GPDV Response
March 2007

Comments on AGPN's Paper:
Funding general practice based multidisciplinary team care in Australia

Key messages

Victorian divisions are keen to strengthen their role in the primary care system through a stronger role in population health. They strongly support the opportunity to help break down the Commonwealth–State divide in health service delivery and believe that divisions represent an ideal platform to integrate Commonwealth and State health services at the primary care level.

General comments

- Victorian divisions already hold budgets for certain programs and support the idea of extending this role.
- Any proposed funding model should be developed in the context of a national primary health care policy/plan that involves shared commitment from national and State governments.
- Divisions are ideally placed to play a prominent role in any changes to the primary care system.
- Any new funding model must be monitored and evaluated during implementation.

Comments on specific aspects of AGPN's proposal

- Multi-disciplinary teams are basic to good chronic disease management so there is support for a change to the current funding system in order to fund teamwork more effectively.
- Fee for service must be retained for episodic care but blended payments are appropriate for chronic disease management.
- Clinical leadership is the province of the GP.
- Care co-ordination can be provided by a non-GP.
- If divisions are to hold funds, then funding must be provided for appropriate infrastructure and capacity building, including staff recruitment, training and development.
- A form of capitation already applies to the funding of divisions and in several programs such as the PIP. Developing a chronic disease program would require some idea of the patient numbers to be treated by such a program so some form of capitation would need to apply to any chronic disease programs that involve blended payments for the GP. Capitation must not replace rebates under the MBS.
- There was some support for regional registration for patients with chronic disease (i.e. at a division level) to enable planning and tracking of progress while retaining flexibility for patients to change doctors within an area if they choose. There was also a concern that if patients are registered on the basis of a particular condition rather than as a whole person then the advantages of general practice in treating the whole person would be lost.

Concerns

While supporting the overall direction, Victorian divisions have some reservations about the proposal.

1. The need for clarity about what is being agreed to

A common reference point in Victorian division discussions about fund-holding has been the MAHS program. The MAHS program has demonstrated that divisions of general practice can successfully hold budgets for allied health services thereby strengthening the links between general practice and State-funded or private services without threatening the status quo in general practice in any way. Similarly, the Victorian Hospital Admission Risk Program (HARP) achieved great success in improving health outcomes by funding divisions to roll out services that integrated private practice, hospital service and community health services. Nevertheless, despite these recent positive experiences, the fear remains that fund-holding could entail some measure of control over general practice, especially by dictating the details of service provision and by altering the form of payment.

There is general agreement among Victorian divisions that, while there is support for extending the present role of divisions, at this stage divisions do not know what they are being asked to agree to. A recurring phrase in the consultation has been 'the devil is in the detail'. Victorian divisions require another round of consultation to respond to a detailed specification of the nature of the fund-holding arrangements proposed. As one division board member put it:

> My comment about this discussion paper is that it is only a preliminary overview of the issue. Sooner or later, AGPN will have to outline a specific alternative to the current patchwork model. Then individuals and divisions can decide how they line up in relation to this.[1]

2. The need for flexibility

While one of the justifications for proposing the fund-holding role is the need to overcome the Commonwealth–State divide, it is vital to recognise that each State's primary care infrastructure is different from that of the others so there can be no one model that suits all. In particular, Victorian divisions cannot commit to a proposal that involves divisions as the only fund-holder for primary care services given that there is already an extensive infrastructure of services, many of which would claim that they are equally well placed to hold funds. Victorian divisions and GPDV have worked hard over the life of the Divisions Program to develop effective working relationships with State-funded services and do not want to give the impression that divisions are now proposing to enter into competition with them.

GPDV proposes a regional governance model involving a consortium of neighbouring divisions and State government services. While this may not apply uniformly across the State it is likely to be seen in most parts of the State as the most acceptable way to integrate State and Commonwealth services.

3. The need for an effective implementation strategy.

The majority of Victorian divisions are keen to support the direction of the proposal but recognise that it has major implications for the Divisions Network. In particular they are concerned that the relationship of divisions with GPs could be worsened if both the development of the proposal and the implementation of the change process are not handled effectively. Suggestions for ensuring that GPs are engaged in the process include:

- Start with a clearly defined group of the community, selected on a population or disease basis, to test the models.

[1] Dr Peter Schattner, Board member, Monash Division of General Practice

- Ensure adequate support in the form of proper guidance, clinical governance, evaluation, quality framework, and adequate data.
- Build on existing models of team-based care with which divisions are familiar, especially through the Victorian HARP and proceed in an evolutionary fashion.
- Avoid using loaded expressions such as 'fund-holding', which had a specific technical meaning in the British NHS of which GPs tend to disapprove.

There are also political issues to solve, especially in relation to Commonwealth and State participation, privacy issues about data collection, provision of choice of doctor and selling the idea to the community.

GPDV's consultation process

GPDV's response to AGPN's paper is informed by our member divisions' comments. We consulted using a range of mechanisms:

- The Victorian Divisions Forum on 18th February 2007 attended by representatives from 23 of the 30 Victorian divisions (10 rural, 13 urban), where Dr Chris Pearce presented a summary of the AGPN paper. (GPDV forwarded written comments to AGPN following this event).
- The regular teleconferences of the metropolitan and the rural division Chairs on 20th and 21st February, attended by 10 urban divisions and 12 rural divisional representatives respectively.
- Following these events we received written comments from five divisions as well as three sets of individual comments from divisions.

GPDV board discussed the Victorian response at its meeting on Friday 16th March.
