincial studies of the health care system and set out commitments by First Ministers to reform the health system and make it more accountable to citizens.

In 2004, the Canada's First Ministers held a meeting on the Future of Health Care and released a 10-year plan to strengthen health care. They acknowledged that it needed to be a whole-of-government approach, with the participation of health care providers and patients and strategic investments in areas such as: increasing the supply of health professionals (e.g. doctors, nurses and pharmacists); effective community based services, including home care; a pharmaceuticals strategy; effective health promotion and disease prevention, and adequate financial resources (Health Canada, 2004). As well as a focus on reducing waiting times and increasing quality of care, they also acknowledged the importance of the increased role of Home Care and Primary Care Reform. They recognised there needed to be an increased focus on prevention, promotion and public health.

Recent reforms in primary health care delivery have included: setting up more community primary health care centres that provide services 24 hours a day, 7 days a week; creating primary health care teams; placing greater emphasis on promoting health, preventing illness and injury, and managing chronic diseases; increasing coordination and integration of comprehensive health services; and improving the work environments of primary health care providers (Health Canada, 2007).

Drivers for reform

The primary drivers for health reform in Canada are the need to reduce costs and the demand by consumers for high quality care (Canadian Institute for Health Information, 2000). The Canadian Institute for Health Information found that there are two ways to contain costs of health services: to keep people healthy and thereby reducing their need to access the health system; and providing appropriate health and support services for people at the time of their contact with the health system.

As with most developed nations, Canada has an ageing population. In 2001, one in eight Canadians was aged 65 years or over and by 2026, one in five Canadians will have reached age 65 (Health Canada, 2002). Canada's population also has an increasing rate of chronic disease. Canada's *Centre for Chronic Disease Prevention and Control* states that chronic diseases are among the most common and costly health problems facing Canadians (CCDPC, 2007). Haydon et al (2006) state that chronic disease results in substantial morbidity and mortality for Canadians, with chronic disease such as cardiovascular disease, cancer, respiratory disease and diabetes being the leading cause of death in Canada. Health Canada has reported that more than four out of five seniors living at home suffer from a chronic health condition with the most common chronic health problems reported being arthritis and rheumatism, followed by high blood pressure, allergies, back problems, chronic heart problems, cataracts and diabetes (Health Canada, 2002).

In 1997 deaths due to diabetes accounted for 2.6% of all deaths and by 2002 this had risen to 3.5%, an increase of 35% in only five years (Haydon et al, 2006). As a response to this increase in chronic disease, the Canadian federal government announced \$300 million for chronic disease prevention, with the focus being on improving diet and levels of physical activity in all Canadians.

Structure of the community primary health care sector

Romanow (2002) cited the essential components of an accessible and strong primary health care (PHC) sector to be: continuity and coordination of care; a focus on early detection and intervention; better information on needs and outcomes; incentives for health care providers to participate in PHC approaches; certainty and stability of PHC initiatives; recognition of frontline staff; flexibility regarding organisation, delivery, scope of practice; and quality of care.

In Canada, primary health care comprises comprehensive medical, nursing and other health care services with disease prevention and health education programs. Services are provided to individuals and communities, including public health programs and health promotion programs designed to reduce risks related to tobacco, alcohol and substance abuse, with services organised to address the needs and characteristics of the local population either based on geographical or social and cultural groupings. Services are available 24 hours a day, 7 days a week and there is an emphasis on teamwork and interdisciplinary collaboration for health care workers.

Coordinated primary health care teams include family doctors, nurses, nurse practitioners and other health professionals, and provide a broad range of primary health care services. These team members can vary according to the needs of the community they serve and provincial and territorial priorities. This team approach, along with the introduction of medical telephone call centres (telehealth), reduces the use of emergency units by providing advice and after-hours access to primary health care services.

Decision making has been decentralised to community-based organisations to ensure services are adapted to the needs and characteristics of the local population and so communities can have a say in developing the health services and health priorities for their community.

Primary health care networks and teams (Saskatchewan Health, 2007).

Primary health care is managed in some Provinces and Territories by establishing primary health care Networks and Teams. For example, the *Saskatchewan's Action Plan for Primary Health Care* is based on a collaborative, interdisciplinary team approach to service planning and delivery with each Regional Health Authority (RHA) developing a network of care provider teams to deliver primary health care services and to provide case management to coordinate services. Primary health care networks throughout the Saskatchewan province offer a full range of core primary health care services.

Primary Health Care Networks and Team structures vary depending on the geographic or social needs of the population, with teams varying in size and workforce complement depending upon the assessed needs of the community and availability of resources. Teams include representatives from the community and other human service sectors such as Education, Social Services, Justice and Municipal Government, and members of the public.

A network within a Health Region consists of all the teams that interact with each other. This may include Program Teams, Central Teams, Satellite and Visiting Teams. RHAs will generally be a network as specialised program teams may service the whole region.

Program Teams

Program teams form part of the network and there may be one or several Program Teams in a Health Region depending on the population served. These teams may provide a variety of services including mental health, public health (population based), emergency response teams and chronic disease management teams (e.g. diabetic management team). These teams would link to all teams in the network. As much of care occurring in a hospital or emergency department is considered primary health care, Teams also exist in institutions. The hospital and emergency department teams are linked to the community teams. Teams that provide service in special care homes also function on primary health care principles.

Central Team

A Central Team will have at a minimum a group of 3 - 4 physicians and a primary care nurse practitioner serving a population of approximately 5,000 including satellite and visiting locations. In urban areas physician groups may serve a larger population and therefore be larger with 5 - 10 physicians and 1 or 2 primary care nurse practitioners. Co-location may be desirable for all team members but at a minimum, the nurse practitioner should be co-located with the physician group. An urban centre may have many Central Teams serving different communities within the urban boundaries.

A Central Team may provide visiting services to satellite and visiting locations and provide support to smaller teams. An urban centre may have several central locations and team members may actually be part of a virtual team. The key idea is the core team members know each other well and can share the responsibilities of clinical management, proactive care, or health promotion and injury prevention.

