



Response to Primary Health Services Plan Discussion Paper No 2

General Practice Tasmania welcomes the Government's broad directions for primary care in this State as articulated in the Issues Paper released on 27 March. The proposed service framework and associated reforms, including the tiered statewide service model and the need to change the role of many rural health centres, is generally supported across the network although it is acknowledged that there is significant detail that is yet to be worked through. To that end General Practice Tasmania requests that the Government moves quickly to announce a practical plan to implement the changes accompanied by a comprehensive and funded process to engage general practice and other service providers in developing and actively demonstrating the specific practical solutions and alternative models of healthcare at a community level.

The General Practice Tasmania network supports:

- A comprehensive approach to primary health care that includes health promotion, illness prevention, treatment and care of the sick, community development, advocacy, rehabilitation, population health approaches and inter-sectoral action.
- A wellness oriented, primary health care system with general practice in a pivotal role
- Multidisciplinary teams, with GPs as essential members, as a valuable means for delivering population health initiatives and community development activities
- A partnership approach to setting the primary health care agenda.
- Service integration supported by effective e-health and information technology/ information management systems.
- A diverse general practice workforce that includes a range of practice configurations and clinical roles across the spectrum of care, including secondary and tertiary care.
- Divisions of General Practice as preferred providers of regional primary health care service planning, delivery, brokerage and fundholding.

Other key areas that General Practice Tasmania considers must feature in the Government's final plan include:

- A clear intention to increase investment in primary care, health promotion and illness-prevention programs.
- A commitment to information and communications technology infrastructure to support communication between the public health system and general practice.
- A plan for appropriate transport systems including emergency response to support equitable access to services.
- A clear statement about how services are to be sustainably and equitably distributed across the State.

The members of the General Practice Tasmania network look forward to working with the Minister, the Department other professions and the community in planning the implementation of these key reforms.

The additional comments that follow are in particular response to the directions provided in the issues paper in relation to:

1. The Acute Primary Interface (Section 3.2, p28)
2. The Interface between Primary Care and secondary services (Section 3.3, p29)
3. The proposed development of Primary Health Partnerships (Section 3.4, p.29)
4. The potential funding of general practice to allocate allied health services and support to practices and their patients (Section 3.5, p.29)

The potential for “increased support through GP Workforce to aid in the recruitment of General Practitioners to Tasmania” (p.31) is addressed by a separate submission from General Practice Workforce.

1. Acute Primary Interface

Strengthened linkages between hospitals and community must be underpinned by effective information technology and information management systems. The primary health care system must:

- capture accurate and timely clinical information through electronic systems;
- develop a networked information technology structure where patient records are available to all health professionals involved in their care while preserving patient privacy;
- support innovation and interoperability of data between software systems for easy information transfer between providers and standard information technology health classifications;
- expand liaison GP positions to support up skilling, education and training in information management; and
- foster integrated care systems at state level.

The intention to facilitate the introduction of more after hours GP clinics as an initiative to strengthen the linkages between hospitals and community is noted. In its first submission, General Practice Tasmania recommended “that the Government work with the general practice community to investigate new models of care including short stay facilities, GP after hours services and integrated care centres”. We continue to recommend that consultation and partnership arrangements underpin the development of any alternative models of care.

2. Primary Care – Interface with secondary services

The interface between primary care and secondary services needs to be developed to ensure state government, local and Division initiatives are coordinated with Australian Government initiatives. This interface would then provide opportunities for Australian Government programs to significantly add value to state and other local programs rather than risk duplication and/or serious omissions in service provision.

Emerging health care programs at the federal level have the potential to influence both primary and secondary health sectors statewide. The development of a primary health services plan at this time provides an important opportunity for the General Practice Tasmania Network to explore the possibility of leading the development of a more detailed primary care framework for mental health as a natural progression of this process. This would ensure that the interface between primary and secondary services provides a coordinated framework for the effective and efficient delivery of health care services.

3. Primary Health Partnerships

The Issues Paper (Section 3.4) highlights the intention to establish local Primary Health Partnerships that bring together the Australian Government, local government, non-government organisations, general practice and State government service providers to foster greater coordination of services within areas.

General Practice Tasmania supports the need for greater collaboration at a local level through partnerships but suggests that in the planning of such partnerships the Government undertakes a comprehensive assessment of the experience of other States including canvassing the views of government departments interstate Divisions of General Practice and other stakeholders that have already gone down this path to capitalise on their experience and the lessons learned. Ideally, representatives from other stakeholder groups that are envisaged to be involved in the partnerships should also be given the opportunity to participate in such an assessment.

Other states particularly known to have gone down this path include Victoria and more recently Queensland.

In Victoria the Primary Care Partnership (PCP) Strategy is a key government policy initiative that aims to create a primary care service system that will improve outcomes for consumers and reduce preventable use of hospital services.

