Community Health Australia European Study Tour Report

Background
The 2014 Community Health Australia European Study Tour was attended by eight Community Health CEO’s, a Melbourne Medicare Local CEO and Board Chair and the CEO of Community Health Australia.

The study tour included attendance at the European Primary Healthcare Conference in Barcelona followed by site visits and meetings across Spain, Belgium and the Netherlands. The tour was facilitated by the International Federation of Community Health Centres and the European Forum for Primary Care.

Delegates
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Purpose of the Report
The purpose of the report is to provide a starting point for discussions on how the learnings from the study tour may be applied to improve the health system.

Information gathered was summarised into three themes relating to the planning, funding and delivery of community health and primary healthcare. The themes were as follows:

1. Funding models that support integrated care and enrolled populations, particularly those that focus on chronic disease management
2. Primary healthcare’s role in improving health outcomes
The themes and post-tour evaluations have been reviewed to develop opportunities that if further explored and implemented have the potential to improve service delivery and outcomes.

**Context**
The sites chosen were innovative and integrated and provided examples of quality healthcare. On average they supported less than 10% of the population and constituted one component of the health systems visited.

The services visited were primarily family GP-led, with additional services such as nursing, physiotherapy, social work and sometimes other allied health being available. These ‘family GPs’, generally held a gate keeper role, and over time had diversified and added integrated services to provide a range of services for the wider general community. Funding was predominantly for a defined population (enrolled or capitation basis). Thus, they were not directly comparable to the current Victorian environment.
Opportunities

These opportunities take selected highlights from the three health systems studied, and translate them into locally relevant suggestions that may improve service delivery and outcomes.

1. That community health services are the ideal platform to provide innovative service delivery models, supported by appropriate funding models, to support clients with multiple co-morbidities and chronic disease. These may include:
   a. Extend and further develop current successful models of chronic disease management.
   b. Investigate integrated wraparound care for chronic disease management;
   c. Work closely with identified population cohorts with high need.

Community health services suggest working with Government and health insurers to explore funding models such as:
   a. Capitation funding;
   b. Bundled payments;
   c. Blended funding;
   d. The use of an appropriate “trigger point” that would qualify a client to receive a high intensity, multi-faceted approach to care and management.

2. Community health services are an important element of the primary health and broader health system. A robust community health sector will assist in achieving better client outcomes. This may include:
   a. The commitment to developing a Victorian and combined state and commonwealth primary healthcare strategy be actioned;
   b. Continue development of chronic disease management programs that focus on keeping people well and out of hospital;
   c. Investigate opportunities for community health services to provide a wider range of non-acute services in the community setting;
   d. Develop care packages that support self-management and are responsive to individuals’ needs;
   e. Consider broadening and diversifying services to provide for the wider general community. This could incorporate a range of public and private services.
   f. Ensure care models and primary care policy is based on best-practice and academic research.

3. The community health sector takes responsibility for its future role by investing in research into the efficacy of primary and community healthcare and seeks to speak with a single voice on policy issues. This includes:
a. Seeking sector-wide agreement to invest in research and advocacy for community health services in partnership with Government and tertiary sector;
b. Develop partnerships with tertiary institutions to scientifically validate health outcomes delivered by community health services;
c. Linking existing data repositories and evidence held by Centres of Research Excellence into a central and accessible location;
d. Promote the collection and housing of best-practice and research in primary healthcare;
e. Collaborating as a sector to develop data relating to the benefits of community health services within the health system, including cost for services and as a benefit to the health of the community as a whole;
f. Advocating for access to, and reporting of, existing data held by the Department of Health that is collected as part of routine performance management and compliance reporting.
Theme 1: Funding models that support integrated care and enrolled populations, particularly those that focus on chronic disease

European countries are operating in a tight fiscal environment with increasing demand for their health services. All countries visited utilised a mix of public and private community health services.