Satellite Teams

The Satellite Team will be connected to and receive visiting services from a Central Team. A 'satellite location' is a community a range of basic services is delivered to meet the health needs of the individual, family and community closer to home. Resident or visiting staff provide health promotion and prevention services, clinical services and access to emergency services. A satellite location will at a minimum have a primary care nurse practitioner; and a primary care physician (visiting) on site. Laboratory (specimen collection abilities) visiting or part time services; public health; home care; therapies; and emergency services based on geographic needs would be offered by visiting staff. The client or patient would generally need to travel for other services.

Governance

Most provinces and territories have tried to control costs and improve health service delivery by decentralising decision making on health care delivery to the regional or local board level. Regional authorities are managed by elected and/or appointed members who oversee hospitals, nursing homes, home care and public health services in their area.

Aboriginal health

The Romanow report (2002) recommendations included consolidating funding for Aboriginal health programs and to form Aboriginal Health Partnerships (AHPs) to manage and organise health services for Aboriginal peoples and to promote Aboriginal health. The AHPs would be designed to use funding to address the specific health needs of their populations, improve access to all levels of health care services, recruit new Aboriginal health care providers, and increase training for non-Aboriginal health care providers

Funding

Funding by the Federal Government to the Provinces and Territories is known as the Canada Health Transfer (CHT). The CHT is the primary federal transfer to provinces and territories in support of health care. The CHT is seen as a way to support the Government's commitment to maintain the national criteria and conditions of the *Canada Health Act* (1948). The CHT cash transfer will be \$21.3 billion in 2007-08 and CHT tax transfers will amount to \$13.3 billion in 2007-08 (Department of Finance, 2007). CHT support will be allocated to provinces and territories on an equal per capita total entitlements basis until 2013-14.

In 2000, the Government of Canada established an \$800 million, five-year Primary Health Care Transition Fund (PHCTF) to support the implementation of large-scale Primary Health Care renewal initiatives which would improve access, accountability and integration of services (McDonald et al, 2004). This funding ceased in 2006.

In 2004, the Prime Minister announced \$41 billion of new federal funding over 10 years in support of the Action Plan on health. The funding was designed to be used to strengthen ongoing federal health support provided through the Canada Health Transfer (CHT), meeting the financial recommendations from the *Royal Commission on the Future of Health Care in Canada* and to address wait times to ensure Canadians have timely access to essential health care services.

3. Australia

Reform

Most Australian health jurisdictions have undergone review and subsequent reform of their health systems over the last decade². The Federal and State governments have implemented new policies and frameworks to manage the changing health needs of the population. There has been a significant move to provide care away from acute (hospital inpatient) settings (such as Hospital in the Home and Hospital in the Nursing Home programmes), to prevent avoidable hospital admissions and to provide care in the community and in the home, if possible.

Drivers of reform

In Australia the drivers of reform have included an ageing and increasing population; rising costs of health care; increased consumer demand; persistent health inequalities (particularly in the Aboriginal population); new diseases and health risks; cultural diversity; reduced availability of carers and volunteers (who are also ageing); changes to the private health sector; and a shortfall and misdistribution of the health workforce.

Vision – primary health care

The key strategic directions of new health policies in Australia have been on based on primary health care principles, with each jurisdiction implementing these principles by developing community-based health care adapted to their existing health systems and population. Primary health care is defined by the World Health Organisation as essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-determination. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where the people live and work, and constitutes the first element of a continuing health care process (WHO/Alma Ata Declaration, 1978).

The primary health models of care in Australia have emphasised prevention, early intervention, holistic and integrated care with an increased emphasis on management and self-management of chronic disease. Primary health care encompasses prevention, early intervention and treatment services and rehabilitation, maintenance and continuing care programs (Cranny, 2007).

The emphasis on a primary health care model of service delivery is supported by the Australian Institute of Health and Welfare's report, *The Burden of Disease and Injury in Australia 2003*, which shows that an estimated 32 per cent of disease in Australia is due to poor lifestyle choices which would respond to prevention and early intervention. Approximately 70 per cent of the total burden of disease and 78 per cent of all deaths in Australia is attributable to six disease groups (cardiovascular problems, cancers, injuries, mental problems, diabetes mellitus, and asthma) (AIHW, 2002). All of these diseases have the potential to be either prevented or managed in settings and modes other than bed-based inpatient care. Chronic health conditions are increasing and are expected to account for about 80% of the overall disease burden in Australia by 2020 (AIHW, 2002).

Although community-based health services are delivered differently in every State, each jurisdiction has highlighted similar principles to support health service delivery, which include: access; equity; patient-centred care; early intervention, prevention; integration;

² ACT *The ACT Health Review* (2003); NSW *Menadue Report* (2000); SA's *Generational Health Review* (2003); WA *Reid Review* (2004), QLD *Forster Health System Review* (2005) and *Davies Report* (2005); Victoria *Governments Working Together*; NT's *Bansemer Report* (2003); TAS *Richardson Report* (2004).

partnership and collaboration; continuum of care; continuity of care (seamless care between sectors and service providers), quality improvement and outcome-focussed care. For example, Victoria has highlighted service integration as key to seamless continuity of care, the importance of capacity-building in the community to help people manage their own health, multidisciplinary approaches to service provision and population-based services and planning and has Northern Territory focussed on the need for locally-provided care and accountability.

3.1 Commonwealth government

A mix of public and private health care professionals and non government organisations provide health care in Australia. Two levels of Government, the Commonwealth and the States and Territories have responsibility for the policy direction, funding and provision of health. The Commonwealth Government has a leadership role in policy making and with national issues such as public health, research and national information management (Australian Government, 2000). The States and Territories are primarily responsible for the delivery and management of public health services and for maintaining direct relationships with most health care providers, including the regulation of health professionals (Australian Government, 2000, pg1). The regulation of health professionals will become the responsibility of the Commonwealth government from July 2008 with the introduction of a national registration scheme for health professionals (COAG, 2007). The States and Territories deliver public acute and psychiatric hospital services and a wide range of community and public health services including school health, dental health, maternal and child health and environmental health programs. The Commonwealth funds most medical services out of hospital and most health research. The Commonwealth, States and Territories jointly fund public hospitals and community care for aged and disabled persons (Australian Government, 2000, p2).