The Victorian Department of Human Services (DHS) describes its commitment to the strategy through:

1. Using PCPs to inform and coordinate all initiatives that require partnerships across primary health care services, or between these services and other health and community services and sectors;
2. Implementing Service Coordination, specifically the state-wide Service Coordination Tool Templates where relevant; and
3. Using the Integrated Health Promotion (IHP) framework for all State-funded community-based health promotion initiatives and having all local planned health promotion activity funded by the State (either directly or via member agencies) informed by catchment-wide IHP planning.

Over the five years since Primary Care Partnerships were introduced in Victoria local relationships and strategies between agencies and between PCPs and the State Government have generally been consolidated and have matured. The PCP Strategy has become a key component of inter-agency local network development. PCPs are now an important organisational platform for the ongoing development of primary and community care in Victoria but, as noted in the 2005 Evaluation of the Primary Care Partnership Strategy, “the challenge for the future is to build on the considerable achievements that have been made, to protect PCPs from being undermined by the introduction of alternative policies and mechanisms aiming to achieve similar outcomes, and to provide appropriate resources to ensure they remain sustainable.”

In Queensland the Government has committed \$34 million over 5 years to the Connecting Healthcare in Communities (CHIC) Initiative. Formal partnerships will be known as Partnership Councils and will focus on enhancing service coordination and sharing service delivery, will target the reduction of chronic disease risk factors and provide better primary clinical care. Each Partnership Council will be required to jointly identify priorities from existing data and health plans and deliver shared primary health care services from within the scope of the Government health priorities of chronic and complex care, integrated health promotion and illness prevention, early childhood health (including ante and post natal care), community mental health and drug and alcohol services.

To support its CHIC initiative, Queensland Health has contracted the Queensland Divisions Network (18 Divisions) to lead partnership initiatives with District Health Services and other local service providers under the Capacity for Local Partnerships Initiative. This Initiative is an integral part of the roll-out of the Queensland Strategy for Chronic Disease 2005-2015 and a forerunner to the types of integrated planning and service delivery arrangements that are likely to result from implementation of the Connecting Healthcare in Communities Initiative (CHIC) and the formation of Primary Health Care Partnership Councils in Queensland. Funding of \$2.5 million is to be provided directly to Divisions to establish sustainable partnership mechanisms with the local District Health Services over the period 1 November 2006 – 30 June 2008.

4. General Practice Fund-Holding

4.1 The Concept

The General Practice Tasmania network supports fund-holding and funds-pooling as a framework that consolidates regional fund allocations, under a single point of management, for a defined period of time. Fund-holding needs to operate within clearly defined service areas and target population groups and be used as a mechanism to improve the availability of, or access to, primary health care resources. Recent evidence in Australia indicates that fund-holding improves patient wellbeing and leads to significant changes in service mix, which may in turn produce longer-term health gains. ¹

While it is accepted that there are alternative models including fund-holding by individual general practices, local government and community organisations and consortia as well as Divisions of General Practice. General Practice Tasmania has recommended in its original that the Government recognise members of the General Practice Tasmania Network as *proven alternative service providers in the delivery of primary care services and commence purchasing arrangements with the Network as a provider of choice.*

4.2 The Capacity of the General Practice Tasmania Network

The General Practice Tasmania Network is a unique health infrastructure covering the entire State. The Network supports and links general practice with the wider health system and brings together Australian Government and State Government Programs for integrated service delivery. Each member of the Network provides services responsive to local community needs and can hold funds independently. The three Divisions in this State, General Practice South, General Practice North and General Practice North West, already support general practice and primary care teams through education and training, clinical and practice support, and greater access to practice nurses and allied health professionals. General Practice Workforce already has comprehensive workforce recruitment and retention strategies in place that can be built upon.

Fund-holding by Divisions already occurs in Tasmania through programs such as the More Allied Health Services (MAHS), Better Outcomes in Mental Health Care and the Aged Care Panels initiatives.

The Network has demonstrated capacity to:

- enter into productive purchaser-provider relationships with various levels of government;
- hold funds to provide access to relevant allied health services / multidisciplinary teams to support chronic disease care / secondary prevention activities – especially in areas where these services are not otherwise provided;
- pool funds from a number of sources to provide locally appropriate PHC services to small remote communities that would otherwise have no service providers;
- broker relationships with local government, State Government agencies and local business for better community health outcomes;
- engage with their communities and to identify local / regional needs and to provide innovative solutions to service delivery in remote areas;
- deliver a better return on investment by using existing resources more effectively;
- provide local health promotion solutions that fit with and support a state and national agenda;
- effectively preserve and grow the service workforce;
- demonstrate visible and accountable health outcome benefits through contracting relationships;

¹ Beilby J and Pekarsky B. 2002. Fundholding: Learning from the Past and looking to the future. *MJA*. 176. 321-325

- allow for greater levels of service delivery flexibility and responsiveness to emerging local and regional needs across both the rural and urban centres in the region; and
- operate in an accredited quality framework where standards are assured.

Effective use of the Network, within a broader State primary health care framework, has the potential to address many of the problems in the current system. Members of the network are well equipped to expand and enhance their roles in service planning, integration and delivery.

