Submission
September 2005

DHS Ambulatory Care Policy and Planning Framework

Background

GPDV consulted Victorian divisions of general practice by circulating a background paper on DHS's *Ambulatory Care Policy and Planning Framework consultation paper* for comment at the beginning of August. GPDV board considered and discussed the consultation paper at its August meeting.

This submission to DHS is the result of our consultation with our members and our board's discussion.

Introduction

Our view of the Ambulatory Care Framework is that it is based on the idea that health care should be provided in community-based settings wherever possible, and that "inpatient care will become an option of last resort." (p.6)

Although the consultation paper poses some (mostly very broad) questions about various aspects of how to build an effective ambulatory care system, the main idea in the paper is that services should be provided through "health precincts", which would bring together a wide range of primary care services for a catchment area.

The paper also discusses what geographical areas (regional/PCP/LGA/sub-LGA) should be used as the basis for planning the delivery of the various types of services. It provides a 'possible classification of ambulatory care services' whose purpose seems to be to assist geographical planning for service provision.

A number of questions relevant to general practice have been inadequately addressed in the paper, or not addressed at all:

- how general practice services fit into these health precincts or connect with the services in them
- the role of general practice in helping to achieve the policy aim – that people are cared for in community-based, rather than hospital settings (wherever possible)
- what models of care might be necessary to achieve the policy aim.

This submission addresses these questions, under the following five discussion points:

1. The framework's consideration of general practice appears to be limited to co-location of general practice services within health precincts
2. The consultation paper describes "health precincts" as a "first port of call", which fails to take into account how the current health system operates
3. Models of care involving general practice need to be included in the framework
4. The framework needs to examine the interfaces between general practice and the rest of the health system, to find the best contribution of general practice to care that will help to keep people out of hospital
5. Area-based planning for health services is essential, and must be properly resourced
6. The possible classification system of ambulatory care services is unclear and conflates criteria for each grouping

Issue 1. The consultation paper's consideration of general practice appears to be limited to co-location of general practice services within health precincts.

Co-location of general practice services would not achieve integration with other health services or even necessarily better coordination, as the vast majority of GPs and the vast majority of general practice patients will remain outside the Health Precincts. Close to 80% of the population see a GP each year. For example, in 2002-03, there were 24,318,770 GP services in Victoria[1]; 77.18% of the population saw one or more GPs in 2001-02 in Victoria[2]; and the average number of consultations per person in Victoria in 2002-03 was 4.93.[3] GPs within a health precinct would not be able to cope with the demands of the whole population, and to provide the ongoing, whole-patient care that characterises general practice.

A crucial issue for general practice is to ensure that their patients can access those other health services which they need. This means that it is the pathways between general practice and other health services that need to be examined, to enhance patient care, rather than whether or not GP services are co-located within health precincts.

Issue 2. The consultation paper describes "health precincts" as a "first port of call" for a range of health services (p.11), which fails to take into account how the current health system operates. If health precincts were to become the "first port of call," they would need to take over the enormous load of general practice, which currently functions as first port of call/gatekeeper (and is located at sub-LGA level, whereas health precincts would be at PCP catchment level). Becoming the "first port of call" would be well beyond the capacity of DHS-funded services, and would represent a major shift for the whole health system.

If it is the presence of community health services (which include GPs in their workfoce) within health precincts that leads to thinking of the precincts as a "first port of call", it is worth looking carefully at the numbers of clients within and outside of CHSs to check how realistic the "first port of call" notion is. Somewhat under 5% of the population are CHS clients[4] (some of these access GP services and some do not)[5] and less than 3% of the number of fulltime equivalent GPs in Victoria work in CHSs.[6] On the other hand, as cited above, about 77% of the Victorian population see at least one GP each year, and obviously the other 97% of GPs work outside CHSs.

If health precincts are to operate as CHSs do currently, as far as providing the first port of call, they would presumably be able to deal only with a subset of population (disadvantaged, with high needs), due to resource constraints. Yet health precincts must have services available for the whole population, if they are to be effective in diverting care from hospital settings. It seems that the role of general practice as the major entry point to the health system has not been seriously considered within the Ambulatory Care Framework.

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[1] From MBS statistics from the Health Insurance Commission. www.hic.gov.au; statistical reports; annual report financial year statistics; 2002-03; Table 6.
[2] As above, Table 21.
[3] As above, Table 6; and population from Table 1A.
[4] CHSs have 200,000 registered clients per annum, DHS, January 2004, *Community Health Services – Creating a Healthier Victoria public consultation draft,* p.iv.
[5] 30% of CHSs have medical practitioners, *Community Health Services public consultation draft,* p.iv; and about 25 have general practice clinics, p.2.
[6] Based on approximately 100 fulltime equivalent GPs working in CHSs, and 3,527 fulltime equivalent GPs in Vic in 2001-02 (there were 4,144 fulltime workload equivalent, or FWE GPs in Vic in 2001-02). From General Practice Statistics provided by Dept of Health & Ageing, derived from Medicare statistics, and numbers calculated from average billings – further explanatory notes on FTE and FWE measures at http://www.health.gov.au/pcd/programs/gpstats/gpstate.htm.

