A healthy bottom line

Jenni Parsons

There has been a lot of talk in 2010 about the bottom line of health care expenditure in Australia, and how we as a community manage, control and allocate the available health care dollar.

In April, the Council of Australian Governments meeting reached a majority agreement (without Western Australia) to fundamentally alter the funding structure for hospital funding, with the establishment of a National Health and Hospitals Network.[1] Within this agreement, hospitals will be funded by a 60/40 commonwealth/state split. They will be managed by local hospital networks funded on the basis of a 'national efficient price' for each public hospital service they provide. While this system may work well for larger hospitals, with economies of scale, the bottom line for small or rural hospitals is that they may be unable to provide the broad range of services their community requires, at an 'efficient' price. To compensate for this difficulty some smaller and rural hospitals, and other 'agreed services' will be block funded to reflect their higher cost of service delivery. However, for many small rural hospitals the devil will be in the detail, and there will be community concerns as to the financial viability of their local hospital facilities.

But what of primary care? The Commonwealth Government will assume all funding for general practitioner services, primary health care (including community health centres, primary mental health care, immunisation and cancer screening services) and aged care.

The 2010–2011 Federal Budget has included a number of primary health targeted initiatives.[2] There will be funding for 400 additional GP vocational training places annually by 2014. There will be incentive payments of $25 000 per annum per full time GP for practices employing practice nurses (up to five per practice). This is a significant change from the current fee for service Medicare rebates for dressings, vaccinations, Pap smears and nurse GP Management Plan reviews (Item 10997) delivered by practice nurses, which will now be suspended. The start of a blended payment system for GP care of patients with diabetes will be introduced, with patients invited to 'sign up' to a GP practice that will be responsible for their care. The detail is somewhat of a grey area, with payments 'partly based on keeping patients healthy and out of hospital'.

Funding was announced for a network of primary health care organisations ('Medicare Locals'). The first priority of these networks is to coordinate improved after hours access to GP care, and 'over time' to have a role in supporting community health promotion and prevention programs, and community based mental health service provision. (How these organisations relate to existing GP networks is unclear.)

The potential of e-health to improve patient safety and reduce duplication of services has been recognised with funding for the establishment of a patient controlled e health record to include information regarding medications, test results and immunisations. Other initiatives included rural allied health clinical training scholarships, rural nurse locum support and substantial infrastructure grants for general practices.

While these recent changes appear to affirm the important and central role of primary health care in the Australian health system, the bottom line is that funding alone does not produce improved outcomes. We need to encourage and support recent medical graduates to take up these new opportunities for a career in general practice, supervisors need to be available for those trainees and GP training needs to continue to improve. Workforce capacity in rural areas for GPs and allied health workers needs to be increased by improved training infrastructure and support and encouragement for recruitment and retention. Aboriginal and Torres Strait Islander health, mental health services and rural health service provision are all exceeding complex areas of unmet health need that require adequate funding, but also a multifaceted approach. Co-location of allied health and GPs in 'superclinics' does not necessarily result in effective teamwork. The e-health funding initiative has considerable potential, but any database can only be as good as the quality of information entered. So some work remains for all of us.

In this month's issue of *Australian Family Physician*, our focus has taken a much more literal and earthy 'bottom' line... with articles on perianal disorders. Paul Kitchen discusses the management of pilonidal sinuses, from the relatively straightforward to the complex and recurrent; MacLean and Russell provide us with a practical approach to excluding serious underlying causes and alleviating the distress of a patient with pruritis ani; and W John Daniel provides tips and traps in the management of haemorrhoids and anal fissures. The bottom line from all these articles is that anal symptoms are always distressing for patients, and sometimes are associated with serious underlying disorders that should not be missed. For those of you hoping for a more business orientated bottom line issue, and who prefer coloured bar charts to graphic clinical images, this month's article in the 'tips from the toolkit' series may be more your style.

Author

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References

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2. Australian Government Department of Health and Ageing. Health measures 2011–2012 budget. Available at www.health.gov.au/internet/budget/publishing.nsf/Content/budget2010-healthindex.htm [Accessed 14 May 2010].

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