The Commonwealth Government is responsible for Medicare Australia, which administers the Medicare Benefits Scheme (MBS), subsidised medicine under the Pharmaceutical Benefit Scheme (PBS) with a projected cost of \$7.7 billion in 2007-2008 and the Office of Aboriginal and Torres Strait Islander Health funding, including MBS and PBS for community controlled Aboriginal Medical Services. The Commonwealth also has responsibility for residential care services (including community care packages), joint responsibility with the States for HACC services and cancer screening, some elements of palliative care and aspects of rural health programs (Cranny, 2007).

The 2007-08 Federal Budget provided \$772 million for improved detection and treatment of chronic and complex conditions; \$486 million for medical research infrastructure in 2006-07 and \$1.6 billion for aged care initiatives. The key strategic directions outlined in the 2007-08 *Health and Ageing Portfolio Budget Statements*, were listed as: ensuring Australians have access to Medicare after-hours GP services; better meeting the primary care needs of aged care residents; helping people self-manage their chronic conditions; supporting general practices to manage the care of people with chronic disease; improving access to primary mental health services; continuing to support training for GP registrars in rural and urban areas; and improving access to female general practitioners in rural and remote areas. (Australian Government, 2007)

To ensure Australians have access to high quality, well-integrated and cost effective primary care the Australian Government funds the provision of primary care through General Practice (through fee for service reimbursement under MBS) and the Divisions of General Practice to build capacity in general practice (Australian Government, 2007). Primary medical care in Australia is predominantly provided through general practice, with approximately 85 per cent of Australians having at least one contact with General Practitioner each year (AHM, 2007), which equates to over 90 million consultations per annum. Medicare benefits are payable for services by nearly all doctors currently registered

in an Australian state or territory (Australian Government, 2006) with a projected cost for 2007-2008 of approximately \$12.6 billion per annum (Australian Government, 2007).

General practitioners provide public health care, diagnosis and treatment for acute health problems and continuing medical care for people with chronic and complex health problems and are they are the key referral agents to secondary and tertiary specialist services (Cranny, 2007). Seventy eight percent of Australian GPs (77.5% in Queensland) work in private rooms, 5% work in acute hospitals, 3% in 24 hour medical clinics and 1% in Aboriginal Health Services (Cranny, 2007).

Divisions of General Practice represent over 95 per cent of general practitioners in Australia and provide support via education, training and resources to General Practices to improve their capacity to provide high quality primary care (AGPN, 2007). The first Divisions of General Practice were established in Australia in 1992 and have been established across Australia since 1998 (Scott & Coote, 2007). The Division network comprises a national organisation, the Australian General Practice Network (AGPN), state-based organisations in each State and Territory and 120 geographically based Divisions.

The AGPN receives funding from the Australian Government under the Divisions of General Practice Program (AGPN, 2007). In 2004-05 the Australian Government funded the Divisions of General Practice Network \$302.4 million over four years to assist general practice to provide services to the community and achieve improved health outcomes (Australian Government, 2006). Some of the current programs provided by the AGPN include: Aged Care GP Panels Initiative; Enhanced Divisional Quality Use of Medicines; Medication Management Review (Home Medicines Review) ; National Primary Mental Health Care Network; the Can Do Initiative: Managing Mental Health and Substance Use in General Practice ; National General Practice Immunisation Program ; Nursing in General Practice ; Rural Palliative Care ; Divisions Network Information Management Support Program ; and Broadband for Health (AGPN, 2007).

State-based and geographically-based Divisions of General Practice perform a range of activities to improve and address access, integration, chronic disease management, workforce issues and consumer needs and are funded by the Australian Government to provide programs such as allied health services in rural areas, support for GPs, and immunisation. Sprogis (2007) states that the highly representative nature of the Divisions makes them “the third component of the Australian national organised health care system ...(alongside) ...the public health/hospital and private insurance sectors”. The Divisions receive funding from state health departments, specific government programs (such as Chronic Disease Strategy funding) and other sources. The impact of the Divisions on the performance of general practice was recently evaluated and it was found that in the period 2002-2004 the Divisions influenced the primary care performance of General Practice by improving infrastructure and the use of care plans and health assessments but not in clinical areas (Scott & Coote, 2007).

The Commonwealth Government has also recently invested further in primary health care programs such as the *Australian Better Health Initiative: Promoting good health, prevention and early intervention* (2006) and the National Chronic Disease Strategy. They have shown commitment to primary health care through the establishment of the Australian Health Ministers Advisory Council's (AHMAC) Australian Population Health Development Principal Committee (APHDPC) who coordinates a national effort towards an integrated health development strategy that includes primary and secondary prevention, primary care, chronic disease and child health and wellbeing, the introduction of new MBS item numbers, such as Enhance Primary Care items and the National Primary Care Partnerships (2003).

3.2 Australian States

3.2.1 New South Wales

In 2006, New South Wales Department of Health released the *NSW Integrated Primary and Community Health Policy 2007-2012* and introduced HealthOne Centres, which are designed to provide fair and timely access to health care, with a focus on prevention and early intervention. The priority areas for the *NSW Integrated Primary and Community Health Policy* are: integrated service planning; integrated service delivery; improved models of care; stronger partnerships; improved workforce capability; and enhanced information management and research. The priority areas are based on the values of: equity, access; health and well-being; community engagement; responsiveness; collaboration; and multidisciplinary and evidence-based approaches.

The policy aims to ensure the activities of the primary and community health sector are integrated to facilitate the delivery of accessible, affordable primary care services that are responsive to the needs of patients. The policy includes directions for partnerships between NSW government-funded health services, general practice, other private health care providers, non-government organisations, consumers and carers, other government agencies and the Australian Government.

