VICTORIAN GENERAL PRACTICE

Number 3. Winter 2000

QUARTERLY DIVISIONS

Caring for refugees

Developing partnerships:

- GPs and pharmacists
- GPs and hospitals
- GPs and primary care

Corporate governance

INTEGRATING CARE: GPs IN THE HEALTH SYSTEM

QUARTERLY DIVISIONS

CONTENTS

CONTRIBUTIONS

The *Divisions Quarterly* is a journal produced by General Practice Divisions Victoria to enable all Victorian divisions and their GP members to participate in discussion about the changes in general practice that divisions are funded to implement. Others associated with the Divisions Program including consumers are also invited to contribute.

All articles submitted for inclusion in the *Divisions Quarterly* are subjected to a review process by the Editorial Committee prior to publication. The Committee may request changes be made to the article before publication. All changes will be sent to authors for approval before printing if possible. The Editorial Committee cannot promise that all contributions will be automatically printed in the journal.

Divisions Quarterly will not usually reprint articles that have been submitted to other journals.

Please send your article in either Word 97 or earlier version or Rich Text Format to the following address:

c.macdonald@gpdv.com.au

If you do not have email facilities, then send a disk copy in one of the formats previously mentioned. If this is not possible, send us a typed copy of your article to the address below.

Feature Articles

Feature articles are approximately 1500 to 2000 words long. Please adhere to this length.

Ideally, a *Divisions Quarterly* article will meet as many as possible of the following criteria

- generate debate about the theme
- promote analysis of issues
- inform others about issues in the Divisions' Program
- promote and affirm divisions and their work
- contribute to setting the research agenda for the Divisions' Program.
- have state-wide relevance

The next issue

The third issue is scheduled for Spring 2000.

The theme will be the role of GPs and divisions in population health. We seek contributions on this theme as well as other articles of interest to the Divisions' Program.

Deadline for contributions:
Friday 15th September

LETTERS TO THE EDITOR

Divisions Quarterly seeks letters from GPs and others. As part of the purpose of the journal is to generate debate and discussion within the Program, the Letters to the Editor section will be a significant feature of subsequent issues. Letters of more than 300 words may be edited to that maximum.

Address letters to:

The Editor
Divisions Quarterly
1st Floor, 458 Swanston Street
CARLTON 3053

Fax:03 9348 1375

Email:b.newton@gpdv.com.au

GPDV is a state-based organisation of divisions of general practice owned by all the 31 divisions in Victoria. It is funded by DH&AC to provide support to Victorian divisions, to develop policy and to represent and advocate for divisions and for general practice.

General Practice Divisions – Victoria
1st Floor, 458 Swanston St
CARLTON VIC 3053

Ph: (03) 9341 5200
Fax: (03) 9348 1375

Email: gpdv@gpdv.com.au

Website: www.gpdv.com.au

DISCLAIMER

GPDV
GENERAL PRACTICE DIVISIONS
VICTORIA

Editorial

Bill Newton

When the idea of divisions was first seriously on the political agenda, the need to bring GPs out of isolation from the rest of the health system was defined as one of the most important problems for divisions to address. In their 1992 paper, The Future of General Practice, the General Practice Consultative Council wrote that GP isolation '...has led to a breakdown in continuity of care for patients. This lack of integration with hospitals, allied health professionals and other community services was one of the key structural weaknesses recognised in the 1991 Commonwealth Budget.'

THE ARTICLES IN THIS ISSUE CONSISTENTLY HIGHLIGHT THE STRENGTH OF DIVISIONS, EIGHT YEARS LATER, AS VEHICLES FOR IMPROVING THE RELATIONSHIP BETWEEN GPS AND THE REST OF THE HEALTH SYSTEM.

The articles in this issue consistently highlight the strength of divisions, eight years later, as vehicles for improving the relationship between GPs and the rest of the health system. Vladimir Vizec, Chairman of Western Melbourne Division and a GP practising in the western suburbs of Melbourne, graphically illustrates the way in which the need felt in his practice in St Albans for better care for refugees was picked up by the division and taken to The Victorian Foundation for Survivors of Torture. From there the relationship between the division and the foundation has expanded to include a number of other divisions and organisations in a statewide network dedicated to improving health care and welfare for refugees.

Paris Aristotle and Kim Webster describe the relationship from the foundation's point of view. The two articles together illustrate what can happen when two organisations see a mutual need to work together and have the capacity to establish a working relationship.

The question of mutually felt need seems to be at the core of effective integration work. In his examination of a successful obstetrics shared-care program in Brisbane, Gawaine Powell Davies points out that 'it meets the hospital's need to reduce the burden of outpatient care. It meets the GPs' need to maintain a clinical role and it meets the patients' needs to have continuity of care with someone they know and trust.'

Unfortunately, there are times when GPs feel the need to work with others but are not themselves seen as a priority. Lenora Lippmann defines the ways in which hospitals and GPs need each other but she also points out that in practice hospitals are interested in very specific focused interactions, for example on risk assessment for coordinated care. On the other hand, she suggests, GPs are interested in a multi-dimensional relationship with hospitals and are still a long way short of achieving it. Peter Schattner notes that the '(health care) network remains dominated by the concerns of its hospitals, and these revolve largely around patient access and working to a budget. Not surprisingly, GPs are not a high priority in comparison to these fundamental issues....'

In some instances the need for integration is perceived by the government or by some other part of the health system rather than by GPs. This external agenda can put extra pressure on the relationship building that is an essential precursor to successful integration work. Jo Chandler shows how federal government concerns about the cost of the medical mishaps due to medication problems has led to pressure on GPs to establish better communication with pharmacists. Adele Hamlyn discusses the Victorian government's efforts to promote better integration between GPs and other parts of the primary health care system.

The writers for this issue show that the age-old barriers to forming integrated care still exist: perceptions of role, territorial tensions, lack of motivation, lack of time, lack of structure, lack of incentive and so on; and there are some very difficult questions to resolve. If the GP is to be the gatekeeper to an integrated primary care system, as Rob Ferguson points out, then how does that role fit with the notion of equal partnership with other health professionals? How are questions of autonomy and professional status, and even professional survival in some instances, addressed for each of the professional groups involved in health care integration?

These articles also show that divisions are working in many different ways to break down the barriers, to overcome cultural differences and to form productive relationships with other parts of the health system. Whitehorse Division invites other health professionals to participate in CME sessions - thus 'increasing understanding of each other's role and fostering trust in the skills they all have to offer.' West Vic Division has set up a regional pharmacy group and GPs and pharmacists discuss professional issues in a monthly teleconference. In the Inner South East Melbourne Division GPs and pharmacists are together reviewing cases of polypharmacy. Lenora Lippmann tables the wide range of strategies divisions and hospitals have applied to improve links between GPs and hospitals. And much has been learned in the

IN VICTORIA, THE GP TAKE-UP OF THE HEALTH ASSESSMENT ITEM IS XX% BUT TAKE-UP OF THE CARE PLANNING AND CASE CONFERENCING ITEMS, THE ITEMS THAT REQUIRE GPS TO TAKE TIME OUT TO WORK WITH OTHERS, IS STILL MUCH LOWER AT YYY%.

Divisions Program, as Gawaine Powell Davies shows, about the principles underlying successful integration.

However, it seems clear that building mature interprofessional relationships will only go part of the way towards achieving consistent continuity of care for patients. Systemic and structural changes, including changes to the system of incentives, are sometimes even more important: the electronic health record and the GPDV registry being two examples of systems that are designed to improve communication and access to information in the interests of continuity of care without requiring any major change of relationship between participants. Sometimes changing the systems and incentives is still not enough, especially when the incentives are designed to take GPs away from the individual consultation that forms the core of general practice work. The early evidence about GP use of the new MBS items is a case in point. In Victoria, the GP take-up of the health assessment item is xx% but take-up of the care planning and case conferencing items, the items that require GPs to take time out to work with others, is still much lower at yyy%.

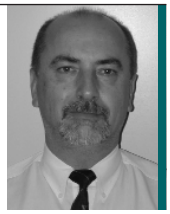
There may be several explanations of this low figure but one possibility is that higher levels of integration require greater structural change – and this does not necessarily mean the merging or takeover of organisations. Lenora Lippmann hints at this when she refers to the difference between incremental change through divisions and systematic change such as that being trialed through the Coordinated Care Trials or through fund holding by primary care groups in the UK.

ONE WAY OR ANOTHER, THE IDEAS OF FUND HOLDING, DIVISIONS OF PRIMARY CARE OR SOME OTHER SORT OF STRUCTURAL CHANGE IN DIVISIONS WILL NOT GO AWAY.

One way or another, the ideas of fund holding, divisions of primary care or some other sort of structural change in divisions will not go away. Later this year, the Central Australian Division of General Practice plans to become the Central Australian Division of Primary Health Care and chances seem high that others will soon follow suit. In fact, Andrew Tongue, Assistant Secretary, General Practice Branch of DH&AC, referred to the idea of divisions of primary care at the GPDV 1999 conference but he pointed out that the department would be reluctant to burden divisions with greater responsibility than they have at present until they can demonstrate that their corporate governance is up to standard.

This brings us to the last article in this issue – the only article not on the nominated theme. Helen Threlfall discusses the idea of governance, spelling out the principles on which GPDV's advice to divisions is based. She argues that GPs on the boards of divisions should not also be employed by the division – an important component of the principle of transparency. However, divisions provide a wide range of opportunities for GPs to participate without creating problems of accountability and conflict of interest and in fact she suggests that the more GPs participate in divisions, the better it is for open and transparent governance. We would like to hear from divisions that have applied the ideas Helen outlines as well as from those that opt for different models. The way divisions are run is vital to the success of the program and this journal presents an opportunity to discuss the principles and practices that make them work.

Integration – A GPs perspective



Vladimir J. Vizec

As a practising GP in Melbourne's western suburbs, Vladimir Vizec encounters a large number of refugees from the world's trouble spots. The effort to meet the overwhelming need through the 1990s led him to seek out links with others who could provide complementary services and support. In this article he describes the development of a productive partnership between the Western Melbourne Division of General Practice and the Victorian Foundation for Survivors of Torture.

In the early 1990s at our practice in St Albans we encountered a flood of refugees from the war in the former Yugoslavia. As one of the many ethno-specific practices in the area, we spoke all the dialects and understood the politics and culture of this group. Even so we were unprepared for the scale and the nature of the problems that we faced.

Refugees from Yugoslavia did not generally present with the acute medical problems that we were used to seeing in refugees from the Horn of Africa and the Middle East but they still suffered intensely the emotional and psychological consequences of war. They were suffering trauma due to what they had experienced, but even those who had never heard a bullet fired suffered the trauma of relocation – a problem that is often not recognised or talked about. The need for psychiatric and psychological services was great but we had problems meeting the need. The one culturally sensitive psychiatrist available to us was inundated and our practice had the services of two psychologists who were generously seeing patients free of charge – a situation that clearly could not be sustained. Yet we were fortunate in our practice. Many GPs in the area could not speak the language of the refugees and had no idea of their cultural and political backgrounds. Aside from the experience of a small number of GPs, some of whom had personal associations and similar cultural backgrounds to the refugees, there was little or no material available to assist in managing this difficult and increasing workload.

ASIDE FROM THE EXPERIENCE OF A SMALL NUMBER OF GPs, SOME OF WHOM HAD PERSONAL ASSOCIATIONS AND SIMILAR CULTURAL BACKGROUNDS TO THE REFUGEES, THERE WAS LITTLE OR NO MATERIAL AVAILABLE TO ASSIST IN MANAGING THIS DIFFICULT AND INCREASING WORKLOAD.

Reaching out

As a GP actively involved with Western Melbourne Division, I went to the division to see what we could do and it was through the exploration of possibilities that we began our working relationship with the Victorian Foundation for Survivors of Torture (VFST).

VFST were also separately concerned about the dearth of information available to address the specialised health needs of refugees and, while they had broad experience in dealing with a wide range of refugee issues, they did not have the expertise or capacity to prepare and disseminate appropriate medical advice.

In 1996 using a seeding grant under the former divisions project arrangements the division carried out a needs analysis of refugee health issues in the area in conjunction with the VFST.

