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PHACS - response to DHS discussion paper

Towards a stronger primary health and community support system

The following paper was submitted to the Victorian Department of Human Services, in response to its call for submissions on the DHS discussion paper, *Towards a Stronger Primary Health and Community Support System*, which was released in June.

GPD-V supports the DHS policy goal of developing an integrated primary health and community support system in which referral process are simplified and appropriate information shared. However, the lack of detail in the discussion paper about some aspects of the proposed model hinders a clear picture of how the system will work on a practical, day-to-day level.

Some of GPs' specific concerns have been put to Alan Clayton at various meetings including the GPD-V Forum he attended on the 19th July. While a number of issues were clarified at the Forum, some questions remain unanswered. This paper addresses those issues.

Place of general practice in the primary care system

There has been a tension in the discussion paper, and in subsequent discussions, between descriptions of GPs as an integral part of the primary care system, and of GPs as a stakeholder group who will be affected by the reforms and should be consulted about them, but who are outside the central system. DHS has indicated more than once that the Commonwealth needs to participate in discussions about how to involve GPs, given the current funding arrangements and the paper does mention local government as another purchaser of primary and community care. Alan Clayton reiterated at the July GPD-V Forum that the reforms to PHACS are more far-reaching than affecting only the State Government-funded parts of the primary care system.

However, throughout most of the discussion paper, GPs are described as providers to whom the PHACS platform refers or from whom it receives referrals, but they are not a part of the system itself. This description promotes the view that it is indeed only the State-funded elements of the system that DHS is attempting to overhaul. While GPD-V understands that DHS is not directly responsible for areas of the health system that it does not fund, we have grave concerns that the current focus is on reforming only part of the primary health care system and this will not achieve the goal of integrated primary health care.

GPs would welcome a system that: allows them access to clear information about services to which they can refer easily; will provide detailed and timely information back to them about their patients; and is likely to enhance relationships between GPs and other health service providers. However, it is unclear exactly how the system will work given that GPs' income is influenced by fees-for-service reimbursed to patients from the Commonwealth (or provided directly to GPs in the case of those who bulkbill). Alan Clayton has said that while DHS does not have the resources available to fund a change in the way GPs work, he would be happy to look into the provision of incentives for GPs to participate in the PHACS models

with the Commonwealth. GPD-V believes that detailed discussion with the Commonwealth should be undertaken as a matter of urgency if GPs are to play a meaningful role in the new system. These discussions might include possible ways in which the Practice Incentives Program might be used to enable GPs to participate in integrated models of care such as PHACS.

Possible roles for GPs

GPD-V has put to Alan Clayton that the appropriate GP role is one of *medical case manager* in the community. If DHS agrees with this role for GPs, it needs to promote that message to other agencies and health providers. While providers are aware of the need to consult with their local division of general practice in preparing for demonstration models, it has not always been made clear that this consultation must be about involving GPs as full players in the system, not merely requesting the division to endorse existing projects developed without real GP input, or without a real role for GPs.

Many GPs are keen to have a role in assessment in the PHACS model, given that medical assessment is a core part of general practice. However, assessment is another aspect that is not entirely clear in the discussion paper. Nor is it clear how a single point of entry will work when it comes to the assessment of complex patients, and whether entry to the system will be determined by the convenience of services or by the needs of consumers. GPD-V suggests that a single point of entry is neither realistic nor fundamental to an integrated system covering a substantial geographic area and population, nor justified on health criteria.

Determination of need

The question of how need for particular services will be established should be further examined by the Department. Is it the task of the bidders for demonstration projects to establish need in their local area, or is this the task of policy planning at the Department level? If the responsibility falls to consortia rather than to public employees, the definition of need is likely to be driven by existing services. Streamlining existing services may be a worthwhile aim in itself, but the resulting system may take a different form from one designed to address identified service gaps and community needs. The funding arrangements must promote equity by taking account of the needs of specific populations or target groups in a particular catchment area, rather than being driven simply by previously existing services in the area.

It is important that need for a particular service be established, not assumed. For example, the discussion paper refers to the establishment of 24 hour access to services. While there may well be a need for the provision of some community and/or medical services on a 24 hour basis, it is important to establish exactly what services are needed in a specific community in order to define a model of service with appropriate characteristics to meet that need, rather than adopt a general one-size-fits-all model which is presumed to be capable of addressing presupposed needs.

