Draft submission
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AGPN draft position statement – Funding models for general practice based multidisciplinary team care

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Summary

GPDV welcomes the opportunity to comment on the latest AGPN paper. We appreciate the clear account of feedback received on the first draft, which greatly enhances the consultation process.

We support AGPN's five principles that should govern development of funding models (workforce and access issues; effective team care; patient-centred care; cost-effective care; improved population health outcomes) but suggest that it would be more useful to adopt the National Health Performance Framework principles, for consistency and simplicity, as these have been agreed by all Australian health ministers.

The strategies in the paper appear to be about:

- Promoting multidisciplinary care
- Increasing emphasis in the health system on prevention and early intervention
- Moving away from "policy by item number alone" to "policy by health outcome"

and we support these broad directions.

But we are concerned that the "funding models" mentioned in AGPN's paper do not constitute a systematic and comprehensive funding model, but rather, are additional options that while working well for a defined group, do little to reduce the complexity and inefficiencies of the system as a whole.

If AGPN are to pursue one of these smaller funding models, we reiterate (as in our submission in March) that it is worth trialling models on a small scale, for a selected population or with a particular disease group. We would prefer to see these smaller models as trials for approaches that could be developed in a systematic way to reduce complexity, enhance efficiency and to ensure consistent and equitable primary care across Australia.

It would be useful to examine more closely and report on what evidence does exist for the effectiveness of current divisional approaches to holding funds. We suggest using the independent evaluations of the ATAPS model (with projects across Australia) and the North East Victoria Integrated Primary Mental Health Service (which combines commonwealth and state funds), to build the case for further exploration of a divisional role in funds pooling that may lead to more effective care, while reducing inefficiency and duplication.

In the long run, our goal should not be to add an ever wider range of options but to identify a funding model that can be applied nationally. At a time when there is growing political interest in reforming the health system, it would be worthwhile for AGPN to engage the necessary external expertise (health economists etc.) to develop proposals, based on evidence, that make full use of the unique position of divisions of general practice to deliver high quality, better coordinated care in their communities.

Background

In January, AGPN circulated a discussion paper, *Funding general-practice based multidisciplinary team care in Australia.* GPDV consulted Victorian divisions[1], GPDV board discussed the Victorian response in March and written comments were sent to AGPN. Our main points were:

Support for points in the paper

GPDV supported the following ideas in AGPN's paper:

- the existing division role should be extended to allow budget holding for certain programs
- multidisciplinary teams are basic to good chronic disease management
- teamwork should be funded more effectively
- fee-for-service should be retained for episodic care
- blended payments are more effective for CDM
- Clinical leadership is the province of the GP; care co-ordination can be provided by a non-GP.
- There was some support for regional registration for patients with chronic disease, but also concern about registration of patients on the basis of a particular condition, as this might undermine the value of general practice's approach to whole-patient care.

Concerns/suggestions

- There was a need for clarity about what is being proposed, and what divisions would be agreeing to in supporting the paper
- There is need for flexibility, in particular to recognise that primary care infrastructure exists outside of divisions, and must be taken into account in the design of new models.
- Any new models must be monitored and evaluated during implementation
- Proposed models should be developed in context of a national primary health care plan that involves shared commitment from national and State governments
- It is important to ensure GP engagement with any new models. We suggested starting with a clearly defined group, selected on population or disease basis, to test the models. We also suggested building on existing models of team-based care with which divisions are familiar.

Current draft

AGPN has now released a draft position statement. The statement includes an appendix of feedback received on the January paper, summarising comments from the field and thus enabling a comparison between feedback and AGPN's decisions in relation to the feedback. This is a major strength in the consultation process used to develop this document.

A key theme reported in the feedback from divisions and SBOs is the need for greater clarity about the funding model(s) under consideration, and how they would differ from the current arrangements, including how the "patient journey" would differ.

AGPN's response to this criticism has been to clarify that this paper is about principles that underlie the development of new models, rather than about models themselves.

[1] The paper was discussed at the GPDV Forum in February 2007. 23 divisions attended; Chairs' February teleconferences – 23 divisions represented; written comments from 5 divisions, and 3 sets of individual comments from divisions.