The relationship was established with a sense of common purpose and it was made a little easier because the executive directors already knew each other. When Paris Aristotle was a defender with the Ivanhoe Amateurs Football Club, I was the club doctor.

There were some differences in emphasis that we noticed from the start. As GPs, we worked at the coalface and so we were service-focused. We wanted to know what we could do now to fix our problems.

The Foundation had broader aims and objectives and thus had to be more of a political organisation. It had an enormous network and access to the decision-makers. It is an organisation that can get things done. Although their agenda is different from ours we have been more than happy to work together and there has never been a hint of conflict. That is partly due to the prior association and the common ground and trust that was there from the beginning. At the same time we have considered it essential to clearly define the expectations. We had to be very precise in our contract with them. This was a

The key factors in the success of the programs included:

A relationship with another professional organisation enabled the project to tap into the full intellectual capacity of both the participating organisations.

The initial personal trust between the directors was converted into organisational respect through formal agreements, with a respect for each others' position.

The entire process was carried out with a focus on the positive outcomes but with an understanding of the limitations and an agreement to ensure the scope of the project was not in danger of taking on too much.

The program has achieved:

The establishment of an enduring open and productive relationship between the VFST and Western Melbourne Division of General Practice in particular, and a working relationship with divisions generally.

A successful education program for GPs and other workers in refugee health.

A quality internationally recognised Refugee Health manual (and updates) and GPs desk top guides.

A working network with the ability to respond to emerging issues quickly, as with the production of information to assist with the recent influx of Kosovar and Timorese refugees

The initiation of a state-wide program to establish a GP Refugee Health Network.

requirement of the grant in the early days and we were lucky to have someone such as Christian Grieves who is meticulous about the details of those kinds of arrangements.

So right from the first meeting the mutual expectations and parameters of the joint exercise were fully negotiated, understood and, most importantly, well documented. We also had an expert advisory group that included GPs and a consumer representative.

All agreements between the two organisations (such as staffing and budget) were negotiated and formed into formal contracts. Where there was some discretion allowed, the contracts specified the limits of the flexibility. Much as we admire each other as organisations, we don't hand over a cent without the terms of the arrangement being formally defined.

Far from restricting the relationship the clarity of purpose achieved by this process built up a high degree of respect between the two organisations. It has made things a lot easier on a continuing basis. We sorted out a lot of potential problems before they became problems.

Ultimately the degree of trust which was established saw this small initial project grow into a major Western Melbourne Division program – Refugee Health and General Practice – in 1997/1998, the Youth Refugee Program in 1999/2000, and a major interdivisional program involving six Victorian divisions to run through 1999–2001. It has resulted in the production of some very valuable resources – an internationally recognised refugee manual that includes updates on the Timorese and Kosovar refugees and an easy-reference desktop guide for busy GPs.

This formal working relationship has enabled an anecdotal need to be analysed, documented and addressed in a number of stages up to the establishment of a state-wide program that will establish an enduring Refugee Health Network. This could not have been achieved by a division acting alone. The working network ensures an ongoing ability to respond to refugees' medical and other needs.

Furthermore, we could not have produced a booklet of such quality within our budget without the Foundation. For us the relationship has allowed us to access much more than we could have if we had done it all in-house.

The benefits to our patients

All the participating GPs in the division have undertaken education in refugee health, have received the refugee manual and the desktop guide and through the VFST can help patients to access other services and supports. Refugee care is being transformed through this process.

As far as our own practice is concerned, we have not yet been able to get the support we needed: that is, more clinical psychologists and family counsellors. In fact the situation has turned on us because the Foundation, which has a charter to help refugees gain access to services, refers patients to us. However, if we continue our relationship with them as well as with the state-wide network then we hope to be able to demonstrate the overwhelming need in our area for psychological and counselling services. Because we are dealing with an organisation that is well respected, has the right contacts and understands the political process, we should have a fighting chance of getting our message to the right places.

Lessons for the division

The relationship with the Foundation has shown us the advantages of working with a professional, well-networked, well-resourced organisation. As a result we have learned to outsource a lot of other things rather than try to do things in-house that other organisations are much better placed to do.

What's next?

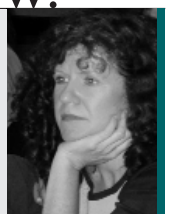
In the future we see the potential to develop a comprehensive on-line service for GPs with the ability to quickly access information and fast track support for patients. This will enable GPs to effect timely referrals to ensure the patients receive the most appropriate care. Ideally this will also foster a cooperative working relationship including all refugee health care workers.

As with all worthwhile programs the real value stems from the commitment of the people involved. In this program there was a full and generous commitment from Division and Foundation boards, executives and staff. These included Paris Aristotle, Dr Fran Bramwell, Dr Christina Drummond, a large group of Western Melbourne Division of General Practice GPs, Steve Francis, Christian Grieves, Jenny Mitchell and Kim Webster, and many more. The cooperation was so integrated it was at times difficult to identify which people were attached to which organisation and there was no evidence of territorial jealousies.

The main lesson learnt was to clearly establish the objectives, identify the best method of implementation, and establish the rules of engagement early.

Vladimir J. Vizec is the chairman of Western Melbourne Division of General Practice and the GP adviser for the division's refugee health program.

From small acorns, great oak trees grow.



Paris Aristotle and Kim Webster

Refugee health and welfare needs are complex and can only be met if those providing services work together. In this article Paris Aristotle and Kim Webster explain the role of the Victorian Foundation for Survivors of Torture and show how the work of the Foundation has been able to reach many more people through a partnership with GPs.

Media reportage of events in regions such as the former Yugoslavia and East Africa speak to the terrible circumstances endured by people from refugee backgrounds prior to their arrival in Australia. Many entrants will have spent prolonged periods during which they were deprived of the basic resources required for health including food and water, sanitation, adequate shelter, personal safety and health care. While an estimated one in four entrants will have been exposed to torture or severe psychological violation, almost all will have experienced traumatic events such as forced dislocation, loss of home and community, separation from family members and other loved ones and witnessing violence and death.

As well as having consequences for physical wellbeing, traumatic refugee experiences may be associated with psychological sequelae such as anxiety, grief, guilt and post-traumatic stress disorder symptoms, with these often persisting long after arrival in a safe country.

Good quality medical care and psychological and social support are important factors in the recovery of people from refugee backgrounds. However, many entrants experience difficulties in accessing this care due to the combined effects of language difficulties, cultural differences and a lack of familiarity with the Australian health care system. These may be further compounded by the impact of psychological sequelae on both help-seeking behaviour and on the experience of health consultation. For example, some people may have an internalised fear of health professionals, with doctors having been involved in perpetrating or supervising torture in some persecutory regimes. For others, aspects of health consultation, such as invasive medical procedures, may serve as painful reminders of past traumatic experiences. At the same time, many Australian health care providers may be unaware of the special needs of people from refugee backgrounds, having had very little professional experience of the health consequences of political repression, conflict and war-related trauma.

The Victorian Foundation for Survivors of Torture

The Victorian Foundation for Survivors of Torture is a counselling and support service established in 1988 by refugee community leaders and health care professionals (among them general practitioners) concerned that people who had survived traumatic refugee experiences were encountering difficulties in accessing sensitive and appropriate health care.

From the outset the foundation recognised that, as a relatively small service, it would not itself have the resources to meet the complex health care needs of survivors. Moreover, since refugee entrants settle across metropolitan and regional Victoria, it was thought that their needs would be more appropriately met by ensuring that support services were available to them in their local communities. Accordingly, the emphasis in the foundation's work has been on supporting individual survivors to facilitate their access to existing health services, while at the same time working with these services to enhance their capacity to meet the needs of people from refugee backgrounds.

General practitioners have a critical role in refugee health care. As well as providing health assessment and follow-up care, they are ideally placed to identify those requiring more intensive support with mental health and settlement difficulties and to refer them to appropriate support and counselling agencies. The role of the community-based general practitioner is particularly important given that many refugee patients will not have had access to high quality, patient orientated care for years. While they will have participated in pre-migration health screening this is conducted for the purposes of migration and is both limited and selective. With routine post-arrival screening ceasing in Victoria in the late 1980s, a general practitioner will be the first health professional many refugee entrants will have contact with following their arrival in Australia.

MANY AUSTRALIAN HEALTH CARE PROVIDERS MAY BE UNAWARE OF THE SPECIAL NEEDS OF PEOPLE FROM REFUGEE BACKGROUNDS, HAVING HAD VERY LITTLE PROFESSIONAL EXPERIENCE OF THE HEALTH CONSEQUENCES OF POLITICAL REPRESSION, CONFLICT AND WAR-RELATED TRAUMA.

A partnership with Western Melbourne Division

While the foundation has worked closely with general practitioners and other medical practitioners since its inception, a formal partnership with divisions of general practice commenced in 1997. In the course of securing health care for families settling in Melbourne's western suburbs, foundation counsellor advocates had contact with a number of general practitioners who were seeing

patients from conflicts in the former Yugoslavia, Iraq and the East African countries. It became apparent through contact with these GPs that they were experiencing difficulties. Many were dealing for the first time with people with war related trauma and complex settlement support needs, with infectious and parasitic diseases rarely seen in Australia and with cultural issues such as female genital mutilation. Many of the patients they were working with had no more than a rudimentary grasp of English.

The foundation's interest in collaborating with the Western Melbourne Division was motivated, in the first instance, by a desire to explore ways in which the two agencies could work together to support GPs providing care to foundation house clients. It was thought that collaboration would provide a context for sharing resources, knowledge and expertise as well assisting the foundation to develop a better understanding of the needs of GPs and the ways in which they could be addressed.

In the longer term, however, it was anticipated that a formal relationship with a general practice division would provide a vehicle for accessing the wider GP workforce, thereby developing a larger network of GPs skilled in providing health care to people from refugee backgrounds.

In the context of the formal collaboration that followed, the Western Melbourne Division and the foundation developed two publications: *Refugee Health and General Practice, a detailed practice handbook,* and *Caring For Refugee Patients in General Practice – A Desk Top Guide*. We also developed a series of professional development seminars.

THIS IMPRESSIVE OUTCOME WOULD NOT HAVE BEEN POSSIBLE BY EITHER THE FOUNDATION OR THE WESTERN MELBOURNE DIVISION ACTING ALONE.

In 1999, the two organisations undertook a small-scale study into the special needs of refugee young people.

It has been the foundation's experience that both the Western Melbourne Division and many individual GPs have a high level of commitment to providing high quality care to people from refugee backgrounds. Nevertheless, caring for this patient group may be a time-consuming, complex and stressful undertaking for GPs. This is particularly the case given the myriad of competing demands on their time and attention, time constraints in general practice and the limited resources available to support them in this area of their work (e.g. interpreters, allied health support).

The major challenge has been to develop an approach to care which meets the needs of refugee patients while at the same time accommodating the realities of contemporary general practice. This has meant that both organisations have had to work in close consultation, to be receptive to different ideas and views and to make compromises. For example, the handbook and guide were developed through a process of consultation and focus-group testing with GPs to ensure that they were relevant and responsive to their needs.

For the foundation, collaborating with GPs has meant recognising that while there is a small core of doctors who share its vital interest and commitment to refugee health care, there are many for whom this area of medicine is not a primary professional interest. This has involved taking a more strategic and planned approach, tailoring resources and approaches to meet the needs of GPs with different levels of interest and involvement in refugee health care. For example, while the *Refugee Health and General Practice* handbook was a detailed publication designed for GPs with a particular interest in refugee health care, the guide is a more concise document written for a wider GP audience.

A refugee health network – going state-wide

From very small beginnings the collaboration between the Western Melbourne Division and the foundation has produced a solid resource base for general practitioners in refugee health care. In the course of developing these resources, significant networks have been formed between GPs, the foundation and other relevant experts, including a significant link with the Victorian Infectious Diseases Service. This work has resulted in a momentum of interest among, and contact between, GPs in refugee health care. There is also a larger network of doctors to which the foundation can refer its clients and from which it can receive referrals for its counselling and support services.