Health promotion and illness prevention

Although the discussion paper appears to promote an increased role for health promotion it is unclear how this will really occur, and how it will be funded. It is essential that the streamlining of funding and the establishment of a new service structure for primary health and community support does not lead to a greater concentration of resources on the complex

end of patient care at the expense of the health promotion and preventive end of the continuum of service. It appears that this may be a danger, particularly if DHS insists on making increased resources in PHACS services conditional on "measurable reductions in the demand for acute and extended care services" (p.26). The point has been made by many parties since the release of the paper, that many users of community health services would never attend hospital in any case, and that a reduction in preventable illness will not necessarily prevent an increase in demand on hospitals for other reasons. Directly linking increased primary health and community support resources to a reduction in demand for acute care is simplistic and will not necessarily enhance health care in the community.

Shared information systems

The issue of patient confidentiality and privacy was raised by GPD-V with Alan Clayton on 19 July, in the context of a shared IT system amongst the sector. We understand that the Department is consulting with consumer groups, as well as ensuring that the system is consistent with privacy legislation, but would nevertheless like to emphasise the issue from a general practice perspective. GPs have particular concerns about the whole PHACS system having access to information that is disclosed by a patient to a GP. Some divisions of general practice have encountered these issues when running projects that involved the sharing of patient information between a GP and other health professionals. Although these projects involved information exchange only with the written permission of the patient, conflicting legal advice was received in the course of some of the projects about the adequacy of a patient signing a once-off general release form about their health records. These medico-legal questions must be addressed well in advance of setting up a system of sharing patient records, or aspects of records.

Catchment size

As a peak body, GPD-V is unable to make comment on appropriate catchment sizes for specific areas and will leave this to individual divisions. We do point out that communities of interest do not necessarily coincide with sub-regions and such large catchments as those proposed may risk losing the benefits arising from the participation of the community. Because of this, metropolitan catchments larger than one LGA must be strongly justified by health benefit criteria, not simply assumed to be preferable on the grounds of economies of scale or administrative convenience.

Rural areas

While the discussion paper states that "PHACS reforms should complement Healthstreams and MPS initiatives" much more detail is required on the relationship between them. There is some ambiguity in the juxtaposition of the statements that a single provider will not necessarily need to manage all services in the community and that the flexible use of all acute, aged residential and PHACS funds in the community "may be made easier if all are managed by the Healthstreams or MPS provider" (p.33).

GPD-V welcomes DHS' commitment to running half the demonstration models in rural areas and half in metropolitan areas. In order to test out possible solutions to the particular rural issues alluded to in the paper, GPD-V believes it is important that at least half the rural demonstration models are run in areas other than provincial towns, as these more remote areas have quite different needs.

Demonstration projects

We understand that the demonstration projects will commence in the new year. Piloting models in order to adequately evaluate them before imposing a new model across the whole system is a sensible approach. However, this approach can lend itself to allowing demonstration models or pilots to shape the new system simply by force of their own momentum. The demonstration models must be carefully monitored by DHS as they progress so that any elements of the model that do not work most effectively can be altered as they become evident. If, for example, it became apparent that the catchment size initially envisaged did not promote effective health service delivery at the local level, this approach would allow that element to be changed. GPD-V would welcome the opportunity to take up Alan Clayton's offer on 19 July by participating in any working parties convened by DHS to help monitor the development of the demonstration models.

Basis for funding

GPD-V welcomes DHS' move away from output measurement to increased emphasis on improving health status. However, there are some concerns about how this will be measured. The recent and continuing experience of the divisions of general practice as they move towards a framework of outcomes-based funding has given some insight into the difficulty of measuring health outcomes and of attributing that measurement to any particular intervention. From a general practice perspective, the divisions' approach is that GPs need to work in ways that will ultimately contribute to improved health outcomes for a community, but it is outside the scope of divisions to measure those outcomes, which will only become evident in the long term, through statistics collected by other means. DHS will need to ensure that it provides clear direction about health outcome indicators, about what data needs to be collected and about who is responsible for collecting and evaluating what data, in order to avoid general confusion surrounding an outcomes focus. This suggests that research is needed to establish health gain models and to develop health outcome indicators.

Conclusion

While some of the issues raised above can be addressed locally, GPD-V believes that some require structural change or co-ordination and therefore need to be addressed at the state level. Two obvious examples are IM/IT and collaboration between state, commonwealth and local levels of government in working through the details of financing arrangements.

As a purchaser of services, DHS needs to give more thought to how it wishes GPs to be involved in the new PHACS system if it is unable to purchase GP services.

A useful role for GPs may be in assessment and *medical* case management, as distinct from the brokerage and wider case management that the discussion paper model suggests.