The paper defines five principles that should govern the development of funding models. These are a commitment to:

- Workforce and access issues
- Effective team care
- Patient-centred care
- Cost-effective care
- Improved population health outcomes.

Many strategies are listed to support the implementation of these principles. Strategies include the need to streamline the MBS but also support for the use of additional MBS items such as the 45-year old health assessment. The paper also defines the characteristics that should apply at the clinician, practice and regional and systems level. The main strategies by level are illustrated in the following table:

Payment options by level

Clinician	**Practice**	**Regional**
FFS - episodic	Infrastructure support funding to house allied health & promote co-location of teams	Extension of fundholding models such as MAHS & ATAPS
Non FSS – population health	Funding for non-GP case coordinators	Division funds pooling from different sources
MBS items for incentives	Incentives for non-contact clinician time e.g. for teaching	Funds to coordinate packages of chronic disease care
Case conference payments for allied health	Practice nurses	Procedural training grants & training subsidies for practice nurses
Streamlined MBS	Incentives for data collection and analysis	Incentive payments for use and development of standardised software between health sectors

Discussion

Discussions with Victorian divisions over time, through forums and teleconferences, on a range of issues, have suggested that there is widespread support for funding forms other than fee-for-service alone. The FFS system has become increasingly cumbersome as MBS items are used for a variety of different needs (including chronic disease prevention and management activities) which the MBS was not designed to address.

These discussions suggest that divisions and GPDV board would support the five principles in the AGPN paper, and additionally, that they would support strategies that:

- Promote multidisciplinary team work in general practice
- Increase emphasis on prevention and early intervention
- Move away (in AGPN's words) from "policy by item number alone" to "policy by health outcome."

While supporting AGPN's principles, we would argue for the use of the principles in the National Health Performance Framework rather than those cited in AGPN's paper. Although there is

considerable overlap, the NHPF defines the principles for health systems agreed by all Australian Health Ministers.[2] The framework addresses three levels: health status and outcomes, the determinants of health, and health system performance. In the category of health system performance there are nine criteria for assessment. It is a well validated set of principles that serve as criteria for developing and evaluating systems and provides a common language; it is another way to reduce complexity if we consistently use that framework.

The nature of funding models

The next step that would be needed to translate this in-principle support is the development of a funding model, or a number of possible funding models. Divisions and SBOs would then need to consider these, and decide whether or not they support them on their merits.

The AGPN paper seems to be constrained by the desire, or perhaps necessity, of supporting continuation and sometimes expansion of all current funding sources and streams to general practice and divisions (e.g. fee-for-service, practice nurse payments, expansion of RMIF) as well as arguing for some new ones (e.g. non-GP case coordinators, regional fund holding for packages of chronic disease care). Divisions and GPDV may well support all system characteristics listed in AGPN's paper[3] but they do not constitute a new, systematic funding model for primary care. AGPN writes that a key mechanism will be "systematic and comprehensive use of regionalised fund-holding and funds pooling options". It is not clear how it could be systematic or comprehensive, or what funds it might pool, while the plethora of different funding mechanisms remains.

Divisions and SBOs, like AGPN, would not want to suggest that they surrender funding sources, but if funds pooling is under discussion, we need to be clear what funds are to be pooled and how the "patient journey" will differ from the current one. It is important to explore ways of pooling state and commonwealth funds as it has the potential to improve patient care and processes. The paper seems to suggest that the system should maintain the status quo and in addition, do something new (regional fund holding). Before establishing a position in relation to fund holding, divisions and SBOs are likely to want to be clear about exactly what it is, how it would work, and what difference it will make.

Trialling funding models

One of the main concerns expressed at the GPDV Forum in February was the need to experiment with funding models before developing a national model. The current version of the AGPN paper seems to suggest that the long term strategy might be to develop a range of funding approaches adapted to local areas. We reiterate the need to experiment with models on a smaller scale either with selected populations or with a particular disease group. However, we would prefer to see these smaller models as trials for approaches that could be developed in a systematic way to reduce complexity, enhance efficiency and to ensure consistent and equitable primary care across Australia.