In the course of this collaboration, however, it became apparent that resource and professional development were only part of the solution to ensuring high quality care for refugee patients, with many of the barriers facing GPs requiring attention at a broader structural level (e.g. interpreter access, Medicare remuneration). Moreover, with refugee patients settling across Victoria, there was a need to extend collaborative work to other divisions of general practice. Accordingly in 1999, the foundation and the Western Melbourne Division worked together to develop a submission to the General Practice Innovations Pool for a *Statewide Refugee Health and General Practice Development Program.* This program, which brings together five metropolitan divisions of general practice, the foundation and mental health and infectious diseases experts, commenced early this year. It will provide a focus for the development of networks across Victoria between GPs with an interest in refugee health care and between them and other relevant experts; for ongoing resource and professional development and for addressing external barriers to providing sensitive and high quality health care to refugee patients.

This impressive outcome would not have been possible by either the foundation or the Western Melbourne Division acting alone. Through collaboration, however, the two organisations have been able to harness their collective resources, expertise and networks to significantly enhance the health care provided to refugee patients through general practice.

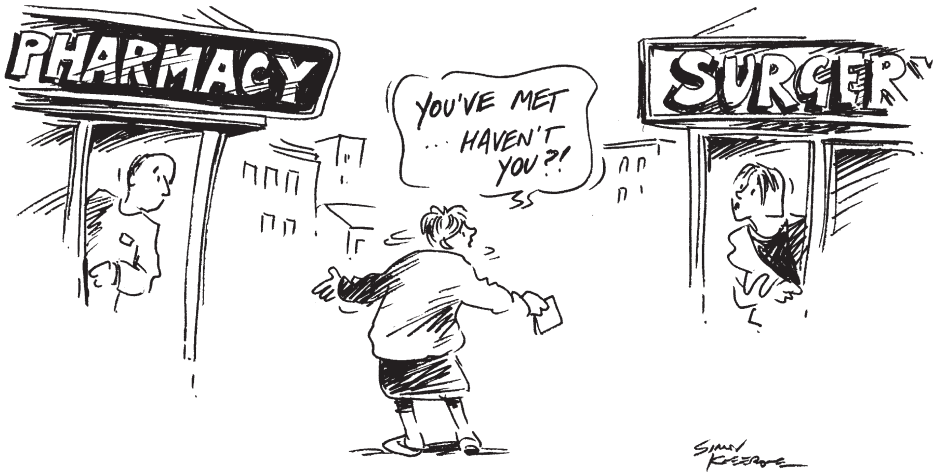
Paris Aristotle is the director of the Victorian Foundation for Survivors of Torture.

Kim Webster is the foundation's special projects coordinator.

An uncertain partnership: GPs and pharmacists

Jo Chandler

Good working relationships between the GPs who prescribe drugs and the pharmacists who dispense them should help improve patient outcomes. Although there are barriers to GPs and pharmacists working together, some Victorian divisions are exploring strategies to overcome them.



It's not hard to find the front line of primary health care – it's in High Street. Whether it's a country town or a suburban thoroughfare, the geography is much the same. Somewhere in the busy heart of the shopping strip, between the baker and the bank, there's the pharmacy. A stroll away you'll find the GP's surgery. Sometimes only a few doors separate their shop fronts. But the people working inside could be miles apart. The communications revolution has achieved many things, but getting the local pharmacist and GP together is a challenge beyond mere technology. It's a task health bureaucrats have now targeted as a firm objective. A range of initiatives launched over the past few years signal that in its effort to rein in the nation's health bill – and achieve better value for money – the federal government has recognised the relationship between drug prescribers and drug dispensers as crucial.

DO WE REALLY WANT THE PHARMACIST TO KNOW THAT OUR SCRIPT IS FOR AN STD AND NOT A SORE THROAT?

What is the problem?

A discussion paper released by the Minister for Aged Care earlier this year about the ageing population and its health care needs[1] estimates that one in ten people hospitalised in Australia are there because of medication misadventure. The figures also show that this is the reason for 35% of unplanned hospital admissions and up to half of all nursing home admissions.

Anne Smail, the National Prescribing Service (NPS) facilitator with Ballarat and District Division of General Practice, talks about the need for GPs and pharmacists to work together to get the best outcome for everyone. 'The government is looking at this very closely because the national health bill just keeps going up. … GPs see the cap is going to be put on something, and while they don't like to be told how to practise, they can foresee something has to happen'.

What are the solutions?

Minimising medical mishaps is cited by Health Minister Michael Wooldridge as one of the factors driving his push for a national electronic health record system. With one model of integrated records, doctors and pharmacists might both be able to access the record each time a script is filled. 'This will close the loop between pharmacists and doctors so you won't have double entry of data, where the doctor writes out the script and the pharmacist then enters it again into a computer, and this will prevent prescribing mistakes', Dr Wooldridge has said. He has stressed the national database would be on an 'opt in' basis. But doctors schooled in a culture of patient confidentiality and consumers wrestling with the notion of improved care at the expense of privacy become nervous. Meredith Carter, executive director of the Health Issues Centre, asks whether we really want the pharmacist to know that our script is for an STD and not a sore throat.

The launch of the National Prescribing Service in March 1998 is perhaps the major development in efforts to improve the prescription and management of medications. The NPS is an independent organisation set up to improve health by improving quality use of medicines. A key strategy of the NPS is to fund the employment of facilitators (usually part-time pharmacists) to organise GP

education sessions and to improve links between GPs and pharmacists. Already 70 divisions of general practice around Australia have employed an NPS facilitator and although their work is in its early stages, they highlight the recognition of the GP–pharmacist relationship as a priority on the health agenda.

Another strategy to improve prescribing patterns through a close GP–pharmacist relationship came with the deal signed in May this year between the Pharmacy Guild and the federal government. The agreement includes payments to pharmacists for participating with GPs and others in case conferences under the new Medicare Benefits Schedule (MBS) items that GPs started using in November last year. A more controversial development is the payment to pharmacists for carrying out medication reviews – previously the province of GPs. Another element of interest to general practice is the plan to redirect Pharmaceutical Benefit Schedule (PBS) savings from those medication reviews to fund a program of pharmacy facilitators in divisions of general practice. The aim is to be able to fund a facilitator working half time in every division in five years' time.

A paper published in the Medical Journal of Australia in 1998[2] looked at the issue of how medical care could be improved by enhanced communication among doctors, pharmacists, other health workers and consumers. It cited a number of studies that had found the quality of care was improved by the building of the health care team, academic detailing, medication review by pharmacists and doctors and feedback of prescribing patterns to doctors. In this vein, the Royal Australian College of General Practitioners and the Pharmaceutical Society of Australia took part in a trial where doctors used codes on scripts to provide pharmacists with more information. The modified scripts – which included noting why the medication was being prescribed – proved popular with all parties. The paper argued for the potential benefits of even more sophisticated collaboration, citing UK models and some local efforts through the Department of Veterans Affairs. These 'found that rational and cost-effective prescribing was best achieved when pharmacists and GPs worked together'.

THE BIGGEST DILEMMA FOR PHARMACISTS IS THAT THEY ARE HIGHLY SKILLED HEALTH PROFESSIONALS, BUT PERCEIVED AS BUSINESS PEOPLE WITH A SHOP

Obstacles to the partnership

The agenda is taking shape. But before it can be implemented, more groundwork needs to be done, according to Kerren Melgaard, the pharmacy director with Ballarat and District Division. 'The networks are not really there yet'. While divisions provide a structure that allows GPs to speak to and hear from other groups, there is no similar conduit for talking to pharmacists.

The biggest hurdle facing better pharmacy–surgery relations is physical. Finding an opportunity to meet in person is difficult. The law requires the pharmacist to remain on the premises and patient demands keep the GP tied to the surgery. Debra Norton soon appreciated the dilemma when she began surveying pharmacists and doctors for West Vic Division late last year. As part of the division's GP–pharmacy liaison project, Debra has visited 28 retail pharmacies, five hospitals and 48 GPs across her patch. Her survey asked questions aimed at identifying the two professions' core business and the issues related to that. Although she is still analysing the results, Debra is happy to share some of her preliminary findings. 'A pharmacist's workload is unpredictable and immediately demanding,' she said. 'The GP's timetable is also restrictive… Phone calls remain the main way to link. Some might meet through the local hospital board or socially', Debra said, though this was largely a matter of luck and personality. But Bill Scott, the Pharmacy Guild's Victorian president and national vice-president, has little tolerance for the arguments that time and opportunity conspire against a healthy relationship. There are 24 hours in every day, he argues, and if the relationship gets its deserved priority, people find the time.

Debra Norton's survey recognised other problems – ones acknowledged anecdotally throughout the sector. They are the product of territorial tensions and professional prickliness. Both groups had negative attitudes to one another, Debra said. Part of the reason for this relates to the demands of running a small business, which by its nature requires a focus on your own work, getting patients through, or prescriptions filled, and doesn't provide much leeway for a focus outside the business. Also, as Jane Measday points out, pharmacy and general practice are both professions that attract people happy to work alone. 'Solo practice can attract people who don't like working with other people, and if you have the wrong mix working in a small community, it can be very difficult.'

Some of the underlying tensions in the GP–pharmacy relationship may emerge in discussion of the Pharmacy

National Prescribing Service

The goal of the two-year-old National Prescribing Service is to improve the health of Australians through quality prescribing of medicines. To achieve this, explains chief executive Lynn Weekes, the service – which grew out of the quality use of medicines programs – aims to provide prescribers and the public with independent, balanced, critically appraised information on medicines. The philosophy is that with access to untainted information and support, prescribers will be able to make the best decisions about their patients' medical regime.

Assisting in containing the national drug bill is an issue for the NPS, but not the driving force in its agenda – rather it's an expected consequence of the work. Key programs offered by the service include monitoring compliance, encouraging clinical audits so that doctors can review their own performance, developing case studies to assist in prescribing, and visiting individual surgeries to give GPs an independent alternative to the drug-rep's appraisals of the latest therapies.

For more information, visit www.nps.org.au

Guild Agreement, which paves the way for pharmacists to be funded by government to carry out medication reviews. (Details have yet to be worked out, but the agreement specifies that there should be collaboration between the pharmacist who is accredited to do the review, the patient's usual GP and usual pharmacist). This initiative might be seen by some GPs as a way of reducing polypharmacy problems, with the potential to ease one of the numerous demands on the GP's time, but it is seen by others as inappropriate. According to Dr Rob Ferguson of Central Bayside Division, if GPs are computerised, they should be able to do medication reviews themselves. Such reviews would be part of check-ups and health assessments conducted by the GP in any case.

"THE CRUCIAL PARTNERSHIP IS THE ONE BETWEEN PATIENT AND DOCTOR; OTHERS SHOULD ACT AS ADVISERS."

Part of the problem in the relationship between GPs and pharmacists, Rob says, is the pharmacists moving beyond their traditional role into one that delves more into diagnosis and management. This can be problematic when the pharmacists don't have the whole clinical picture that the GP has. For example, 'pharmacists might give advice with medication; they don't know the diagnosis but can often put off the patient from taking medication'.

Indeed, some of the more pro-active pharmacists are reported to be frustrated that their participation in the treatment process is limited by a lack of information about a patient's history and diagnosis. Jane Measday of West Vic Division says: 'The biggest dilemma for pharmacists is that they are highly skilled health professionals, but they are perceived as being business people with a shop in the main street… Pharmacists, though, see their role as medication management and would like to work as part of the team'. However, Rob Ferguson puts the GP view: 'The crucial partnership is the one between patient and doctor; and others should act as advisers'.

One of the workers involved in trying to build partnerships between GPs and pharmacists suggested that as the primary care sector is levelled out, 'some GPs feel somewhat threatened… they are no longer up on a pedestal'. When asked for his response to this idea, Rob argued that's it's not so much a matter of feeling threatened, but that 'everyone says GPs are the gatekeepers of primary health care; that's rhetoric that needs to be matched by action'.

Meredith Carter – the consumer voice – acknowledges the benefits better collaboration may bring for patients, addressing adverse medical events, problems on discharge from hospital. Many people with complex conditions who are used to being the victims of 'stuff-ups' don't have a problem with their health team having access to all their information, she says. But better linkages raise the spectre of the unique patient indentifier number and fears about the vulnerability of medical databases to exploitation, leaks and abuse. Meredith also remains suspicious about the mixed messages on the motives for encouraging medical collaboration. On one hand, the talk is about patient outcomes. In the next breath, it is about budgets. Which is the driving force behind the agenda, she asks.