4.3 Examples of Existing Arrangements

Divisions of General Practice across the country offer models of service delivery that blend the benefits of provider satisfaction and staff retention usually only evident in centralised systems, but at the same time afford the level of community based outreach and access that is demanded of progressive primary care.

Divisions service communities by pooling and administering Australian Government, state and territory funds to offer fully integrated services through primary health care teams or regional hubs. These teams include general practice, allied health, after-hours and other primary health care services appropriate to their community. They recruit, register and employ credentialed allied health professionals as part of the general practice team, and broker practice access to these services.

Examples of successful models include:

- More Allied Health Services (MAHS) through which sustainable and efficient systems for employment and service delivery in areas of diabetes education, dietetics, psychology and occupational therapy have been established;
- GP exercise referral schemes contributing to the primary prevention of chronic disease;
- Integrated Primary Mental Health Services combining State Government and Commonwealth Government funding allowing the employment of a critical mass of staff to deliver a co-located mental health counselling service; and
- Pooling of Commonwealth and state funds to coordinate and manage packages of care for people with chronic disease.

Further details regarding how these models operate can be provided on request.

4.4 Principles

The following is a list of suggested principles and criteria governing the development of fund-holding models:

- Alternative service providers must be accountable to the Department for equitable use of resources according to the intended purposes;
- Business cases will be needed to provide transparency and confidence for all parties;
- Models need to capitalise on experience and build on current successes, e.g., MAHS;
- Alternative models must be flexible to enable local negotiations and local solutions;
- Models will need to be assessed in terms of how they will improve access to primary health care for under represented target groups;
- Models will need to show how they measure health outcomes, i.e evaluation arrangements need to be built in from the beginning;

- There will be a need for formal guidelines and contracts that acknowledge that fund-holding will operate within a mixed economy of care (i.e., funds may be provided by and/or be purchased from a mixture of public, private and not-for-profit providers);
- The use of demonstration sites followed by rigorous evaluation prior to wider adoption may be necessary;
- To be used effectively fund-holding needs to be supported by an appropriate funding pool, quality data, a clearly defined population and clearly identified local needs;
- Models must be developed in the context of a risk management framework that allows risks to all parties to be clearly identified and risk mitigation strategies to be developed particularly in relation to indemnity issues; and
- Community consultation must underpin the development of appropriate models of care.

2.5 A Generic Allied Health Service Model

The following information outlines how a Division fund-holding model for allied health service delivery may work. It is intended as an example only and it is acknowledged that adaptation of such a model would be necessary to meet the varying needs of individual communities and the primary care providers within those communities.

- DHHS would enter into a service delivery contract (purchaser / provider model) with a regional Division of General Practice. These funds would typically be for service delivery across the whole region.
- DHHS would provide funds for service infrastructure, administration and employment to an agreed level
- The funds would be used to establish a single integrated allied health service delivery base or Integrated Service Centre with rural outreach services as an essential component.
- The centre would enable providers to have an administrative base that could also serve as a service location for patients/clients centrally resident or able to travel into a central location.
- The centre could be funded so that a diverse range of professionals including diabetes educators, dieticians, exercise physiologists, podiatrists, physiotherapists, psychologists, life coaches, case coordinators, occupational therapists, and social workers could be engaged. Both team based primary care and population health initiatives could be delivered in partnership with general practice.
- The centre would share a centrally located administrative hub with common requirements across all providers and a common referral mechanism developed to meet all needs. The administrative hub would manage all service bookings, referral management, general enquiries etc. Management of the providers and the centre would be contained within this service unit.
- The centre would ensure that integrated case management is provided under a common umbrella location and within a guided policy framework common to all. Obligation to consider a range of service options for referred clients/patients would be built into policy for service delivery and ensure that the best possible mix of resources could be obtained for each patient.
- The centre would serve as a hub from which rural outreach clinics and services would branch. Providers would deliver services to rural locations on a planned and structured service calendar maximising the efficiency and outcome benefit of multiple providers in the same rural location simultaneously where possible.
- In rural locations, allied services would be delivered from the general practice or other central primary facility. Mini-clinic style service delivery to support the management of chronic conditions (eg podiatrist, diabetes educator and dietician for diabetes) or (dietician, lifestyle coach and exercise physiologist for chronic weight management). This would also ensure best use of resources, maximize patient/client compliance and afford excellent integrated rural service delivery for patients.

- Student training across professions would occur with strong emphasis on training and development of the emerging workforce. Professional development (multidisciplinary where possible and beneficial) would be a strong feature of this model.
- Ability to enter collaborative relationships with private providers of service for patients/clients with the means to pay would be encouraged and would also help to extend the capacity of the integrated location to be seen as a one-stop-shop for allied health service access.
- Service delivery through Divisions of General Practice would ensure strong and responsive links with both general practice and specialist medical practice with effective electronic communications systems being established to facilitate rapid and secure exchange of information between providers.
- The purchaser provider relationship would be managed through joint governance arrangements to ensure accountability to the State (the purchaser).