Funding models

- Funding models operated across enrolled populations. These included a wide range of blended and capitation funding systems, with some bundled payments and fee-for-service arrangements with varying out-of-pocket costs. All health systems visited were built on a foundation of universality of access for the enrolled and eligible populations. Some countries funded refugees and others provided no publically funded services to refugees and illegal immigrants. Access and services for this client group was a significant and growing issue;
- Access for disadvantaged or vulnerable communities was not actively sought and there was limited use of outreach models;
- Private and public providers were often co-located with community health services;
- A shift towards capitation funding is evident in Belgium and Spain. Both regions share a view that a capitation model leads to better outcomes for patients than the alternative fee for service model;
- The Belgian model uses an enrolled population. Patients are able to choose their service provider, with the capitation fee being defined by population need according to morbidity and some age and sex adjustments.

Client choice

- Services were for all eligible/enrolled clients, not just for those who were disadvantaged;
- Services appeared to be well-respected by clients (not viewed as ‘last choice’);
- Clients were free to choose which service they would attend/enrol or register with;
- Client satisfaction with the Belgian system was evident, as each new community health GP service had a fully enrolled population within two years of opening. Clients are able to access GP or specialist with no restrictions or referral required.

Care models

- Integrated and locally based care was seen as best for individuals and the community as a whole;
- The use of “Care Groups” – where GP’s fund-hold and organise pathways and report on indicators for defined cohorts, i.e. diabetes and chronic disease, was available for some client groups;
• Jurisdictions in Denmark, Germany and Netherlands use specific payments for secondary care and prevention care coordinated by GPs, however this is used on a voluntary basis in a small number of clinics;
• The use of financial incentives to manage chronic disease was in the early stages of development with some GPs funded to manage chronic disease.

Opportunities

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Community health services suggest working with Government and health insurers to explore funding models such as:
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Theme 2: -  Primary healthcare’s role in improving health outcomes

Community health services had an important and accepted role within their health systems, partly due to sustained advocacy and development of primary health policy. Similar pressures to the Australian context were identified, with ageing populations, chronic disease management and presentations to emergency departments for urgent (but not emergency) care driving health policy and primary healthcare’s role in the health system.

• Barcelona and Brussels had a limited version of primary care, where the GP and nurse were defined as primary care and community health and allied health were considered to be the second tier in the system;
• The primary care system in the Netherlands was similar to that of Australia, with GPs, nurses and allied health professionals being considered primary and community health care;
• There was evidence of a population health approach to improving the health of disadvantaged neighbourhoods in Barcelona. Utilising the social determinants of health, integrating non-health and health workers and linking government health
policies resulted in interventions that had a positive impact on health and wellbeing (based on research presented at the European primary care forum);

- The Belgian system aims to provide integrated care across the primary and acute interface. E.g. the community health service nurse attends discharge planning meetings at hospitals to support continuity of care. The hospital employs discharge coordinators for this purpose;
- Using the enrolled population and capitation funding model, Belgium is expanding the number of community health services, with four-to-six opening each year;
- Community health in Barcelona has a strong interface with the acute sector, with community health services ‘assigned’ for the purpose of referral to one hospital within the catchment/region;
- The Catalan system has an eHealth system, with every patient having a single electronic medical record that is shared with the hospital. This promotes continuity of care and reduces emergency department attendance and emergency hospital admissions.

Opportunities

2. Community health services are an important element of the primary health and broader health system. A robust community health sector will assist in achieving better client outcomes. This may include:
   a. The commitment to developing a Victorian and combined state and commonwealth primary healthcare strategy be actioned;
   b. Continue development of chronic disease management programs that focus on keeping people well and out of hospital;
   c. Investigate opportunities for community health services to provide a wider range of non-acute services in the community setting;
   d. Develop care packages that support self-management and are responsive to individuals’ needs;
   e. Consider broadening and diversifying services to provide for the wider general community. This could incorporate a range of public and private services.
   f. Ensure care models and primary care policy is based on best-practice and academic research.
Theme 3: - Data collection and its use in supporting evidence-based and cost effective practice

A focus on innovation in primary care was supported by research and development. It was generally funded by government in partnership with the sector. The objective was to promote the use of evidence-based healthcare.