Issue 3. Models of care including general practice need to be included in the framework.

If general practice is the main entry point to the health service system (as argued above under issue 2), and simple co-location of a few GP services with ambulatory care services will not provide the solution, then it is crucial to examine the models of care, how general practice fits into them and how general practice will work with the ambulatory care system. General practice can be used to increase the health benefits for patients by developing models that use everyone's expertise where it is most relevant. An example is Dandenong's Integrated Disease Management (Diabetes) model. The role of the GP as the starting point for access to the system is recognised; the GP refers the newly diagnosed patient to the Diabetes Coordination and Assessment Service (DCAS). Timely access to services, particularly self management support through local community health centres, is organised for the patient including follow-up if needed. Feedback is provided to the GP. People who have diabetes and CVD, whose diabetes is difficult to manage, are included in a related program funded through HARP. The focus is to get the main part of the patient's care provided in the general practice setting, which means providing more skills and specialist support to the GPs via a 'trouble shooting clinic'. This makes the best use of specialist time, to look after more patients than s/he could by seeing each of them.

There are other examples of arrangements that can demonstrate viable roles for general practice and other providers and good outcomes for patients. For instance, 'Healthy at Home' and Diabetes Clinical Co-management in General Practice / the Community, which are both projects funded through Hospital Admissions Risk Program (HARP).

At the very least, it is important that Health Precincts do not produce barriers to the implementation of these models. It is conceivable that where there is reliance on co-location as a mechanism for integration, models of care could reduce the involvement of services and practitioners to those working within or close to the health precinct. Maintaining, replicating and building on models of care that incorporate general practice more comprehensively may provide a better basis for strengthening ambulatory care than co-location.

Issue 4. The framework needs to examine the interfaces between general practice and rest of health system, to find the best contribution of general practice to care that will help to keep people out of hospital.

Interfaces between general practice and the rest of the health system can include:

- Referral of the patient to another service, setting, or the addition of another care provider
- Communication between the GP and other health providers to enhance care (referral and feedback information, and discharge information)
- GP participation in multidisciplinary care
- Shared care
- Monitoring where patients are within the service system
- Providing services under the auspice of another organisation (e.g. Hospital in the Home)
- 'trouble shooting' clinics which provide short-term specialist care on behalf of the GP

Looking at these sorts of connections or interfaces and how they could be strengthened might be the most effective way for general practice services to be included in the Ambulatory Care Framework.

In models endorsed by GPs, they are able to retain medical case management rather than having patients transferred to other settings and not necessarily receiving referral/communication back about the patient. The lack of appropriate referral/communication compromises effective medical case management in the community.

Issue 5. Area-based planning for health services. The paper asks how the current range of population-based planning approaches should be re-cast to take account of a new ambulatory care system, and how area-based planning could be integrated with other planning requirements.

GPDV strongly supports area-based planning. Divisions of general practice need to be a part of the planning, to make sure that the general practice contribution to effective patient care, which is not well understood by the rest of the sector, is identified and utilised. This includes understanding and taking advantage of, the wide 'reach' of general practice; taking account of its current role and its potential role; being well-informed about numbers of providers within particular areas; and exploring how models of care might work.

Thorough area-based planning requires more resources than are currently available. The Primary Care Partnership Strategy is DHS's key platform for strengthening primary care, yet the PCPs seem inadequately resourced to do this substantial planning task. Additional, substantial investment might help PCPs and therefore divisions. In addition to an appropriately funded mechanism (whatever governance arrangements are in place), the requirement for the planners to achieve GP engagement will be important, if divisions are to be involved.

Issue 6. The possible classification system of ambulatory care services (Appendix 1, p.14) is unclear and conflates criteria for each grouping.

The system puts services into 3 groups according to which should have larger catchments, medium-sized catchments and smaller catchments (yet for all three, it seems to suggest planning should be based on PCP catchments, though some should "consider needs" at an LGA &/or sub-LGA level).

General practice sits with those to be effectively delivered on a small catchment basis, which seems correct as far as catchment area goes. But the paper says that the groupings were identified for each service on the basis of three factors:

- Complexity (including complexity of interventions, specialisation, level of technology and/or level of clinical risk)
- Average size of population catchment (based on current numbers of service delivery sites)
- Level of functional interdependence between services (how closely one service's needs closely link with another)

It is not clear exactly which criterion was the main one used to place each service, because they are conflated; and according to the criteria of complexity, specialisation, technology and clinical risk, general practice appears to be in the wrong grouping.

We believe this classification is unhelpful, and a different framework for planning is needed. It would need to take account of role delineation between services and the interfaces between them.