Dr Julie Thompson, chair of General Practice Divisions Victoria and vice-chair of Australian Divisions of General Practice, concedes it is a vexed issue: 'Should the pharmacist and the physio know what I know? The system is only just beginning to wrestle with this,' she says. 'In rural areas particularly, it means more pooling of information between a handful of health workers'.

Opportunities

While the nexus between prescribing and dispensing may cause tensions, the common ground also provides a powerful incentive to work together.

'As divisions develop more chronic disease management programs for conditions like diabetes, we have to bring the pharmacists in otherwise it just won't work,' says Julie Thompson. The guild's Bill Scott points to the recent agreements awarding funds for domestic visits by pharmacists, for care conferencing and for more pharmacy liaison workers as important mechanisms for developing the dialogue.

The situations of the two professions are in many ways very similar, Jane Measday argues. They are co-dependent and complementary; they are both threatened by aspects of internet medicine; they have similar recruitment, retention and training issues; they each grapple with community issues such as drug-seeking behaviour; they are both funded by the Commonwealth and as such are often left out of state-based health structures and planning.

Debra Norton identified six common areas of interest through her survey, listed here in the order of importance ranked by her respondents:

- medication use
- polypharmacy
- drug-seeking behaviour
- specific disease counselling
- primary health care
- health promotion.

The NPS has provided resources for divisions to address shared concerns largely through clinical education that is not conducted by drug companies. In West Vic Division, it has taken the form of targeting shared concerns about the use of commonly prescribed therapies for hypertension, and the use of benzodiazepines and antibiotics, and providing forums for GPs and pharmacists to get together.

Strengthening the relationship

The same MJA paper that promoted the benefits of better pharmacy–surgery relations also sounded a strong caution for the professions to make haste slowly. The relationships, both at grass roots and organisational lev-

els, must be built first, it warned. To illustrate, it reflected on the concerns of medicos when consultant pharmacists were brought into nursing homes without the involvement and support of GPs. 'Communication and relationships are the keys to balancing collaboration and optimal patient care with autonomy and privacy issues', the paper concluded.

As Debra Norton has learnt from her survey, 'if you want two groups of people to work together, the basic thing you have to develop at the outset is the relationship – it's vital'.

West Vic Division approached this problem by starting a faxed, fortnightly newsletter, then setting up a regional pharmacy group. Now professional issues between GPs and pharmacists are discussed in a monthly teleconference.

GPs AND PHARMACISTS ARE THREATENED BY INTERNET MEDICINE; HAVE SIMILAR RECRUITMENT, RETENTION AND TRAINING ISSUES; GRAPPLE WITH DRUG-SEEKING BEHAVIOUR; ARE FUNDED BY THE COMMONWEALTH AND LEFT OUT OF STATE-BASED PLANNING

Similar scenarios are being played out through divisions around Australia as project officers and NPS facilitators – usually pharmacists working part-time – become more active. And interestingly, geography and environment don't appear to make much difference – the experiences related in the city echo those of the bush.

In the Ballarat area, the division has just gained funding for a Ballarat and District Pharmacy Alliance to enhance and promote an effective working relationship. Some of its first tasks will include developing a pharmacist needs analysis and inviting both professions to joint meetings.

In Bendigo, the pharmacist working through the NPS has set up a local reference group involving GPs, hospital pharmacists, La Trobe university and community pharmacists.

In the Inner South East Melbourne Division, project officer Jill Day has just completed the third exercise of a popular medicines review project. The program involves a GP working with a pharmacist to review the cases of ten patients each taking more than five drugs. The doctor writes down what he or she believes each patient is on, and then asks them to bring in everything they take. The pharmacist examines the patient's full regime of drugs and dosages and reports back. The doctor returns to the patient to recommend any changes to their medication regime. 'The pharmacists really find it a good learning experience, they enjoy the professional interaction and the mutual respect', Jill Day reports. Generally, the doctor and pharmacist then find ways to 'continue their dialogue' in normal practice. The patients are happy that 'the person who prescribes the drugs and the person who provides them are working together'. And some GPs have also found it enlightening. 'It's really surprising, the number of over-the-counter medications people take'. In the latest exercise, the total number of medications which the GPs believed their patients were taking was 902. The plastic bags dropped on their desks actually contained 1176 medications, of which 262 presented some sort of problem which the pharmacists rated from minor to highly potentially dangerous. One patient taking 22 different medications was taken off five of them after the review process. These projects are just a sample of the programs being trialed, but provide a taste of what is in store in primary health.

Conclusion

Divisions' work in the area of GP–pharmacy links are attempting to bridge the gap between the two sets of professionals. Work to provide mechanisms for communication, to address shared concerns and to establish relationships has been vital. The new MBS items that GPs can use (which may involve pharmacists), the new items to pay pharmacists for participating in care planning and reviewing medication will bring new opportunities as well as challenges for GPs and pharmacists to work together. Effective communication depends both on its being a two-way process, and on how the relationship between the two parties influences the interpretation of messages by each, Roberts and Stokes wrote in their MJA paper. 'Trust, confidence, involvement and a mutual respect for each professional's role and competence are therefore essential in any functioning team'.

Jo Chandler is a journalist and former medical reporter for The Age.

1 Department of Health & Aged Care, *The National Strategy for an Ageing Australia: World Class Care Discussion Paper, 2000,* http://www.health.gov.au/acc/nsaa/wccdp/index.htm, accessed 29 June 2000.

2 Michael Roberts and Julie Stokes, 'Prescriptions, practitioners and pharmacists', *Medical Journal of Australia,* 168, 1998, pp. 317-318.

Integrating care services – a model for success

Gawaine Powell Davies

By now, many divisions have been through two or three generations of 'integration' programs such as shared care, GP–hospital programs and coordinated care trials. In this article Gawaine Powell Davies presents some ideas about effective integration that have emerged from the Mater Mothers' Hospital program. Although this addresses only one area of integration, it has many of the features common to successful integration programs everywhere.

At the Mater Mothers' Hospital in Brisbane's south side 70% of women giving birth since 1998 have been part of a system of integrated antenatal and postnatal care. It is a program that has been tremendously well received by patients, GPs and the hospital and it provides a working model upon which we can draw a framework for future programs.

Before looking at the program, we need to go back to basics and consider why there is so much focus on integration.

Integration – why do we bother?

When GPs and other parts of the health system provide an integrated system of care it is an investment in patients and in communities. Often, informal links between individual service providers are not sufficient. More structured arrangements are needed to ensure that patients and communities receive continuous and comprehensive care. Without them, problems can arise for everyone.

'Integration' means different things to different people, from informal collaboration between service providers to high level Commonwealth programs like the Enhanced Primary Care Program. However, the core idea of integration is straightforward: **GPs working with other health service providers to give patients and communities effective health care within the available resources.**

In a 'dis-integrated' system:

- patients may receive sub-standard care because information is not shared, different service providers give conflicting advice and treatment, or there is no access to the services that they need. For example, many patients with mental illness miss out on good physical care.
- GPs may be excluded from contributing to the care of their patients and lose ongoing contact with their care. For example, they may play no part in pre-operative assessments, or not be informed about inpatient care.
- communities and groups of patients (especially those with chronic conditions) may miss out on the services they need because there is no coordinated planning to fill gaps in services.

When integration is most needed

Most of the work of GPs requires little formal integration. Most consultations are initiated by patients rather than by referral. Most conditions that GPs treat are self limiting and can be managed by the GP alone. In other cases existing channels such as referrals, prescriptions, letters and phone calls are often all that is needed.

However, this is not always enough. There are some areas of health care in which more structured relationships between general practice and other services may be needed. These include:

- chronic disease: patients conditions such as asthma, diabetes or mental illness may need to combine care from a number of services and self help groups over a long period of time. This is hard if the services are poorly integrated.
- hospitalisation: patients may get 'lost' as they move out of the care of the GP to the hospital (which often get none of the GP's knowledge of their health) and then back to the GP for follow-up care. Repeated tests, poorly planned discharges and uncoordinated follow-up care are some of the problems of a 'dis-integrated' system.
- health promotion and preventive care: many of the underlying causes of ill health can be addressed by GPs working in with community-based services (how many practices have a gym attached?) – but neither party can do this effectively on their own;
- service planning: communities – and especially disadvantaged groups – will only get access to the services they need if divisions and other organisations work together to plan services.

How the program works

Women receive their antenatal care from a general practitioner of their choice rather than through the hospital clinics, and then attend the hospital for labour and delivery. The neonatal registrar examines the baby prior to discharge and women then return to their GP for postnatal care. If the woman requires support from the Early Discharge Program a hospital midwife provides for postnatal care up to five days in the woman's home. The midwife liaises with hospital medical staff and the GP about any health concerns for the mother and baby.

The program is structured around an ante- and postnatal pathway which includes both GP and hospital care. This forms part of a patient-held record, which the woman brings to each appointment.

GPs involved in the program receive a kit that describes the program and contains all the documents for the program. It includes names and numbers for direct access to information and advice from the Mater Mothers' Hospital, and patient education materials. They also take part in training for the program and receive a copy of a quarterly shared-care newsletter.

This program is managed by a consortium that includes southside divisions, the Mater Mothers' Hospital and the Queensland University Centre for Primary Health Care Integration (based at the hospital). This consortium recently introduced a revised protocol for the program and then evaluated its uptake. This evaluation showed:

- patients appreciated receiving ante- and postnatal care from someone they knew and trusted;
- GPs and hospital staff were highly favourable to this collaborative approach to care, but some had a 'wait and see' attitude to how the details of the new protocol would work out;
- GPs valued the continuity of care and the clinical role that came with managing patient care throughout the entire pregnancy. As one GP said:

  "Personally I really enjoy it. I don't want to offload this aspect of my work to the hospital, it is the one thing I really enjoy about general practice, it also provides continuity of care."
  (Prasad-Ildes 1999 p.41)

The Mater Mothers Hospital shared care program

Since 1998, 70% of the women who have given birth at the Mater Mothers' Hospital have done so through the shared antenatal and postnatal care program in which 1100 GPs from four southside divisions participate.

What does this program show about successful integration programs?

It addresses the issues directly important to each party involved.

This program meets the hospital's need to reduce the burden of outpatient care. It meets the GPs' need to maintain a clinical role and it meets the patients' needs to have continuity of care with someone they know and trust. Specialists and other hospital staff do not feel that the program takes away their work and GPs do not feel that they are having someone else's problems dumped on them.

In many cases GPs and other services have different priorities for working together - mental health services may want to involve GPs in caring for people with severe mental illness while GPs may want help with treating anxiety and depression. This makes the program hard to get going and difficult to sustain through busy times.

Successful programs take account of both clinical and business interests. GPs and other services will be far more enthusiastic about programs that benefit their practice as well as their patients. However, benefit need not be financial: clinical interest or the chance to do something new may also be important.

The program is well planned and evaluated.

The success of the program depends upon the details – the design of the protocol, the record systems, the communication with GPs. The consortium invested a lot of time in making sure the plan was right and then used the evaluation results to fine-tune any details that needed attention. They took care to feed the results of the evaluation back to the clinicians so that they understood how the program was working and why changes might be introduced.

Equally important, the program was planned and managed by all parties. This encourages commitment to the program, but it also makes sure that everyone's point of view is taken into account.

The 'capacity' is there.

The division and the hospital had the skills, the time, the systems and the resources to develop the program. The Centre for Primary Health Care Integration lent its expertise. GPs and hospital staff had the clinical skills required, and the program gave them an opportunity to brush these up.

The divisions of general practice are particularly important as they allow the 1100 GPs now sharing care to be linked into the program through their own organisation, which represents their views and interests.

There is ongoing support for GPs.

GPs receive information and support from the program kit, from the newsletter and through CME. They received feedback from the evaluation so they knew how the program was developing. In addition they have a number to ring at the hospital if they have any queries about the program. This was important for maintaining enthusiasm, and making GPs feel that they were not being left on their own.

Patients play an active role.

In the Brisbane program they choose the kind of care they will receive. It is they who support communication and continuity of care by looking after their own patient record and taking information between GPs and the hospital. GPs listen to their patients! Their involvement and support are powerful forces for reinforcing programs.