This policy is supported by the strategic directions contained in the *NSW Future Directions for Health in NSW – Towards 2025* (2007) and the NSW State Health Plan, *A New Direction for NSW* (2007) which includes the priorities of embedding prevention and early intervention into Government services and reducing avoidable hospital admissions.

HealthOne NSW services are provide an integrated model of care through multidisciplinary teams, including GPs, community health workers, allied health professionals and other medical professionals in one place. The core components of the integrated model of care include: collaboration (between individuals and communities and health professionals to support self managed care); a patient focused approach to care; multidisciplinary teams; coordinated care (between community health, hospital based providers and other services such as NGOs, private health care providers and Aboriginal Community Controlled Health Organisations); accessible patient/client records and integration of clinical information (documenting the diagnosis, advice, plans and treatment offered by health professionals working in all the above settings); financial resources made available by both state and federal governments; governance arrangements (across private and public services); clinical service provision and record keeping with monitoring, evaluation and research activities (NSW Health, 2007).

Governance for HealthOne NSW services must be consistent with the preferred model of care, allowing integration of primary health and community care clinicians in one team. Governance arrangements must ensure that the services is a legally separate entity capable of both private and public sector participation with minimal financial and related risk and must comply with section 19(2) of the Commonwealth *Health Insurance Act 1973* (HIA) relating to payment of Medicare Benefits Schedule benefits. Governance needs to be flexible enough to meet the needs of different sized and types of HealthOne NSW services, with efficient and effective structures and acceptable staff employment and contracting options.

The NSW State Government has also recently funded GPs to establish after hours clinics co-located with emergency departments in hospitals. Up to ten such services will be established in 2007. The clinics are designed to speed up the process for patients to see a doctor when they attend the Emergency Department (Haas, 2007).

3.2.2 South Australia

In line with the fact that 85 per cent of Australians see a General Practitioner each year (AHM, 2007) and general practice is usually the first point of contact for most people with the

health system, South Australia has decided to make General Practice the centre of their community-based health care system.

In 2006, the South Australian government announced a \$72 million investment in community-based health care, which will create 10 *GP Plus Health Care Centres* in metropolitan areas and *Local Integrated Health Services* in rural, remote and country areas. The funding includes the provision of 50 nurses and 56 mental health workers in GP clinics across Adelaide. The aim of this investment is to prevent illness and will include a focus on improving care for patients with chronic disease and providing outreach to adolescents with mental illness and substance abuse issues. The GP Plus Centres will also coordinate health promoting activities, be a community resource for self-management groups and may provide teaching and training for health professionals (AHM, 2007).

GP Plus Health Care Centres will be open for extended hours and, depending on local need, may provide Aboriginal health; after-hours GP services; Allied Health – podiatry, dental, physiotherapy, occupational therapy; Children and Youth health; Chronic disease self management programs; Community mental health; Counselling; Drug and alcohol services; Health education; Minor medical procedures; Nursing and Midwifery services; Physiotherapy; and Specialist Clinics. In rural, remote or country areas, local hospitals will now provide access to GP services.

3.2.3 Tasmania

Tasmania has recently released *Future Health: Tasmania's Health Plan. May 2007*. The Department of Health and Human Services has committed to ensuring that Tasmania's health services will be accessible as close as possible to where people live, providing services which can be delivered safely, effectively and at an acceptable cost and appropriate to community needs. Health services will be client and family focused integrated through effective service coordination and partnerships between providers; and designed for sustainability. The new Plan will implement the Richardson Report (2004) recommendations for the development of dedicated and general service centres and a greater focus on community-based models of care.

Tasmania has 23 community-based health centres which provide non-inpatient services including counselling and support, health promotion, medical, nursing and allied health services and accommodation and meeting spaces for visiting services including housing, disability, and family and child health services.

Tasmania's community-based health care also include specific primary health services including Aged Care Assessment Teams; Community Equipment Scheme; Community Options Service; Community Rehabilitation Services; Community Therapy Services (Physiotherapy, Speech Pathology, Occupational Therapy and Podiatry); Continence Services; and Health Promotion Activities may be provided at a Community Health Centre or Rural Inpatient Facility or as a visiting service across an entire region.

Tasmania will be establishing a tiered service delivery model which will include new integrated care centres that provide a range of health services working in partnership in an integrated manner, regardless of which organisation funds or provides them. Integrated care centres will be designed to provide greater certainty of access for the community as they will have clearly defined core business. The centres will operate under a philosophy which is less interventional and oriented towards care in the community.

The service model for Primary Health sites in Tasmania will be a new three-tiered model. The sites have been developed based on population trends and levels of community need; distance from other services; and sustainability considerations, such as cost and workforce availability. Tier 1 sites will provide core primary health and community care services within a

local community. They reflect the increasing emphasis on community- and home-based care and the provision of these services through an integrated team approach.

Tier 2 sites will operate rural inpatient services (subacute beds) in addition to their primary health and community care services and Tier 3 sites will provide extended primary health services with significant outreach across the network and a stronger representation of acute services including integrated care centres developed in association with the Acute Health Services.

The Department of Health and Human Services is currently examining alternative service models in conjunction with local communities to best meet their needs. Examples of services that could be part of alternative local service models are individualised packages of care for older people to enable them to remain in their own homes (both post-acute and community care); more allied health services as an outreach; maintenance of general practice additional community nursing and on site nurse clinics (especially for chronic disease treatment, including diabetes); and an increased focus on health promotion and healthy lifestyle activities.

3.2.4 Victoria

Victoria has an established network of Community Health Services, which provide primary and community health care in every local government area. Like all Australian health jurisdictions the Victorian Government have identified the growing pressure of increased demand on their community health services, based on population growth and the ageing population, as well as increased incidence of chronic disease, rising cost of medical technology and increased consumer expectations.