Assessing the effectiveness of fundholding models

The background to the draft position statement mentions some of the current divisional approaches, such as MAHS and ATAPS as well as the need to develop region funds pooling

[2] National Health Performance Committee, *National health performance framework report: A report to the Australian Health Ministers' Conference*, Queensland Health, 2001

[3] For example, recent discussions convened by GPDV about workforce shortage and GP education have raised the possibility of arguing for expansion of RMIF or similar to help practices support GP training places.

models. But the paper does not include evidence of the effectiveness of the various models. It would be useful to review whatever evidence does exist, both to secure more divisional support and to persuade policy makers that it is worth exploring these options. In Victoria, one division board noted that "the AGPN paper finds that there is little evidence to support funds holding." The board goes on to say that the division does not support funds holding for general practice. Divisions may still choose to disagree with the solutions proposed by AGPN, but the position statement could make better use of evidence, so there is a clearer basis for informed debate. A brief overview is provided here of a regional funds pooling model (North East Victoria) and a divisional fundholding model (ATAPS)

Regional funds pooling: North East Victoria Integrated Primary Mental Health Service.

The North East Victoria model for mental health, referred to in AGPN's paper is a model that should be adapted to other areas. In 2002–03, the North East Health Wangaratta Area Mental Health Services (State Government funded) and the North East Victoria Division of General Practice (Commonwealth funded) joined forces to combine three funding sources into the provision of one service. As the Integrated Primary Mental Health Service, they used resources from the Primary Mental Health & Early Intervention Initiative (Victorian State Government), the More Allied Health Services (MAHS) (Commonwealth) and Better Outcomes in Mental Health Initiative (Commonwealth) to create an integrated primary mental health service with 12.4 EFT and which provided for co-located clinicians in GP clinics as well as specialist services in dual diagnosis and perinatal mental health provided through the Area Mental Health service. This model of service integration resulted in a 30% reduction in referrals to Wangaratta Adult Mental Health service sustained over 18 months, and provides a strong argument for the effectiveness of primary care prevention and treatment of mental health disorders and problems.

The inefficiencies that this service has avoided are:

- three separate initiatives attempting to engage primary care
- single workers struggling to operate separate outreach models of service delivery, involving extensive and time-consuming travel
- separate workers visiting primary care services extolling the virtues of their particular initiative
- primary care providers, such as GPs, having to differentiate which initiative best suits the needs of a particular patient, and then grappling with one of the three referral pathways
- each initiative requiring separate infrastructure support, separate governance and clinical support and separate models of service delivery.[4]

An independent evaluation of the service was conducted in 2004 by a team from La Trobe and Charles Sturt Universities. It found that "clients of the IPMHS have had a significant decrease in their major symptoms and difficulties experienced as a result of their mental illness".[5] This finding was also reported in the evaluation report for the following 12 months (conducted internally, but using the same methodology)[6].

[4] Williams R, 'Integrated Primary Mental Health Service—North East Victoria', *PARC update*, Issue 13, Primary Mental Health Care Australian Resource Centre, September 2004

[5] D Maybery, C Gullifer, R Brown, J Neale, June 2004, Program evaluation: Integrated Primary Mental Health Service: Measuring client mental health outcomes and client and staff satisfaction. p.7 <http://www.ipmhs.org.au; documents; publications>

[6] R Williams, G Bourke, 2005, Evaluation of the Integrated Primary Mental Health Service: measuring client mental health outcomes and client and staff satisfaction. p.8.

Additional benefits to consumer outcomes found in both reports, were that "the IPMHS team has very high morale and relatively low levels of workplace distress" and the 2005 report noted "a *very high level of GP satisfaction with the collocation model and services provided by the IPMH Service.*

But the efficient use of primary mental health resources in NE Victoria is one of the exceptions that prove the rule. Concerns about accountability for separate funding sources and about double-dipping have prevented this efficient solution being repeated elsewhere. It would useful for AGPN to recommend trials that expand this model to other regions and other disease categories. Any trials should include rigorous evaluation, planned in detail before implementation commences.