AS INTEGRATION BECOMES MORE AMBITIOUS THE DIVIDE BETWEEN COMMONWEALTH (GP) AND STATE HEALTH SYSTEMS BECOMES MORE SIGNIFICANT.

There is a long-term commitment.

Short-term projects are good for testing the water, but successful programs need long-term commitment from both parties. The shared-care program has become the normal form of care for women having babies within the public system. This is only possible because of the long-term involvement of GPs and other clinicians, and divisions and other health services.

There is a commitment to best practice.

The Brisbane program was based on a thorough review of literature and drew on the combined expertise of specialists and GPs. This provided an opportunity for developing best practice for reviewing care and drawing on the best possible evidence and evaluation.

Looking to the future

The Brisbane program shows how, with a common interest, the capacity to work together and a good working relationship, GPs and other services can develop effective integration programs. But what of the future? As the opportunities for integration develop, new issues are likely to come to the fore. Here are some suggestions based on current developments.

1 Working on a larger scale. We are starting to see programs that operate across divisions and even across states. The Brisbane program is providing the basis for developing a Queensland-wide pathway for ante- and postnatal shared care. This will be more cost-effective and will make it much easier for GPs who have to deal with a number of different hospitals or health services. However, such programs will need to retain their relevance to local GPs.

2 Developing a stronger patient/community focus. Patients and communities are the third (or fourth or fifth) partners in any integration program and the one common factor between GPs and other services. Programs that are truly patient or community focused are likely to be more successful in harnessing the knowledge, power and influence of these groups.

3 More focus on outcomes. To date, many programs have focused more on the number of GPs and patients enrolled and their satisfaction with care. There will be more emphasis on showing better health outcomes and/or cost savings. These will show GPs that their programs are on the right track, and will encourage state and Commonwealth governments to invest more in integration.

4 Better policies and funding systems. As integration becomes more ambitious the divide between Commonwealth (GP) and state health systems becomes more significant. Programs will have to be increasingly smart about working within the current rules, or lobbying for change. Programs such as the After Hours Trials and Enhanced Primary Care show the Commonwealth starting to address the problem, but more fundamental reform will be needed to enable general practice to make its full contribution to the health care system.

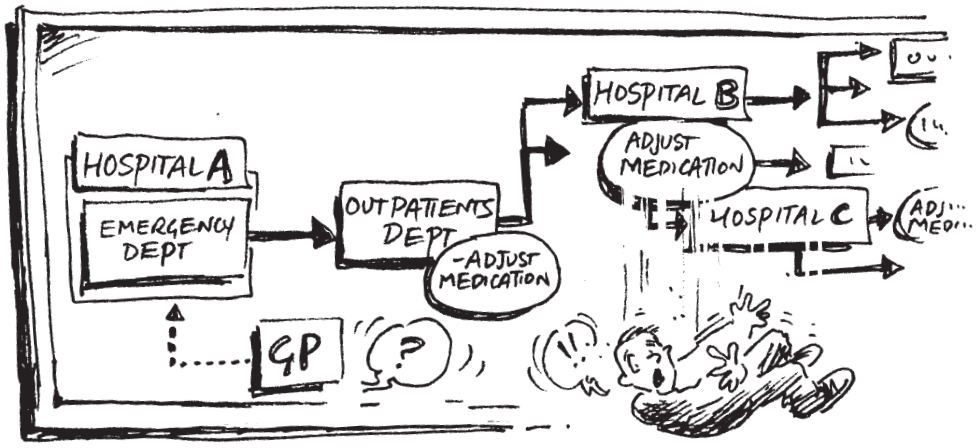
Many thanks to Assoc. Professor Claire Jackson for reviewing the case study and encouraging its use.

Gawaine Powell Davies is the Coordinator of the Centre for General Practice Integration Studies at the University of NSW.

Bring down the wall and start dancing.

Lenora Lippmann

Poor communication between GPs and hospitals is a continuing theme in the Victorian health system. Lenora Lippmann examines why GPs and hospitals need to establish better communication and she highlights what is being done to overcome the communication barriers.



'[The GP-hospital relationship is] like teenagers staring at each other from opposite ends of the dance floor, occasionally flirting but a long, long way from consummation'.[1]

General practice and the hospital sector appear to have been developing in isolation from each other. The enormous advances in technological developments in health have led to public expectations of a technological 'cure', and at the same time hospitals in Victoria in the last decade have been under enormous financial pressure to increase the throughput of patients. The imperative for the hospital sector has been to keep up with the new technologies and look after large numbers of very sick patients. In the process the bigger hospitals have become increasingly disconnected from the communities they serve as though they were walled cities. Even in the rural and smaller suburban and regional hospitals, which once relied upon a GP workforce, the growth of medical specialisation is pushing GPs out of the hospital arena.

In general practice the advent of Medicare and the pharmacological revolution have led to rising public expectations of access to high-quality comprehensive care, including preventive care. This has led to pressure on GPs to keep up with the full range of medical advances, to deal with the open-ended demand of a very wide range of patients coming through the door in a fee-for-service system, and to become more business oriented. The imperative for general practice has been to be everything to everybody everywhere. One consequence of this process is that the overlap between the patient load of the GP sector and the hospital sector is relatively small.

At the same time that we have seen the hospital sector become more specialised and the generalists become more general, the nature of health care needs has changed. The incidence of chronic illnesses and the awareness of co-morbidities appear to have vastly increased with the advent of better testing and increased longevity in most population groups. This means that some patients are now more likely to go back and forth between the GP and the specialist services provided by the hospital sector, and that the GP role in having a grasp of the whole picture is becoming increasingly important. Patient medical need is therefore creating an imperative for the two sectors to work together more cooperatively.

Likewise the growing recognition of the social determinants of health, as seen in the case examples cited, is also creating pressure for the various parts of the health and

CASE ONE (1998): A GP was called to the home of an elderly patient and found her in bed in a pool of urine. The woman had recently broken her arm in a fall and gone to the local hospital emergency department to have it attended to. The registrar had attended to the arm but not asked about her home situation. In fact the woman looked after her husband who had Alzheimer's disease and she herself was dependent on a walking frame. Without the use of her arm she could not manage the walking frame nor could she get out of bed. Her husband was not in a position to assist her.

CASE TWO (1999): A patient with epilepsy was seen at the emergency department of a hospital after a seizure. The patient was referred through to the appropriate outpatient department and his medication was adjusted. However, some time later his condition was still out of control and so he was given a full neurological assessment at another hospital in the network. Again his medication was changed. His condition did not improve. At yet another hospital unit his renal functioning was assessed and again the medication was changed. Although the patient's GP was not informed of any of these activities, eventually someone from a hospital unit made contact with him. The GP informed the hospital registrar concerned that the patient's home situation had recently changed and nobody was checking whether the patient actually took the medication prescribed.

support system to work together more effectively. In both the GP and the hospital sectors the medical profession has struggled to come to terms with the social determinants of health. And yet the GPs are much closer to the social circumstances of the patients and well placed to see the consequences of the silo approach taken by hospitals.

So we see that four main factors have led to the increasing recognition of the necessity for hospitals and GPs to talk to each other:

- the pressure on hospitals to increase throughput
- the pressure on GPs to ensure high-quality patient care
- the need for the generalist medical overview in response to the rising incidence of co-morbidities
- the need for better coordinated health care and social support in response to the rising incidence of chronic illness.

What do GPs and hospitals need to communicate about?

From the hospital's point of view there are a number of needs GPs can address.[2]

Hospitals, especially private hospitals, need GPs as a source of business.

In rural areas, hospitals need the GP workforce to provide medical in-patient care for their patients.

Rural hospitals also need the GPs to help lobby for the maintenance of local services.

All public hospitals need GPs to assist in reducing demand, particularly for outpatient services and for accident and emergency departments. This is most clearly evident in rural areas where GP workforce undersupply leads to very high demands on the local hospitals.

Some public hospitals need GPs to help them manage their elective surgery waiting lists.

All hospitals need GPs to improve effective throughput of patients and to assist in reducing length of stay and patient readmissions. One aspect of this is that all hospitals need GP input on the medical and social situation of many patients relevant to the current episode of acute illness.

From the GPs' point of view there are a number of needs hospitals can address.[3]

GPs need hospitals to provide accessible specialised acute care for their patients.

To facilitate access, GPs need clear information about the services provided by the hospitals, and how to reach the services to ensure appropriate referrals.

GPs also need information about waiting times for procedures and outpatient services.

GPs need hospitals to recognise their role in providing comprehensive community based care for patients seen by the hospital.

To demonstrate this recognition, GPs need clear information about what has happened to patients attending the hospital. This includes timely information about all accident and emergency attendances, significant test results, and deaths.

GPs need clear information about the medical care required by all patients discharged from hospital and who will provide what care. Effective discharge planning can prevent night call-outs. This is particularly relevant for GPs providing their own after-hours service, such as in regional and rural Victoria.

GPs need advice from specialist services to assist in their effective care of patients in the community.

In addition to these service management imperatives, external incentives from both levels of government have encouraged GPs and hospitals to work together. The Divisions Program, the National Demonstration Hospitals Program Phase 3, the Coordinated Care Trials, the Divisions and Hospitals Integration Program, and Victoria's Effective Discharge Strategy have all contributed substantial funding to encourage links between GPs and hospitals despite structural barriers.

These initiatives are all relatively recent so we have as yet no clear information about for whom coordinated care is most effective. Some of the risk assessment tools developed for the coordinated care trials and the Victorian Post Acute Care Program will assist in this identification process. For instance, St Vincent's Melbourne is adopting risk assessment criteria that asks: Does the patient live alone? What services was the patient receiving prior to

admission? Will the patient require post-discharge services? Does the patient have to care for others? Does the patient live in a hostel/nursing home? Is the patient homeless or of no fixed address?

To date risk assessment to target some patients for coordinated effort appears to be a hospital rather than a GP concern but it reflects a common theme that GPs are interested in a multi-dimensional relationship with hospitals, while hospitals are more interested in strategic targeted interactions. As one GP said, 'hospitals treat conditions while we treat people'.

How can the communication gap be addressed?

Whether or not divisions or hospitals have grasped the nettle of improving communication has depended initially on the strength of feeling of the local GPs about the problems being experienced with the hospital(s) concerned. As the 1999 GPDV audit of GP–hospital interaction showed, the geographic setting markedly affects the nature of the relationship between the division and the relevant hospital(s). In rural areas a division may cover several different hospitals with relationships varying with each. It is therefore difficult for a division to identify issues with one or two hospitals that affect a large number of members. The formation of rural hospital alliances in Victoria may alter this situation. From the hospitals' point of view, rural divisions' work in GP retention and recruitment has been very valuable in reducing demand on hospitals and in maintaining the hospitals' medical workforce.

The GPs in regional centres, on the other hand, do have a strong interest in the one local base hospital. Consequently many of these divisions established their first premises in hospitals and built up informal relationships from this base. Victorian divisions in regional centres have employed a number of strategies including the funding of GP liaison officers and the allocation of substantial CEO and executive director time to working with the hospital on a range of issues.

Metropolitan divisions have been much more variable in the importance given to GP–hospital communication. Some were in a similar position to regional divisions in that their GPs related primarily to one or two hospitals and thus the GP–hospital linkage was a high priority. More than half the metropolitan divisions established themselves initially in hospital premises. However, only a third of metropolitan divisions are still in such premises. This is a tangible indication of the disappointment many divisions experienced in the response of hospitals to the GPs' overtures. Nevertheless some divisions persisted with a range of strategies to engage the hospitals in dialogue.

The strategies outlined in the table below have been used primarily by the regional divisions, the 'persistent' metropolitan divisions and the state-wide hospitals that have employed GP liaison officers to improve GP–hospital communication. The common advice from the division GPs and the GP liaison officers is to start with building a relationship, choose small achievable outcomes, and take advantage of any opportunities that arise. As Lesley Soong, Peter Eizenberg, and George Golding stated, 'it takes patience, persistence, joint effort, and innovative problem solving' to achieve improved GP–hospital communication.[4] The presence of senior 'champions' on both sides also appears to be fundamental to progress.