In 2004, the Victorian Government released the *Community Health Services – creating a healthier Victoria* policy (Department of Human Services, 2004) and the *Governments Working Together: A better future for all Australians Report*. The Victorian Government are orienting their health sector and community health services more towards prevention, early intervention and primary health care models of care in order to improve access, continuity of care and service integration. The Government's role is seen to be one of leadership in improving health outcomes and reducing health inequalities of local communities throughout Victoria. The policy direction identifies the importance of adopting a benchmarking approach to performance management, developing a stronger governance to support the delivery of effective primary health care services and improving the transparency and accountability of their community health services.

The overarching strategic direction of the *Community Health Services – creating a healthier Victoria* policy is to strengthen Community Health Services in their provision of comprehensive primary health care services. The principles for care are: access; quality; equity and targeted services; health and well-being; capacity building; continuity of services; population-based services and planning. The funding investment attached to the policy direction includes 120,000 extra GP bulk-billing appointments in areas identified as difficult to obtain access to a GP.

In 2000, Victoria highlighted the need for service providers to work in partnership by introducing the Primary Care Partnership strategy. The Strategy aimed to create a primary care service system that would improve outcomes for consumers and reduce preventable use of hospital services through partnership development, service coordination and integrated health promotion. Primary Care Partnerships (PCP) have focused on building relationships between agencies, service system reform, better coordination of services and an integrated approach to health promotion. The strategy provided a framework for improving the planning and delivery of primary care services and for ensuring all health care providers work more collaboratively and effectively. There are over 800 organisations involved in 31 PCPs across the state, covering from two to four local government areas each

and 19 PCPs in rural areas and nearly all PCPs have community health services and local governments on their executive group.

An independent evaluation of the Strategy in 2005 (AIPC, 2005) showed that over the five years since PCPs were introduced local relationships and strategies between agencies, and between PCPs and the Department of Human Services, had developed and consolidated, enabling agencies to cooperatively implement new community-based health care initiatives such as health promotion activities and improved care pathways for people with chronic disease, ultimately improving the health of those involved.

3.2.5 Western Australia

In 2004, the WA Health Reform Committee released the Reid Review, with recommendations to improve the Western Australian public health system. Based on these recommendations, WA Department of Health identified six priority areas to set the strategic direction for public health: Healthy Workforce, Healthy Hospitals, Healthy Partnerships, Healthy Communities, Healthy Resources and Healthy Leadership.

Healthy@Home is WA Health's community-based health care services (also called ambulatory care). This priority is aimed at helping people manage their health in the community and care is provided at the patient's home, in the community or in another setting such as a doctor's clinic. The services are aimed at preventing unnecessary hospital admissions and enabling safe early discharge from hospital. The *Healthy@Home* health care teams are multidisciplinary and include doctors, specialists and allied health professionals. Services include: a Chronic Disease Service (for people with Diabetes, Chronic Obstructive Pulmonary Disease or Chronic Heart Failure); a Community Physiotherapy Service; Hospital in the Home services; Telehealth; and WoundsWest (wound management program). The *Healthy@Home* service is managed out of the acute setting (i.e. ambulatory care) but is provided in the community.

Western Australia's community health services are now focussed on child and family health, with the reorientation of community health services in Western Australia placing emphasis on the 'Birth to Age Two Years' population group and their families. The Child and Community Health branch is part of the Child, Community and Primary Health Care Directorate, Department of Health. The branch is responsible for the strategic policy and service direction which guides regional Community Health services. The reorientation has occurred in line with international and national recognition that the "Early Years" is an important period in which to influence potential health outcomes. The future directions of Community Health in WA are underpinned by the principles of the *New Vision Community Health Services for the Future Policy Framework*, with a focus on prevention and early intervention. The core functions of the Child and Community Health branch include: working at the community health interface; community development and capacity building; enhancing and re-orientating the health system to focus on health promotion and prevention; focusing on the importance of the early life and life course determinants; focusing on the determinants of health and health inequalities; and ensuring universality of access to health and other services (Department of Health, 2007a).

The Community and Primary Health Care Directorate of Department of Health also has a Primary Health Care branch, which was established to strategically address issues across the primary health sector. It does this through Primary Health Partnerships (PHPs), a Bilateral Agreement in the Area of Primary Health and Community Care, the development of integrated programs, building information technology and management systems and developing commonwealth funding proposals. The PHPs are voluntary alliances between Population Health Services and Divisions of General Practice to identify common priorities and strategies to achieve better health outcomes for members of the community. The Bilateral Agreement in the Area of Primary Health and Community Care is used to provide a

framework for Commonwealth/State cooperation in areas of mutual interest in primary health and community care and identifies joint priorities and is an agreement to pursue a number of projects. The integrated programs focus on improving communication and service delivery between community health services and general practice, particularly in the area of chronic disease and the IT/IM initiatives are attempting to build knowledge, policy and strategies to enable the transfer of information between the acute care, primary health care and community care sectors (Department of Health, 2007b).

4. Indigenous models

4.1 New Zealand – Māori Health

Policies and action plans

In 2002, the New Zealand Government released the *He Korowai Oranga - Māori Health Strategy*. The strategy was designed to place whānau³ which is seen as the centre of Māori society, at the centre of public policy. It provided a framework for the public sector to take responsibility for its role in supporting the health status of whānau. This included public policies that actively promote whānau wellbeing, quality education, employment opportunities, appropriate housing, safe working conditions, improvements in income and wealth, and addressing systemic barriers including institutional racism (Ministry of Health, 2002).

In 2006, the Minister for Health and the Associate Minister for Health released the *Whakatātaka Tuarua: Māori Health Action Plan 2006-2011*, to build on the work of the *He Korowai Oranga*. The overall aim of He Korowai Oranga is whānau ora: Māori families supported to achieve their maximum health and wellbeing. The Action Plan states that an approach that recognises and builds on the integral strengths and assets of whānau is needed, with support given to Māori health service providers. However, as a high proportion of Māori continue to access mainstream service and an overwhelming proportion of health and disability funding goes to mainstream providers a focus will remain on District Health Boards and mainstream providers to ensure greater effectiveness of the resources and initiatives aimed at improving Māori health outcomes.

