Policy Issues Paper no. 1
July 1998

Reforms to Primary Health & Community Support System (PHACS)

DHS released the discussion paper *Towards a Stronger Primary Health and Community Support System* on 15 June.

The thrust of the new policy is to make providers responsible for delivering defined core services in a catchment area (boundaries have yet to be defined) probably through consortia or alliances, with one "lead agency" in each area acting as the fundholder. Alan Clayton stated that the aim of the policy is to make a sector of independent providers function as a whole system. There are to be links between services, a single entry point for consumers accessing the system and the sharing of information between various parts of the system. DHS plans to fund demonstration projects later in the year involving consortia or alliances between different services. Divisions of General Practice are one of the stakeholders that are required to be consulted in the development of the demonstration projects.

Feedback on the discussion paper is sought by DHS. The focus of the consultation will be on interpretation of policy and implementation arrangements (including specifying catchment areas) rather than on the policy itself. The deadline is 14 August. Julie Thompson has been representing GPD-V on the DHS working group on the issue and GPD-V will be making a formal response after consultation with the membership. Alan Clayton will attend the GPD-V Forum on 19 July to discuss this issue.

The discussion paper can be downloaded via the internet at
http://hna.ffh.vic.gov.au/acmh/chcoord/ph-css.pdf

The PHACS policy starts from the premise that primary care is fragmented, given that it involves general practice, pharmacy, allied health, rehabilitation, prevention, and community development aimed at networks and self-help. The policy is trying to streamline primary care to improve quality, cost-effectiveness and access.

DHS argues that changes in health needs and health service delivery give rise to an urgent need to co-ordinate primary health and community services. Changes include the ageing population, changing role of hospitals, deinstitutionalisation, and the expectation that chronically ill people are supported in the community.

On Pages 12-13 of the paper is a set of outcomes that providers will need to achieve in order to qualify for primary care funding in defined catchment areas:

- Services will be packaged around the needs of consumers - an optimal mix allowing for substitution, choice and targeting.
- An agreed core set of services will be well understood and universally accessible, supplemented with more specialised services targeted to individual needs.
- The needs of people from diverse linguistic and cultural backgrounds will need to be addressed.
- Assessment will be streamlined, outcome-focused and will link services to relative need.
- Services will respond to consumers in the places where they live and work, and at the time of day the needs arise.

- The system will focus on preventing illness through health promotion, including health education, personal services and community action.
- Providers in a catchment will be more aware of and accountable for the health outcomes and health status in the community.
- Providers will be required to establish working relationships with GPs, relevant dental practitioners and relevant acute and extended care providers.
- Definitions of appropriate catchments will be clear and will reflect communities of interest.
- Information systems will facilitate the smooth movement of consumers through the system and the reporting of outcomes.
- Funding and accountability arrangements will be simplified and made more flexible.

The proposed PHACS service elements group the many existing primary health and community support service types into a smaller number of functionally related activities:

- Health information and co-ordination
- Health promotion
- General care
- Independent living
- Case management and brokerage
- Assessment.

The attached chart (from Page 18 of the discussion paper) illustrates the components of each of these categories.

Issues for general practice and divisions

Involvement of divisions and GPs

Obviously, this needs to be the crux of the GPD-V response. How will GPs fit into the system? Due to the fact that general practice is funded by the Commonwealth, it is considered to be a stakeholder rather than a component of the proposed primary care system. A primary care case management system that refers to general practitioners as stakeholders rather than as case managers may be an issue for GPs. On the other hand, there is obvious benefit to GPs in receiving more user-friendly information, an improved referral service and so on. There is also a clear potential for improving the relationship between GPs and other community health providers.

There are two levels of involvement to consider:

1) GPs' direct involvement in PHACS system – i.e. referral to and from system, information exchange, GPs' understanding of referral options open to them, receiving patients referred by PHACS

2) Divisions facilitating GP involvement, and contributing to planning process.

The question of GP and divisional incentives to participate should also be addressed.

Size of catchment area

The proposed catchment areas are very large and risk losing a sense of community. Communities of interest do not necessarily coincide with sub regions. The issue underlines the fact that divisional boundaries constitute another set of arbitrary boundaries, which may make it difficult for services to know which divisions to consult with, and vice versa. This might negatively influence referral patterns and access to services.

Links to acute sector funding

The paper proposes that "the increased provision of primary health and community support services must equate to agreed and measurable reductions in the demand for acute and extended care services." Many of the potential clients of community health services may never need hospitalisation. It may be a mistake for both sectors to link the funding in this way. Also, will there be an increase in primary health and community support services or will they simply be repackaged?

Health promotion

There is a strong emphasis on health promotion throughout the paper, although it is not clear how this will really occur. It may be particularly difficult to link resources for health promotion to reductions in the acute sector budgets.

Privacy/IT

Consumers/patients may disclose information to one health professional (e.g. GP) without wanting it to be available to every related PHACS service. If there is one general consent form, this is what could happen. Also, divisional projects have already highlighted different values about confidentiality between GPs and many other service providers. There are also medico-legal issues involved here.

Definition of needs

The goals of the policy are very broad - integration, outcome focus, 24-hour service access, etc. "Needs" for specific aspects should be more clearly defined, if they are to be adequately addressed. For example, the clearest lesson from the recent Commonwealth call for after-hours care proposals was that community need must be clearly identified before the characteristics of new service models are defined.

Rural divisions

The paper says that MPSs are likely to be best placed to hold/manage funds in rural areas. It seems to be suggesting that Health Streams, MPS and the new PHACS system were 3 ways of labelling virtually the same system.

Leona Mann, Central Wellington Health Service, at the conference on 22 June, argued that rural areas are better placed to create the sorts of alliances outlined in the paper than metropolitan areas. But rural workforce issues, especially the lack of GPs, could negatively affect the development of PHACS.

Outcome focus

There will be the same problems specifying outcomes and measures as elsewhere in the system. Alan Clayton has stated that the proposal is about moving away from measuring only throughputs, to improving health status. But how will this be measured? GPD-V may wish to endorse Catherine Elvins' (VHA) recommendation of research to establish health gain models and to develop health outcome indicators.