Conclusion

To go back to Montalto's analogy at the beginning of this article, we have found that GPs and hospitals are at least sharing a dance floor and some productive relationships have been formed. To switch analogies, there are signs that the mortar is crumbling in the old walled cities. Technological advances have made day procedures and 'hospital in the home' feasible. This is now an expanding part of hospital care. Most hospitals in non-metropolitan Victoria are now called 'health services' and the metropolitan hospitals will become metropolitan health services, following the Duckett review of health care networks. This implies that responsibility for health will extend beyond the walls of the hospital.

Changing patient needs and incremental initiatives by divisions and hospitals have led to increasing government and hospital commitment to improving GP–hospital communication. In such a context an increasing number of hospitals are beginning to see that partnership approaches to the care of patients can assist in their management of scarce resources and lead to better patient care. This cultural shift is necessary whether the approach taken is incremental change through divisions or systematic change such as that being trialed through the Coordinated Care Trials or the UK type fund-holding

CASE THREE (2000): In a regional centre a GP met a woman in the supermarket and asked after her husband, his patient. The woman told him that her husband died three weeks ago. The GP was very embarrassed that he did not know about this and sorry that he did not have the opportunity to even send a timely card to the family he had looked after for over 20 years. In this area the local GPs received no notification of admissions, discharges or deaths of their patients. To receive notification of admissions and discharges entailed changes in a number of processes within the hospital. These changes are being examined but will take time to implement. However, for GPs to receive notification of deaths the local division of general practice has negotiated the establishment of a simple measure. After certification of death by the hospital medical officer, the mortuary officer, who collects the bodies from the wards, now notifies the identified GP directly of the death of their patient.

arrangements. The challenge for divisions and hospitals now is to maintain and increase Government resource commitments to the GP-hospital communication process, and to evaluate the effects of these efforts on patient care.

Lenora Lippmann is a divisions' consultant at GPDV.

[1] Michael Montalto, 'It takes two to tango', *Australian Family Physician*, Vol 29, No. 4, April, 2000, pp. 376-377.

[2] Most of the points about necessity came from participants at the GPDV GP–hospital workshop May 2000. Participants included division staff, GP Liaison Officers, hospital discharge coordinators.

[3] The source for these comments is Isaac (1997), *[leave some space here to insert full reference blah blah blah blah blah blah, possibly even one more line]* and the above workshop.

[4] GPDV – hospital workshop, May 2000.

Strategies employed in Victoria to improve GP–hospital communication

Issue	By divisions	By hospitals	Joint action
Establish relationship	Locate in hospital premises*	Allocate GP car parking	Negotiate and implement Heads of Agreement
	Organise regular meeting times with hospital senior staff*	Participate in regular meeting with division	
Identify mutual needs	Survey GPs to identify main concerns with hospital*	Identify problems concerning communication with GPs from discharge patient record audit*	
Resource the commitment	Organise and pay for GP representation on hospital committees*	Invite division representative onto relevant committees	Develop agreed clinical pathways for specific conditions
	Allocate senior staff and program officer time to GP–hospital liaison*	Appoint GP liaison officer	
	Solicit GP feedback on what should be division position in developments of joint action*	Appoint discharge coordinator*	
	Solicit GP feedback on whether joint arrangement is working and its value*		
Facilitate appropriate admissions	Encourage all GPs to write clear referral letters	Include GP role in education of HMOs and registrars, students	Negotiate and implement means for GPs to access current waiting list information and expert advice
	Provide GP cards for patients with signed consent for information to go to GP	Identify the GP at admission (make GP field compulsory)	Negotiate and implement shared care arrangements
Facilitate appropriate admissions (cont.)	Inform GPs of hospital programs and procedures for access*	Establish library access for GPs	Negotiate and implement means for expediting appropriate GP admissions*
		Distribute regularly updated accessible service directory to GPs* (includes procedures for access)	Negotiate and implement community based pre-admission management
	Help fund clinical attachments	Offer clinical attachments	Negotiate and implement after hours agreement*
Improve discharge	Encourage all GPs to get a 24-hour dedicated fax or email facility	Develop mechanisms for patient consent to transfer information to GP	Negotiate content & timing of discharge summary
		Develop systematic direct GP notification of admissions, discharges, deaths, transfers, accident & emergency attendances	Negotiate and implement mechanisms for the hospital and the GP to directly negotiate the after care of at risk patients (utilising MBS item numbers as required)*

* These strategies have also been employed in division areas served by a combination of larger regional hospitals and small rural hospitals.

The General Practice Resource Unit: 1997 – 2000
An experiment in GP–Network collaboration

Peter Schattner

In 1997, the Southern Health Care Network funded a small unit to coordinate the linkage of five divisions of general practice with the network's hospitals and community health centres. Peter Schattner reviews the experiment.

What has happened?

The Southern Health Care Network* in Melbourne has recently announced that its funding of the General Practice Resource Unit (GPRU) would end shortly. The main reasons given included the various internal initiatives undertaken by the network through its acute access projects such as the 'effective discharge strategy' and community-based pre-admission assessments. New directions are also likely to be put in place with the establishment of a network primary care program involving its community health centres. With these initiatives, the network managers believe they now have other ways of achieving the original goal of the GPRU, which was better communication between GPs and network services.

I have been the director of the GPRU for the past three years. I wish to report my personal views on GP–network–hospital relations in the hope that this is helpful to others in this era of restructuring and significant health care system change.

The history of the GPRU

The Monash University Department of Community Medicine and General Practice made attempts in the 1980s to set up an academic unit of general practice at Sandringham Hospital. This was to be modelled on the department's unit located at Box Hill Hospital. This idea was discussed in general terms at a strategic planning meeting held in the mid-1990s by a group of seven divisions in the region (the Southern Metropolitan Region Divisions of General Practice, or SMRDGP). They agreed that a 'co-ordinating body' to facilitate relationships with other health services in southern Melbourne was desirable.

The previous Victorian government established health service networks in Melbourne which consisted of groups of public hospitals and some community services, e.g. community health centres. The current government has broken up these networks into smaller 'metropolitan services'. One of these networks – the Southern Health Care Network – provided the bulk of the funding for the General Practice Resource Unit which was to facilitate collaboration between the Network, the Monash University Department of Community Medicine & General Practice and five local divisions of general practice.

I continued to develop this concept and presented it to the network. In 1997, Professor Just Stoelwinder, then CEO of the network, announced that money would be made available not only for a unit with a small number of staff (administrative and project officers and a part-time director), but also for GP 'liaison' officers who would work with the clinical programs. The GPRU therefore commenced operation in mid-1997.

Main areas of activity

The GPRU's activities have covered two broad areas: GP–hospital communication and collaboration with the network's programs. An example of the former included support for the introduction of automated faxing of admission and discharge notifications. The latter involved a wide range of projects such as improving communication between GPs and mental health crisis and assessment teams, evaluating the GP role in a coronary care hospital in the home project, and providing a forum for GP–network meetings. Working with the mental health program was particularly gratifying. There has been too much separation between general practice and specialist services to patients with serious mental disorders. The GPRU's project encouraged crisis teams to contact the patient's GP, or to suggest to patients that they find a GP if they did not already have one.

A list of 'achievements' is difficult to produce without a somewhat lengthy explanation on the important contributions made by other health care groups in collaboration with the GPRU. Moreover, I am principally interested in drawing attention to some of the lessons learned about GP–network collaboration rather than providing an in-depth history of the Unit.

Relationships with collaborating organisations

The GPRU's policy direction was in part set by its steering committee which consisted of representatives from the network, the Department of Community Medicine and local divisions of general practice. In spite of a clear focus on GP–network communication and integration issues, bringing about change within the network did not prove easy. There were several reasons for this.

- The GPRU was not a part of the organisational hierarchy of the network, which meant that, at best, tbe GPRU could advise and inform but not decide what should be done. For example, while other networks

explored electronic communication with GPs, this one chose to postpone its consideration of this issue until its own internal systems had been updated. The GPRU was not able to force the pace of change in this area or in a number of other ones.

- The network remains dominated by the concerns of its hospitals, and these revolve largely around patient access and working to a budget. Not surprisingly, GPs are not a high priority in comparison to these fundamental issues, and unless the GPRU had been more politically empowered (i.e. given some authority over staff and internal network policies) it was unlikely to overcome network resistance. This was in spite of good intentions and general agreement by the clinical program directors and network management personnel on the need for better communication.
- The network structure was based on 12 programs in clinical areas such as mental health. These programs operated across all the hospitals in the network. From a divisional or GPRU perspective, this structure was difficult to work with. Each program has its own director, so that issues such as hospital residents writing timely discharge summaries had to be dealt with 12 times over rather than once at the top of a 'pyramid'. Divisions working with single hospitals might find the political process more direct.
- Working with the community health centres within the network did not prove any easier. The 'flat' structure that linked the six centres meant that implementation tended to get bogged down in bureaucracy.

However, it is important to realise that some of the issues which the GPRU tried to introduce are now being 'driven' by government-led incentives, e.g. hospital discharge planning. While it is important to work with the people on the ground, a push from the top is sometimes the critical ingredient for success.

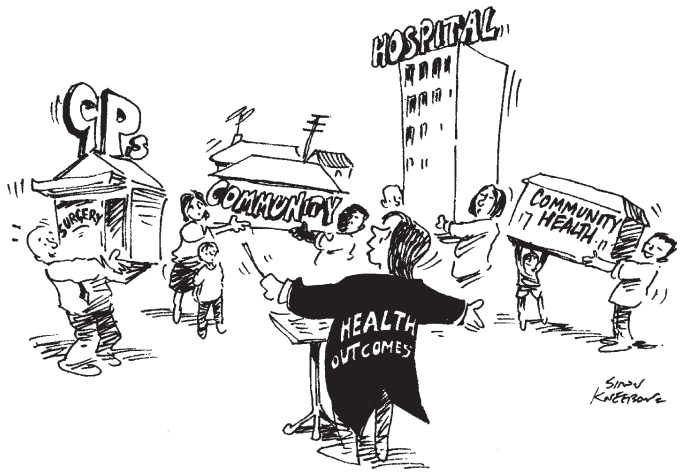
The Department of Community Medicine at Monash has provided significant infrastructure support, encouragement and a physical home to the GPRU. I was therefore careful to ensure that the unit maintained a degree of academic responsibility through involvement in health service evaluation, the production of several comprehensive reports and conference presentations on the topic of integration.

Finally, in spite of the GPRU being an explicit 'resource' for divisions of general practice, it became clear that these organisations looked internally for most of their support. The concept of a facilitating body to coordinate the linkage of five divisions with a single health care network was difficult to achieve. An organisational psychologist might have predicted that at the outset.

In spite of these unit's project officers were closely involved with their divisional and network counterparts in the implementation of many practical matters, and the unit helped raise the profile of GP issues within the network.

GP–health system integration: where to now?

Several models of GP–hospital liaison exist throughout Australia. For example, where one division of general



practice is closely affiliated with a local hospital, then that division can act as the representative of its GPs. In a second model, hospitals appoint GP liaison officers who spend one or two sessions per week in the wards to ensure that actions such as the production of discharge summaries are carried out.

However, the Southern Health Care Network tried a novel means of collaborating with GPs by setting up a unit dedicated to the linking of divisions and Network services. Whatever the future model adopted in this region – and it would appear that direct communication between the network and local divisions is the preferred option – some of the lessons of the past three years should be taken into account if better communication and integration is to be achieved.

I believe that building on government incentive programs such as the Victorian Government's effective discharge strategy, the primary care partnerships and the enhanced primary care program (involving new Medicare item numbers for care planning and case conferencing) is a very useful strategy.

I also think it important that GPs and hospital networks (or metropolitan services as they will be called in post-Kennett Victoria) have very clear objectives for collaboration. The priorities and indeed the cultures of the two groups are very different, and it is important that this is acknowledged and the common ground understood. The principal areas of mutual interest remain better communication about patients entering and leaving hospitals, and better integration of services for the elderly and patients with chronic diseases.

Dr Peter Schattner is the former director of the GPRU

Acknowledgments

I thank the Southern Health Care Network and the Department of Community Medicine for their three year support and funding. I also thank the individual members of the GPRU steering committee, divisions of general practice, and the many people within the Network with whom the GPRU has collaborated. Finally, I thank my staff who, in spite of the barriers, shared the vision of better health service integration.