The New Zealand Ministry of Health has a Māori Health Directorate - Te Kete Hauora. The Directorate's role is to provide policy advice on the overall strategy for achieving the government's objective for Māori health, which is to reduce inequalities in health status for Māori and improve Māori health and disability status. The New Zealand health system also includes Māori Development Organisations (MDOs), Māori co-funding organisations (MAPOs) and Māori provider and professional organisations which all play a role in delivery of health and disability services for the Māori population. There are currently 240 Māori health providers contracted to 21 District Health Boards throughout Aotearoa (New Zealand). Māori health providers range widely in size and the types of health and disability services they provide but usually include access to General Practitioners, Nurses, Immunisation programs, mental health services, nutrition and physical activity programs and well child services. Some services are dedicated to a particular population group, such as youth or family services or particular program areas, such as Alcohol and Drug services or Mental Health Services.

Kaupapa

Māori health provider's *kaupapa* (philosophy or vision) and service delivery frameworks are based on Māori traditions and culture. An example of a Māori health provider's *kaupapa* is stated in the Te Oranganui Iwi Health Authority's Mission. Their underlying principle of care is that "*Tino Rangatiratanga is the spiritual health that will ultimately provide holistic wellness for whānau, hapū⁴ & iwi⁵ and other peoples residing in the region. The Health Service believes it is imperative to acknowledge the traditional social organisation of hapū*

³ Whānau is a wider concept than just an immediate family made up of parents and siblings and it links people of one family to a common tipuna or ancestor (Maori Land Court, 2007).

⁴ Hapū: Subtribe or kin group that is linked to a common ancestor

⁵ Iwi: Tribe, the largest social group within Maori society. Iwi were divided into hapu (sub-tribe), which in turn are made up of whanau (households).

and iwi as most ideal structures for service delivery to whānau, hapū & iwi. Inherent in these structures is the diversity & uniqueness of Tikanga⁶ & Kawa⁷”.

Māori workforce

Māori Health Workers (MHW) are employed by Maori Health Providers whose emphasis is on improving the access and quality of health care to Maori people. MHWs do not have to be Maori themselves but they must be able to display, or show a willingness to learn, skills and knowledge about Maori health issues, culture, local iwi, hapu and whanau development, and customs / Tikanga. Knowledge of Te Reo is also an advantage. The majority of MHW's work is in the primary health sector within the community and included work in private homes, Marae⁸, Kohanga Reo⁹. Community/Family Centres and GP Practices.

4.2 Canada – First Nations and Inuit Health

The mainstream Canadian health system (Health Canada) and First Nations people and Inuit work together to improve their health outcomes. Life expectancy and infant mortality of First Nations and Inuit health has improved but gaps still exist in the overall health status of First Nations and Inuit compared to other Canadians.

First Nations people and Inuit have higher rates of injury, suicide and diabetes. First Nations and Inuit organisations and communities in collaboration with Health Canada provide services and activities aimed at helping people stay healthy, and prevent chronic and infectious diseases. Health Canada's role in First Nations and Inuit health commenced in 1945, when Indian Health Services were transferred from Indian Affairs. In 1962, Health Canada provided direct health services to First Nations people on reserve and Inuit in the north. By the mid 1980s, work began to have First Nations and Inuit communities control more health services (Health Canada, 2007b).

The federal government provides health promotion programs and public health services on First Nations reserves and in identified Inuit communities. In remote and isolated areas, where provincially or territorially insured services are not readily available, the Government of Canada provides on-reserve primary and emergency care services.

Blueprint on Aboriginal Health

The Blueprint, released in 2005, is a ten-year plan for making significant progress in closing the gap in health outcomes between the general Canadian population and Aboriginal peoples, including First Nations, Inuit and Métis. This will be achieved by improving access and quality of health services through comprehensive, holistic and coordinated service provision by all parties to the Blueprint, and through concerted efforts on determinants of health. The Blueprint is the result of collaborative efforts by federal, provincial and territorial governments and representatives of Aboriginal peoples in every region of Canada throughout 2005 (Health Canada, 2005b).

The Blueprint's has a number of approaches to improving the health status of Aboriginal people including increasing the use of traditional healing practices to improve health status (with consideration to community standards of care and safety); to involve women in health service development and service delivery; to use a population health approach to care; to engage the wider community; and to increase service sustainability and accountability.

Community programs - primary health care

The First Nations and Inuit Health Branch operate 213 health centres in semi-isolated communities and nursing stations in 64 remote and 10 semi-remote sites. The Home and

⁶Tikanga: Customary correct ways of doing things

⁷Kawa: Tribal Protocols, local ways of doing things

⁸Marae: traditional meeting place for local Maori community

⁹Kohanga Reo: kindergartens where all instruction is given in the Maori language

Community Care program operates in over 600 communities. The branch employs close to 700 nurses, and is responsible for direct program delivery in two hospitals as well as funding for two more. Health Canada hires over 800 nurses to work directly in First Nations and Inuit communities across the country, and home care workers to take care of the needs of community members in their homes.

The First Nations and Inuit Home and Community Care (FNIHCC) Program provides basic Home and Community Care services designed to be comprehensive, culturally sensitive, accessible, effective and equitable to that of other Canadians and which respond to the unique health and social needs of First Nations and Inuit communities. The Program is a coordinated system of home and community based health-related services that enable people with disabilities, persistent or acute illnesses and the elderly to receive the care they need in their home communities.

To be able to provide health care anywhere in Canada, Health Canada has developed electronic health services, which use computer software, the Internet and telephones for sharing information on health and they provide electronic devices for nurses and doctors to see and talk to one another across Canada.

4.3 United States

The United States has an Indian Health Service (IHS) that runs independently of but in conjunction with the mainstream health system. The Indian Health Service is an agency within the Department of Health and Human Services and is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally-recognised tribes grew out of the special government-to-government relationship between the federal government and Indian tribes.

This relationship, established in 1787, is based on Article I, Section 8 of the Constitution, and has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders. The IHS is the principal federal health care provider and health advocate for Indian people and its goal is to raise their health status to the highest possible level. The IHS currently provides health services to approximately 1.5 million American Indians and Alaska Natives who belong to more than 557 federally recognised tribes in 35 states (IHS, 2007a).