Divisional fund holding: ATAPS

Another funding model referred to in the AGPN paper is that in which divisions hold funds to provide services linked to general practice. The ATAPS program is one such example. Under the Better Outcomes in Mental Health Program divisions of general practice were funded to conduct 111 Access to Allied Psychological Services projects. These projects enable GPs to refer consumers to allied health professionals (predominantly psychologists) for six sessions of evidence-based mental health care, delivered in six time-limited sessions with an option of a further six sessions following a mental health review by the referring GP. The conclusions of ATAPS evaluations found that the projects are achieving improved consumer outcomes.

The 8th interim evaluation of the ATAPS Program[7] found that "Overwhelmingly, the ATAPS projects are having a positive impact for consumers in terms of their level of functioning, severity of symptoms and/or quality of life."[8]

The findings of the most recent evaluation[9] are consistent, as the projects have continued to grow (1180 consumers were referred in July-Sept 2003, and peaked at almost 9,000 in July-Sept 2006): "the projects were shown to be achieving positive outcomes of large or medium magnitude."[10] Demand for ATAPS does not seem to have reduced despite the introduction of the Better Access program.[11] The report suggests this may be because there was excess demand for psychological services that could not be met due to the capped nature of their funding; and that perhaps one reason for ongoing high demand for ATAPS services is that they are achieving positive consumer outcomes.[12] The demographic profile of consumers has been consistent, with around three quarters of consumers being female, the mean age being around 41 years, around two-thirds on low incomes; about half with no previous history of mental health care; and most diagnosed with depression or anxiety disorders. The average number of sessions provided to those consumers who used services was 4.83.[13]

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[7] B Morley, J Pirkis, K Sanderson, P Burgess, F Kohn, L Naccarella, G Blashki, June 2006, Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program, Eighth Interim Evaluation Report, Consumer outcomes: the impact of different models of psychological service provision, University of Melbourne Program Evaluation Unit, <www.health.gov.au/internet/wcms/publishing.nsf/content/mental-boimhc-repts-int8>

[8] Morley et al. p.2

[9] J Fletcher, J Pirkis, F Kohn, B Bassilios, G Blashki, P Burgess, July 2007, Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program, Tenth Interim Evaluation Report, Consumer outcomes: Progressive achievements over time, University of Melbourne Program Evaluation Unit.

[10] Ibid., p.4.

[11] Ibid., p.33.

[12] Ibid., p.34.

[13] Ibid, p.14.

The second evaluation question in the 8th interim evaluation report was:

- Does the level of consumer outcomes vary depending on the model of service delivery?

There is considerable variability in terms of the models of service delivery that the 29 projects reviewed in that report employed (referral systems, location of allied health professionals, and contractual arrangements). Although they do not differ markedly in terms of consumer outcomes achieved, those using a **direct referral** model tend to achieve better levels of consumer outcomes. Also, there are "non-significant trends toward **employment** of allied health professionals being predictive of greater consumer outcomes and **delivery of services from allied health professionals' own rooms** being predictive of lesser consumer outcomes.[14]

Although these findings do not mean that the direct referral and/or co-location of services is necessarily the **best** model to achieve good consumer outcomes, it may well be and is certainly worth exploring further.

Developing a national model

While experimenting in smaller ways, it is vital to ensure that the evaluation design answers the appropriate questions that provide evidence for the effectiveness and wider application of such models. In the long run the goal should not be to add an ever wider range of options but to identify a funding model that can be applied nationally. There is an overwhelming need to reduce complexity and to ensure consistency of treatment and equity of access to primary care. The barriers to moving to this stage include (a) the difficulty of identifying a model that balances professional needs for autonomy over clinical and business decisions with the society's need for high-quality, highly accessible services at an affordable price and (b) the challenge of identifying ways to integrate State and Commonwealth funds and/or organisations.

AGPN has noted on many occasions that divisions already have the infrastructure and the capability to hold funds for major programs. There are strong arguments for moving to the next step: i.e. to regionally based primary health care organisations that hold the funds for population health programs and purchase services on behalf of the local population.

At a time when there is growing political interest in reforming the health system, it would be worthwhile for AGPN to engage the necessary external expertise (health economists etc.) to develop proposals, based on evidence, that make full use of the unique position of divisions of general practice to deliver high quality, better coordinated care in their communities.

[14] Morley et al, pp.9-10.