Primary health care integration

Adele Hamlyn

Over the last two to three years there has been substantial work done by divisions and primary health services across the state in response to the Victorian government's restructure of the primary health sector. The aim is to provide better integrated services for people in the community, but some issues still need to be addressed.

The current reality

A 76-year-old man has just been diagnosed by his GP as having diabetes. He will need to test his blood sugar levels each day and take tablets to control the diabetes. The doctor also noted that he has an ulcer on his toe. The man also cares for his 75-year-old wife who has Alzheimer's. He needs to be linked with a dietitian, podiatrist and a nurse to help him learn how to test his blood each day. The GP is also worried about her patient who reports that his wife is becoming increasingly irritable and very difficult for him to manage. The patient has been making more frequent appointments over the past few weeks to see his GP as he is becoming increasingly stressed by his situation.

The above case study demonstrates the complexity of issues that some patients present with to the GP. The doctor needs to make three separate referrals for her patient to see the podiatrist, dietitian and community health nurse. She is concerned that there may be a long waiting period for the podiatrist. This requires contacting the local community health centre. She knows from experience that it is difficult to get through. She feels that someone needs to follow up and see if her patient has accessed the required services. Who would do this? The GP is frustrated as she would like to be able to make just one phone call to a service that would coordinate the required services for her patient. This does not seem to be available or rather the GP doesn't know whom to contact in the local area.

What is primary health care?

'Primary health and community support services are the first point of call for most people who need assistance to improve or maintain their quality of life and have a physical, mental health, social or environmental health problem.'[1] Hayden Raysmith estimates that 25% of health expenditure in the state is spent on primary care although he acknowledges that it is difficult to neatly categorise what is and what is not part of the primary care system.

Apart from primary care being a set of services, many who talk about primary care are also talking about a specific philosophy. According to Rogers and Veale in *Primary Health Care and General Practice:* 'The term "primary health care" (PHC) gained widespread currency following the 1978 International Conference on Primary Health Care held by the World Health Organisation and UNICEF at Alma Ata.'[2] The conference resulted in a ten-point declaration that included definition of the components and philosophy of primary health care. The philosophy is based on:

- holistic understanding and recognition of the multiple determinants of health
- equity in health care
- community participation and control over health services
- focus on health promotion and disease prevention

- accessible, affordable, acceptable technology
- health services based upon research methods.

According to Veale and Rogers, 'This original ideal of primary health care has become known as comprehensive PHC. This is in contrast to selective primary health care which is more medically focused with a reliance upon medical interventions and doctors for provision of and control over health services.'[3]

Why integrated care?

Hayden Raysmith argues that the current interest in reforming primary care is worldwide and that there are three basic reasons for the interest. First, there is a growing recognition of the role primary health services can play in preventive care and the management of chronic conditions. Second is the extent to which medical technology is enabling the greater part of care to be shifted from hospitals and other institutions into the community. Thirdly, there is the growing consumer demand for adequate service. Such demand includes a requirement for information to be available to help people manage their own illnesses. It includes the need for appropriate sharing between providers so that patients do not have to repeat information each time they see a new service provider and it includes the desire for coordinated service provision that avoids queues and delays.

THE INTRODUCTION OF THE NEW MBS ITEMS HAS PROVIDED THE OPPORTUNITY FOR A TANGIBLE LINK FOR GPs AND DIVISIONS WITH THE PCPs.

Commonwealth initiatives

There is wide agreement at both state and federal levels of government that there needs to be greater collaboration, cooperation, coordination and ultimately integration within the health care system. This has been discussed and reported on by government over several years since the Alma Ata declaration. Thus the first issues paper of the National Health Strategy, *The Australian Health Jigsaw,* addressed this in detail.[4] The GP Strategy of 1993 was intended to strengthen the general practice sector. Further commonwealth initiatives include the coordinated care trials and the 1999 budget initiatives of a range of measures aimed at improving the health and wellbeing of older Australians and people with chronic and complex health needs. The enhanced primary care (EPC) package includes new Medicare Benefits Schedule (MBS) items covering health assessment for non-indigenous people aged 75 and over (and for Aboriginal and Torres Strait Islander people aged 55 and over), care planning and case conferencing. Other programs under the umbrella of the EPC package include extension of the coordinated care trials, falls prevention and chronic disease self-management. These measures are all intended to encourage greater linking between GPs and other primary health care providers.

State initiatives

There have been discussions in Victoria for almost three years now about the need to make changes to the primary health and community support (PHACS) sector. The previous Kennett government commenced this process of restructure. It was driven by a concern that services were fragmented and therefore unable to deliver significant improvements to the health and wellbeing of the population. It was also acknowledged that there was a need to manage the increasing costs and demands for acute health care and to achieve a greater balance between acute health care services and primary health and community support services. The Kennett restructure (or 'PHACS reform') was aimed at getting all local primary health care services to work together cooperatively at a sub-regional level serving a population of about 300,000 in metropolitan areas. The rhetoric seemed to be aimed at a single point of referral (in whatever form) into the system, coordinated assessment processes, common service directory and common patient record information.

The PHACS initiatives certainly resulted in the development of some strong links among a range of primary care services such as aged care, mental health, alcohol and drugs, disability, youth and family services as well as general practice.[5] However, the nature of the PHACS funding system was such that many primary health care services feared for their autonomy. Local government was worried about control over the substantial services they contributed, small agencies feared takeover by the large agencies and regional and specialist services feared being left out in the cold. The general practice sector was concerned that the local territorial battles (within PHACS alliances) were irrelevant to them and their patients. However, GPs were included in the process. GPDV through the leadership of Dr Julie Thompson worked with divisions to develop minimum requirements for divisional involvement in the PHACS restructure process. This gave divisions an agenda to bring to the negotiating table if they wished.

Following the change of government in 1999 the new Minister for Health authorised an independent review of primary health redevelopment.[5] The resulting Raysmith review recommended that redevelopment proceed at a slower pace than previously. Greatest emphasis was given to cooperative arrangements based on centralised frameworks. The issue of streamlined funding arrangements was given a lower priority than previously. From a division point of view, the review reinforced the central role of the general practitioner in the provision of health care, citing the well known fact that over 80% of the population visit a GP each year.

The Raysmith review was followed in April 2000 by the release of the *Going Forward, Primary Care Partnerships Strategy.* PHACS alliances became primary care partnerships (PCPs). PCPs are groups of primary care providers which have formed locally based alliances usually covering two or three local government areas. Across Victoria, divisions of general practice are active participants within these partnerships.

The Department of Human Services has developed a GP integration strategy as part of the *Interim Partnership Development Plan*. The strategy aims to develop service coordination links between GPs and primary care service providers within each partnership.

GP Experience – Dr Chris Watts, executive director of Westgate Division of General Practice

What have GPs done to improve the links between GPs and the broader primary care sector?

GPs have developed one-to-one relationships with individuals in service delivery agencies. This has assisted in paving the way for the development of relationships on an institutional basis through the primary care partnerships.

The division has been successful in improving the integration between hospitals and community agencies. It is in our interest if there is better communication between hospitals and other services as we have to interact with everyone. Western Hospital has been very responsive.

What hasn't worked?

Where there has been only one agency working with GPs or only one agency working with just a few GPs. This has not been successful in improving patient care. This is where the primary care partnerships will help as they will involve the range of services in a given area.

Why do you continue to be involved in integration activities such as the PCPs?

The PCP intake process should make it easier for GPs to make referrals to other agencies and for there to be assessment and feedback protocols.

The division has already seen progress as we worked with RDNS, local government and community health to develop smooth referral mechanisms. The PCP will be an extension and will include all service providers in the area.

GPs through the division have the opportunity to influence planning at the local level through the PCP community health plans. We can contribute to this process as a division.

The new MBS items for assessment, care planning and case conferencing will benefit the PCP as other agencies can now have dialogue with the GP.

I think that GPs in our area may not be the initiators of care plans and case conferences but will be contributing to these. This is a very positive move.

The introduction of the new MBS items has provided the opportunity for a tangible link for GPs and divisions with the state partnerships. The partnerships will provide the framework for the design of processes and systems to assist GPs and other service providers in working more effectively together for the care of their patients or clients.

Divisions' experiences

The Whitehorse Division of General Practice believes that there is respect for the role of the GP as the cornerstone of an integrated primary health care system. There is respect between GPs and other professionals and recognition of the skills that each other can bring to a working relationship.

Whitehorse Division uses the continuing medical education (CME) program as a strategy to bring GPs and service providers together. For example, when a session is held on diabetes the appropriate local allied health professionals are invited to participate. This gives the GPs and allied health providers the opportunity to meet together in person thus increasing understanding of each other's role and fostering trust in the skills that they all have to offer.

The Bendigo & District Division has some staff working for both the division and other local health services. The division has contracted the services of a program worker for immunisation from the local council. The division's adolescent health worker is also employed by the community health service. The division actively engages with other health professionals in joint CME activities. These and other activities assist in building relationships at the local level.

'Most agencies are keen to talk to GPs. There is a great deal of good will. It takes time', says Namanita Patterson, executive officer of the division.

There are also practical issues to consider in integration. One Melbourne GP reported that his practice purchased a phone for a local palliative care service to enable him to have a weekly telephone case conference with the palliative care team who all met at the same time each week. The phone was put in the room where the team met and the GP could communicate with all who were involved in the care of the GP's patient via the phone.

The activities above are examples of strategies that can contribute to the common goal of improved outcomes for patients. It is often very practical and simple solutions that can make a difference to the success of primary care integration.

Discussion

Structural issues continue to challenge the success of integration strategies. This is often related to multiple levels of funding by both state and commonwealth governments.

Coordinated care trials are likely to involve approximately half of the Victorian divisions and about half of the PCPs in Victoria. A key success factor for both programs should

be the degree to which they can develop systems that are connected and complementary to each other.

Other recent examples of programs that ideally should be linked and implemented within the framework of the Victorian PCPs include the following commonwealth budget initiatives:

- funding to rural divisions for allied health workers
- funding pharmacists for their participation in medication reviews of people in the community (criteria to establish which patients or clients this will apply to are currently being developed). This is an extension of the existing program of medication reviews of residents of nursing homes and hostels.
- a payment to pharmacists for their participation in case conferences and care planning with the GP.

Driven as it is by assumptions that improved service coordination will improve patient care, government departments will need to look at whether this assumption is supported by evidence, as it becomes available (e.g. through the evaluations of the coordinated care trials). In the meantime there is another key question for integration efforts at commonwealth and state levels: how will the multiple efforts at enhancing the primary care system work in practice without overwhelming or confusing practitioners?

Adele Hamlyn is the GPDV primary health care consultant to divisions.

i Hayden Raysmith, *Report of the Review of Primary Health Redevelopment,* Victorian Department of Human Services, Melbourne Victoria (also published on the Aged, Community & Mental Health Division website at http://www.dhs.vic.gov.au/acmh), 2000, p. 5.

ii Wendy Rogers & Bronwyn Veale, Primary Health Care and General Practice: A scoping report, National Information Service, Department of General Practice, Flinders Medical Centre, 2000, p. 4.

iii Rogers & Veale, Primary Health Care and General Practice, p. 1.

iv National Health Strategy, (Commonwealth Department of Health, Housing and Community Services), The Australian Health Jigsaw: Integration of Health Care Delivery, 1991.

v Hayden Raysmith, Primary Health Redevelopment, p. 13.

LETTER

Dear Editor,

I have read your latest 'Divisions Quarterly' (Autumn 2000), and felt that I had to respond on behalf of our division to the inaccurate information presented in the editorial.

Firstly our division's registered business name is the Inner Eastern (not East) Melbourne Division of General Practice.

Secondly, the brief paragraph on what our division is doing for GP personal support, did not really represent our divisions activities in this area. The following is a brief summary:

1 Set up a steering committee in late 1998 to oversee the implementation of a gp peer support service

2 Contracted a consultant psychologist, whose area of expertise was in the area of critical incident support, to help us set up this service.

3 Set up a course of four session of three hours and ran it during 1999 to train eight gp's to be a part of the inaugural peer support team.