Consumer Health Representatives

The IHS has a *Consumer Health Representative* (CHR) program that has been in operation since 1968, when the Office of Economic Opportunity funded the Community Health Aide Program in Alaska (see summary below). The Community Health Representative was established to be a community health promoter and educator, a health advocate, and a health paraprofessional who would regularly visit the homes of clients and conduct health assessments and provide transportation, when needed.

The CHR program was a result of Native American Tribes identifying the need for such a program and lobbying to obtain funding (IHS, 2007b). Currently the CHR program employs over 1,400 CHRs representing over 250 tribes in the 12 service areas. There is also a National Association of Community Health Representatives (NACHR) which has a representative from each area to recommend national policies and share program ideas (IHS, 2007b).

Alaskan model of health care delivery to rural and remote areas

Alaska has a total landmass of 586,585 square miles (or 1.73 million square kilometres - equivalent to Queensland at 1.7 million square kilometres). Approximately 50,000 Alaska Natives live in over 178 villages located as far as 1300 miles (2092 km) from the nearest regional centre, with 90 per cent of the villages in rural Alaska being isolated from each

other, separated by very large distances, vast mountain ranges, stretches of tundra, glaciers, and impassable river systems.

Most of the communities are not connected to a road system and air transportation is the primary means of travel on a state-wide basis which makes the provision of goods and services and the delivery of health care to these remote sites a challenge.

Community Health Aide Program

Community Health Aide Program (CHAP) services are established to be a sustainable, effective, and culturally acceptable method for delivering health care to the indigenous population, Alaska Natives and it is the only health care delivery system of its kind in the United States. The Community Health Aide Program was specifically developed to meet the health care needs of Alaska Natives in remote villages.

The CHAP program emerged, in part, as a result of the tuberculosis epidemic in the 1950s and the use of village workers to distribute antibiotics at that time. It became a formal, federally funded program in 1968. Today over 550 Community Health Aides/ Community Health Practitioners (CHA/Ps) are employed by 27 tribal health organisations in 178 rural communities. CHA/Ps are the patients' first contact within the network of health professionals in the Alaska Tribal Health System.

The program has demonstrated adaptability to advances in medicine and the evolving health needs of the population and has been shown to be comparatively low cost. The total combined program expenses of \$55M provide 270,000 emergency and primary health visits annually to approximately 50,000 Alaska Natives (at a cost of approximately \$1,100 annually per patient). Improvement in infant mortality and immunisation rates are a direct result of the work of the Community Health Aides and their long term relationships with their communities.

Training

CHA/Ps complete training and education requirements as outlined in the *Community Health Aide Program Certification Board Standards and Procedures* and must work within the guidelines of the *Alaska Community Health Aide/Practitioner Manual, 2006 Revised Edition*, which outlines assessment and treatment protocols.

Continuum of care

To ensure a continuum of care, there is an established four tiered referral relationship which includes mid-level providers, physicians, regional hospitals and the Alaska Native Medical Centre. In addition, providers such as public health nurses, physicians, and dentists make visits to villages to see clients in collaboration with the CHA/Ps. The success of the Community Health Aide Program model has been used as a template to develop a dental care component; which now has 33 certified providers addressing dental needs specifically. A behavioural health component is in progress to address unmet needs in mental health and substance abuse. CHAP has proven to be a cost effective, efficient and essential component in improving the health of the Alaska Native people by decreasing morbidity and mortality.

(From: Gage, S (2007). Executive Summary - Community Health Aide Program. Overview 2007. Alaska Association of Community Health Aide Program Directors.)

4.4 Australia – Aboriginal and Torres Strait Islander Health

“The severity and human cost of poor health among Indigenous Australians is well recognised” (Dwyer et al 2004, p 1). Aboriginal and Torres Strait Islanders life expectancy is almost 20 years lower than the non-Indigenous population, contrasting dramatically with the USA, Canada and New Zealand where the life expectancy for Indigenous people is approximately seven years less than the non-Indigenous population. Aboriginal and Torres Strait Islander infant mortality is three times the rate of non-Indigenous Australians and more than 50 per cent higher than for Indigenous children in the USA and New Zealand (NACCHO & Oxfam, 2007).

The incidence of chronic disease is also more common in Aboriginal and Torres Strait Islanders compared with the non-Indigenous population and its onset occurs at a much younger age (NACCHO & Oxfam, 2007). The underlying causes of poor health in the Indigenous population include dispossession, poor socioeconomic status, and low levels of education, lifestyle factors, prejudice and discrimination, substandard environmental conditions, inadequate and inappropriate service provision, and a lack of involvement of Indigenous people in policy and decision-making processes (Shannon & Longbottom, 2005).

Over the last few decades a number of policy documents, frameworks and funding initiatives have been developed to address the inequities in health status for Aboriginal and Torres Strait Islander peoples. In 1994, the Australian Government established the Office of Aboriginal and Torres Strait Islander Health as a division of the Commonwealth Department of Health and Ageing to give greater focus to the health needs of the Indigenous Australians.

The long-term strategy of the Office is to improve the access of Aboriginal and Torres Strait Islander peoples to comprehensive primary health care services (OATSIH, 2006). As well as providing strategic advice and direction, OATHSI funds programs such as the Social and Wellbeing Program and the Primary Health Care Access Program as well as providing base funding for Aboriginal Medical Services.

The Commonwealth and State and Territory governments have also formulated strategic policies that recognise self-management and self-determination for Aboriginal and Torres Strait Islander people, such as the development of community-controlled health services, Aboriginal and Torres Strait Islander Forums, policies and programs (such as the Primary Health Care Access Program).

The National Aboriginal Health Strategy was released in 1989 and despite lack of full implementation, it is considered a landmark document that set the agenda for Aboriginal and Torres Strait Islander health (Shannon & Longbottom, 2005). The National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH) released in 2003 outlines approaches to primary health care and population health within contemporary policy environments and planning structures and is to be viewed as a companion document to the National Aboriginal Health Strategy (Shannon & Longbottom, 2005).