NIVEL – The Netherlands Institute for Health Service Research

NIVEL is the national institute for health service research in the Netherlands. It is an independent organisation. Its domain is applied and applicable health services research. NIVEL has a scientific and societal mission. Increasingly, NIVEL has an international orientation. NIVEL's core business is health services research (the multidisciplinary field of scientific investigation that examines how social factors, financing systems, organisational structures and processes, health technologies, and personal behaviours affect access to health care, the quality and costs of health care, and ultimately our health and well-being). Central to its approach is the interaction between patients and care professionals and organisations.

- Data and research underpin the more successful European models;
- Robust data and research is the result of both support from Government and effective EMR systems;
- EMR is fully implemented in Catalonia. While there appears to be a degree of practitioner dissatisfaction with the time required to complete the required inputs, the EMR is driving a deeper understanding of the cost and effectiveness of the healthcare system;
- KPIs for full capitation payment are linked to data collected through the EMR. There appear limited opportunities to ‘game’ the system;
- The Belgian context differs, with the medical community being the only party able to access data within the EMR. Government departments and statutory authorities cannot access information.

Opportunities

3. The community health sector takes responsibility for its future role by investing in research into the efficacy of primary and community healthcare and seeks to speak with a single voice on policy issues. This includes:
   a. Seeking sector-wide agreement to invest in research and advocacy for community health services in partnership with Government and tertiary sector;
b. Develop partnerships with tertiary institutions to scientifically validate health outcomes delivered by community health services;

c. Linking existing data repositories and evidence held by Centres of Research Excellence into a central and accessible location;

d. Promote the collection and housing of best-practice and research in primary healthcare;

e. Collaborating as a sector to develop data relating to the benefits of community health services within the health system, including cost for services and as a benefit to the health of the community as a whole;

f. Advocating for access to, and reporting of, existing data held by the Department of Health that is collected as part of routine performance management and compliance reporting.
**Appendix: Health funding definitions**

**Blended funding**
Blended funding usually refers to a mix of population-based and fee-for-service funding. Individual clients who live within the catchment area and receive core primary health services from the health agency are registered to the blended funding site. Registered clients generate daily revenue based upon their health status. All other services provided by the practice; services to non-registered clients, clients outside of the catchment area, or for non-core services generate fee-for-service revenue.\(^1\)

**Bundled payments**
In 2007, a bundled payment system for diabetes care was introduced on an experimental basis in the Netherlands. This scheme created a new health care entity—"care groups"—to which insurers pay a single bundled fee to assume responsibility for a patient’s diabetes care for a defined time period. Care groups are made up of health care providers, often only general practitioners, and either provide the diabetes services themselves or subcontract them out to other providers. The services covered under the bundled payment are nationally defined and agreed on by all providers and patient associations, and must be offered free of charge to patients. Price negotiation occurs on two levels: between insurers and care groups on the bundled fee, and between care groups and any subcontracted providers.\(^2\)

**Capitation funding**
Capitation-based payments are based on the numbers of the enrolled health catchment population. This means that health services within the catchment are paid according to the number of people enrolled, not the number of times a provider sees patients. This system is generally called capitation since it is based on a payment per capita (per head). In general, people need more care when they are very young and as they get older. Women in their child-bearing years tend to need services more frequently than men. The formula for calculating capitation payments takes into account the demographic make-up of the population.\(^3\)

**Fee-for-service**
A funding arrangement that provides health services with a fee payment for each instance of health care. The Australian Medicare system is an example of a fee-for-service funding

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\(^1\) Accessed from http://www.health.gov.bc.ca/pcb/phc.html
arrangement. A key issue with this model is that it does not take health outcomes into account, and rewards throughput.

**Out of pocket**
Out of pocket costs are directly borne by clients. This occurs when there is an absence of government-subsidised/provided healthcare, and when private health insurance is not available.