4 Established a name for the service (PSST) and distributed an information folder to all 300 divisional members. This folder contained full details of the service, and a fridge magnet with the contact number on it, to allow a beeper system to be established.

5 Surveyed all members of the division on the service, and obtained over 100 replies. Most of them support the Peer Support initiative in a very positive way.

6 Plan to re run the training course in 2000, due to their being excess numbers responding to the training course in 1999.

7 Offer ongoing support through the consultant psychologist for the peer supporters

(care for the carers), with regular meetings of the Peer Support Team.

Despite the positive feedback, there have been few formal requests for support, as most approaches have been informal. Most responses to the survey indicated gp's would utilise the service if they felt the need, so we are now changing the mode of contact to make it more informal.

John Addis,
Chairman, Steering Committee, Peer Support Service
Member, Peer Support Service Team
Inner Eastern Melbourne Division of General Practice

The Next Issue

The next issue is scheduled for October 2000.

The theme will be

GPs and population health

This issue will include articles on:

- the meaning of population health in a general practice context;
- the role of GPs in population health;
- approaches to population health in divisions and in general practices.

We seek contributions on all of the above and encourage readers to contribute to the discussion of divisional issues by writing letters and articles on any matter of relevance to the Program.

The deadline for contributions is Friday 22nd September.

TAX INVOICE

GPDV
GENERAL PRACTICE DIVISIONS
VICTORIA

Subscription Form

❑ Individual ❑ Organisation

Individual Name: _____

Organisational name: _____

Address: _____

_____

_____

Telephone, Home: ( ) _____
Work: ( ) _____
Fax: ( ) _____
Email: _____

PAYMENT

Subscription period is for one year (4 issues) with each subscription costing $44 (including GST).

❑ I enclose a cheque for $44 made payable to General Practice Divisions – Victoria Ltd

❑ Please charge my credit card $44:
- ❑ Bankcard
- ❑ Mastercard
- ❑ Visa
- ❑ American Express

Card Number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiry: __ __ / __ __

For Amex only: Batch Code (3 or 4 digits) _____

Cardholder's Name & Address:

_____

_____

_____

Signature: _____

❑ Please send me a receipt once my payment has been processed

Please note that this journal is provided free of charge to all Victorian divisions of general practice and all Victorian general practitioners who are members of divisions.

Please fill out the subscription form and send it together with payment to:

Journal Subscriptions
General Practice Divisions – Victoria Ltd
ABN 80 081 371 968
1st Floor, 458 Swanston Street
Carlton VIC 3053
Tel. (03) 9341 5200
Fax. (03) 9348 1375
Email: subscriptions@gpdv.com.au

Why support good governance in general practice divisions?

Helen Threlfall

Divisions of general practice are seen by some as membership-based organisations not unlike the AMA and RACGP. But they are also publically-funded organisations that must be accountable to their members and to government. Helen Threlfall argues the case for the right approach to governance.

One of the key aspects of the work of General Practice Divisions Victoria, is to provide advice, support and assistance to the divisions of general practice so that they function effectively and achieve the aims of the Divisions Program. This has meant a focus on support for organisational development, and for the development of division boards and staff, in addition to a focus on the content of the work of the divisions and the restructure and enhancement of general practice. Currently GPDV is providing a Governance Series of workshops for divisions as one aspect of this support and advice, which is a large part of the work of the division consultants.

In providing this support and advice, the division consultants use a framework that is based in part on Australian corporations and associations law and in part on the work of John Carver, an American organisational consultant who specialises in helping not-for-profit organisations to conduct themselves efficiently, effectively and ethically.

There is little disagreement within divisions about the need to get the processes of governance right, but we have encountered a range of views on the best way to structure divisions, as well as on the kind of processes that make for good governance. To facilitate debate on governance issues, we present this article and invite responses.

What is good governance?

This article sets out the key principles our support and advice is based on, and gives examples of their successful operation within divisions.

Separation of powers

One of those key principles is:

> *The separation of powers, whereby those who decide what the organisation should spend its money on, ëthe governmentí, do not then become the staff doing the work, ëthe executiveí reporting to itself.*

In divisions this means that board members cannot at the same time be employed by the division in an employerñemployee relationship with the board. Implications for structure are that there will be a CEO, however titled, who is not a voting board member, and that all staff, whether GPs or non-GPs, report to the board through the CEO. The CEO is accountable for the performance of the organisation as a whole. A number of conflict of interest and other ethical issues have arisen in divisions, such as board members voting on programs in which they have a beneficial interest, that could have been prevented had there been clarity of structure and of role. Although divisions can use board policies to set out their approach to resolving conflicts of interest and espousing an ethical approach, it is more effective to prevent such conflict by getting the structure right first.

A response to the first board governance workshop on this issue of role clarity sets out the dilemma. ëÖ role definitions for functions, i.e. board/CEO excellent. Good to hear support for consistent standard board/CEO roles, particularly as it is often heard that divisions are different therefore do not need to heed best practice for governanceí.

Balance of power

There is no evidence in the literature or the law that any particular type of organisation is different and hence exempt from the rules of governance. This principle of the separation of power, which ensures clarity about roles, is related to other basic principles, such as the accountability of the CEO, and the need for a balance of power:

> *Balance of power, whereby the board is led by a chair or president with adequate powers to balance those of a chief executive.*

The underlying structural issue is the role and power of the chair. A crucial role of the chair is to contribute to the development of board agendas, ensuring that they focus on the key issues. The position should be sufficiently well funded so as to enable the chair time to be informed about the division and its plan, and about the program so that the chair can separate the key issues from the peripheral ones. The success of the board as a body capable of providing leadership to the division as a whole depends to a great extent on this position. The chair also has to be able to develop a relationship with the CEO that enhances teamwork, and hence accountability, usually being in contact several times a week by phone, fax or email.

A chair with time to spend in the role, and time to develop knowledge and skills, ensures that the boardís

priorities are addressed, and provides leadership for the board and the members. There are organisations, including divisions, where the chair is disempowered; where the job is limited to turning up each month and running meetings; where there is a strong executive director running the organisation, and where the chair can provide no guarantee to the members about stewardship of their interests.

Over the last few years, the chairs of divisions have taken on the public role of representation of the organisation in the many negotiations with other health service organisations, working together with other board members such as the deputy chair and the CEO. By assuming this leadership in the representation role, the chair is in a position to follow up the agendas that the members and the board have identified. Although it is important for a CEO to be involved in these discussions, if the CEO is involved without the board being represented, the board has failed to provide that link to the members.

An accountable CEO

Part of getting the balance of power right is a reporting format that makes the CEO accountable. The balance is important, as the CEO should have a mandate to achieve the boardís priorities, with clear limitations on his or her powers, but with a system of reporting that makes him or her accountable.

> *The CEO is accountable to the board for the performance of the organisation, and it is impossible for the CEO to be fully accountable if he or she is working only a few hours a week, as the complexity of division work requires full time management.*

The observance of this principle requires boards to spell out clearly their expectations in the strategic and business plan, and to require reports that enable them to ascertain whether the goals of the plan are being met. It also means that boards will spell out the delegations they make to the CEO, including powers to act, power over finances, over staff, and so on. This principle is based on the understanding that the Divisions Program is a change program for general practice; that it is a complex program that requires the board, staff and CEO to operate at a high level. If divisions were funded simply to deliver services to GPs, rather than assist GPs to change general practice, then it may be possible to get away with a part-time CEO, an extensive network enabling cooperative activity by GPs and some administrative staff. Given this is not the case, that the work of divisions is to restructure general practice, divisions require staff to match the ability of GPs, and a structure that involves as many GPs thinking about the work of the division as possible.

The interdependence of a functioning board and a good CEO makes all the difference to the achievement of the aims of the Divisions Program. The Central Bayside Chairman, Dr Michael Nolan, says that ëwe couldnít have survived without a non-GP CEO. We would have stayed narrow ñ not having the skills to run a division effectivelyÖand certainly not having the timeí.

Involved and informed members

> *The Divisions Program is a development program for general practice. It should offer opportunities for many GPs to be involved in a range of ways, in particular in activities that assist the profession to work through the question that the program asks: ëwhat is the place of the GP in the health system?í*

Involvement is a crucial aspect of good governance. The informed population is a better watchdog on a board and a CEO than an uninformed and uninvolved one. In the North East Victoria Division this has been achieved through the operation of a number of taskgroups, where GPs with a strong interest in an issue or program area can be involved, and contribute to the development of division programs. This principle is also being achieved in divisions by more professional preparation of the agendas for board and other sub-committee or taskgroup meetings. At the Border Division, rather than a board agenda that lists in one line the item for discussion, board members are given the background on the item, the issues involved, and a recommendation. The chair and other board members guide the preparation of the agenda, rather than it being the work of the CEO acting alone. Several board meetings a year are scheduled for open-ended discussion of the issues facing the divisions, and there are opportunities for the GP members to be involved in these more wide-ranging discussions with the board members.

This principle also means that some GPs contribute through the board, while other GPs are involved in taskgroups, or as program or project advisors or consultants. For example, in Inner South East Melbourne Division, these GP positions are advertised to the members, and GPs are interviewed for the position. Once appointed, the GP program consultant works with the staff member who is accountable for the delivery of the program. The GP provides the expertise in program design and delivery from a GP point of view, while the staff member has skills in management, implementation and evaluation of programs or projects.

One of the tendencies in board development is the emergence of oligarchies. In all organisations there is this natural tendency for some people to be more enthusiastic and harder workers for the cause, and an inner board clique can develop which exerts control, simply through being the willing workers. Attention to a structure that involves GP members on various levels, and separates board contribution from other kinds of contribution can prevent the emergence of powerful oligarchies.

The right structure

This framework, of a board accountable to the electorate, a chair and board responsible for ensuring the strategic plan is developed and implemented, and a CEO and staff responsible for the implementation of the plan, is common to all levels of elected organisations which are in receipt of public funds. A different framework or structure, where elected board members also do the work of the organisation, is common in membership-based organisations where the work is done on an honorary basis. Divisions are in the same situation as

local councils or the boards of community health centres, not in the situation of school councils, or professional organisations such as the AMA or the RACGP.

The legislation for community health centres specifies that no staff member of a centre can be on its board, as does that for local councils. Although many of the GPs involved in divisions are also in private practice, divisions are not private organisations; they are publicly-funded organisations. As such, organisational structures that apply to them are those of the public sector, not the private, and the rules for accountability are similarly those that apply in the public sector. Although divisions are membership based, they are not cooperatives, where everyone gets together every few months to decide what to do next. They have contracts with the government to achieve outcomes, using strategies and activities clearly set out, and they have articles or constitutions that set out their rules of operation.

A fully accountable board

> *The expenditure of public funds has to be ethical and transparent, with full accountability.*

In structural terms, this means less of an emphasis on the treasurer being the person on the board who understands the finances, and more on all board members being financially au fait. There are many processes to be put in place in divisions to meet this principle, but some examples are that board members now expect that they will receive year-to-date and month-to-date budget and expenditure and income figures with an explanation of the variance, if any. There is also an understanding that divisions have to meet the requirements of the corporationsí law in matters such as directorsí remuneration.

> *The taxpayer is owed best use of the funds allocated.*

This is related to principles above, but one implication for structure is that where a job can clearly be done by a staff member, and does not require GP expertise, such as administration, it will not be done by a GP. It means that boards have to justify being larger than seven or eight members, and generally that boards will be from seven to nine members. It also means GPs are involved in divisions, at GP rates, but not to do the work that more cheaply paid staff can do. This requires divisions to think through using the considerable ability of their GPs to best advantage.

Although having an organisational structure where the roles of key people such as board members and the CEO are clear and separated, where powers are identified and delegated where necessary, is no guarantee that the organisation will be a high achieving one, it is a necessary pre-condition. Getting the structure right frees boards to focus on membership involvement, on developing a plan that provides a focus for members, and on ensuring that staff capable of delivering on the plan are employed. After the structure is in place, the board can ensure that the processes are right.

Helen Threlfall is a GPDV consultant to Victorian divisions of general practice.

John Carver, Boards that make a difference, 2nd edition, Jossey-Bass Publishers, San Francisco, 1997.

Evaluation Report, Star Boards, GPDV, March, 2000

GPDV

GENERAL PRACTICE DIVISIONS

VICTORIA