NSFATSIH establishes an agreed Commonwealth, State/Territory and Indigenous health stakeholders approach, emphasising a whole-of-government and whole-of-health-system responsibility, and the need for sustained effort. Dwyer states that “successful implementation will require sustained investment and sustained effort by all parties” (Dwyer et al 2004, p i).

Aboriginal Community Controlled Health Services (ACCHS)

The Commonwealth Government first became involved in action to improve Aboriginal and Torres Strait Islander health in the early 1970s via grants to the States to establish Aboriginal Community Controlled Health Sector. Aboriginal Community Controlled Health Services (ACCHS) developed in response to the identification of a range of barriers inhibiting access to mainstream primary health care services by Aboriginal and Torres Strait Islander

people, which was leading to poor health outcomes and reduced life expectancy and in recognition of the principles of self determination.

The first Aboriginal Medical Service in Australia was established in Redfern in 1971 (Shannon & Longbottom, 2005). According to the Aboriginal Medical Services Alliance Northern Territory (AMSANT), community control is “*the local community having control of issues that directly affect their community*”. That is, the ability for the people who are going to use health services determining the nature of those services and then participating in the planning, implementation, and evaluation of services” (AMSANT, 2007).

ACCHSs are primary health care services initiated and managed by local Aboriginal communities to deliver holistic and culturally appropriate care to people within their community. Board members are elected from the local Aboriginal community. Whilst ACCHSs form a network, each is autonomous and independent of both one another and of the Government (NACCHO, 2006).

Queensland’s community controlled health sector comprises member organisations which range from large multi-functional services employing several medical practitioners and providing a wide range of services to small services without medical practitioners which rely on Aboriginal health workers and/or nurses to provide the bulk of primary care services, often with a preventive, health education focus (QAIHC, 2007).

National Aboriginal Community Controlled Health Organisation

The National Aboriginal Community Controlled Health Organisation (NACCHO) is the national peak body representing 127 Aboriginal Community Controlled Health Services (ACCHSs) across Australia on Aboriginal health and well being. NACCHO is governed by a Board of Directors whose members come from the Community Controlled Health Sector and who are elected through NACCHO’s State/Territory Affiliates. Administration and co-ordination is undertaken by NACCHO’s National Secretariat, established in Canberra in 1997 (NACCHO, 2006).

Primary Health Care Access Program.

Increasing access to primary care services (funded through the Medical Benefits Scheme and the Pharmaceutical Benefits Scheme) has been targeted by the Commonwealth Government as Indigenous Australians use these services less than half the rate of non-Indigenous Australians (with no adjustment for the relatively higher burden of disease) (Dwyer et al, 2004).

The Primary Health Care Access Program (PHCAP) is a program of health system reform to improve access to and provision of appropriate primary health care services for Aboriginal and Torres Strait Islander people at the local level (AMSANT, 2002). PHCAP establishes a framework and funding for the expansion of comprehensive primary health care services, including: clinical/medical care; illness prevention services; specific programs for health gain; facilitation of access to secondary and tertiary health services; client/community assistance and advocacy on health-related matters within the health and non-health sectors. PHCAP is based on joint responsibility, joint planning and joint (pooling) funding between the Commonwealth and the States/Territories. PHCAP currently has \$54.8 million recurrent funding from the Federal Government and is considered by the Commonwealth Government to be their contribution to the cost of providing comprehensive primary health care to Aboriginal and Torres Strait Islander people.

A core element in the implementation of the PHCAP is new partnership arrangements between the Community Controlled Health Services and the State or Territory Governments. Aboriginal and Torres Strait Islander Health Forums/Partnerships have been formed in each State/Territory based on the *Aboriginal and Torres Strait Islander Health Framework*

Agreements. These Partnerships have a key role in providing advice on priority areas and in developing implementation arrangements best suited to each region (AMSANT, 2002).

Regional and local planning occurs to identify gaps in health service delivery and to identify the capacity in the ACCHS to expand their health services. If there is an area of high need identified but no capacity currently in the sector to expand, funding for capacity building may be allocated. Increases in funding via PHCAP are linked to increases in the capacity of the sector and relative need of the local area, as well as availability of funding.

Rosewarne & Boffa (2004) undertook an analysis of PHCAP in the Northern Territory and concluded that the basic funding model within PHCAP (a grant payment plus access to the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme) is the best possible way to fund comprehensive PHC in Indigenous communities at the present time.

5. Conclusion

The health system reforms and models of care that are developing within Australia and internationally are following a similar path, as outlined in this quote from McDonald & Hare (2004) below. Each model outlined in this report is responding to similar supply and demand forces, such as an increasing and ageing population, increasing prevalence of preventable chronic disease, a desire to reduce avoidable hospital admissions and a move to provide patient-centred, accessible and equitable primary health care away from a hospital setting.

“Despite the differing health system structures and funding systems (which have implications for how the reforms are implemented), there are a number of common themes and developments being pursued in Canada, New Zealand and the United Kingdom including:

- *Defining a core range of primary care services for defined populations, including essential services.*
- *Improving 24/7 access to essential primary care services, for example walk in clinics in the United Kingdom.*
- *Greater focus on planning for and delivering services for geographically defined populations (especially in New Zealand and the UK).*
- *Emphasis on prevention, promotion and management of chronic disease;*
- *Use of multidisciplinary approaches (but multidisciplinary team development beyond GPs and primary health care nurses remains an implementation challenge).*
- *Development of regional level organisational structures and networks that bring together general practitioners and other primary care/primary health care providers for the provision of more integrated care for defined populations (for example Primary Care Trusts [PCTs] in the United Kingdom and Primary Health Organisations [PHOs] in New Zealand.*
- *Increasing use of mixed funding models that include capitation in addition to fee-for-service (FFS) components.*
- *Significant funding to support implementation of reforms in all three countries.”*

(McDonald & Hare, 2004, p9).

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