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Australian Divisions of General Practice Ltd

Submission to the Parliament of Australia House of Representatives Standing Committee on Health and Ageing: Inquiry into Health Funding

May 2005

Introduction

The Australian Divisions of General Practice (ADGP) is pleased to provide the House of Representatives Health and Ageing Committee with this response to their inquiry into health funding exploring ways in which the Australian Government can improve the efficient and effective delivery of high quality health care to all Australians.

ADGP notes in the Committee's Terms of Reference that particular attention is being given to the following points:

a. examining the roles and responsibilities of the different levels of government (including local government) for health and related services

b. simplifying funding arrangements, and better defining roles and responsibilities, between the different levels of government, with a particular emphasis on hospitals

c. considering how and whether accountability to the Australian community for the quality delivery of public hospitals and medical services can be improved

d. how best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in the various levels of government

e. while accepting the continuation of the Commonwealth commitment to the 30% and Senior's Private Health Insurance rebates, and lifetime Health Cover, identify innovative ways to make private health insurance a still more attractive option to Australians who can afford to take some responsibility for their own health cover.

About ADGP

ADGP is the peak national body of the Divisions of General Practice. It comprises all 120 Divisions across Australia as well as the eight State Based Organisations (SBOs). Approximately 95 per cent of GPs are members of a local Division of General Practice, all of which in turn are members of ADGP. As a result, ADGP, through Divisions, has contact with the majority of grass roots GPs in Australia. This has enhanced communication between the Commonwealth and general practice and has resulted in greater involvement of GPs in various health service initiatives.

Divisions are an integral component of the Australian Government's general practice strategy. They play a major part in implementing policy, supporting general practice and managing health programs at a local level and have been responsible for progressing many of the current developments in Australian general practice. ADGP, through Divisions of General Practice, provides a key local health infrastructure that enables the planning and delivery of primary care services at the local and regional level. In particular, the Divisions network is focused on supporting high quality, evidence based primary care, integrating health services and engaging the local community.

Given the prime role of Divisions within primary health care and general practice, this submission will focus predominantly on item d) from the Terms of Reference (TOR). However, as one of Divisions' key roles is in integrating services within and between sectors, including the hospital and primary health care sectors, other TOR (which place a greater emphasis on acute care facilities) will also be addressed as appropriate.

Response to items

Item d: How best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between private health funds, private and public hospitals, medical practitioners other health professionals and agencies in the various levels of government.

An essential component of Australia's primary health care sector is based on privately owned and operated general practices. Divisions of general practice exist to support this sector and are a key catalyst for positive relationships. One way in which a strong private primary health care sector can be sustained is to continue to resource Divisions of general practice. Divisions are ideally placed to help ensure a strong private primary care sector, both through the support they provide directly to general practices and other primary care workers, as well as through the integration activities they provide through their linkages within the primary care sector and between the acute and primary care sectors.

Specifically:

Support to general practice

Divisions' prime role is to support local general practice and the health needs of the communities that those practices serve. They do this through:

- Providing continuing professional development for GPs and practice staff in order to encourage the provision of quality, evidence-based care to their communities
- Conducting workforce support programs to help both recruit and retain doctors and other health personnel in their local areas
- Offering community based health promotion and self-management programs which emphasise health prevention and early intervention
- Engaging with health consumers as well as with community groups so that health programs can be adapted to best suit the needs of their local communities
- Promoting multidisciplinary team-based care within general practice and the broader primary health care sector.

Practice teams

Divisions support general practice by promoting a team based approach to care and especially encouraging an expanded role for practice nurses through ADGP's practice nurse program. Practice teams provide benefits to professionals working within general practice through, for example, increased collegiate support[1]. Such support helps sustain the general practice workforce – important in a time of workforce shortage. Multidisciplinary practice teams also help improve health outcomes for consumers, particularly with regard to chronic disease[2] [3].

Service integration

In addition to the support provided directly to practices and communities, Divisions engage in a variety of activities which also contribute to enhancing linkages within the primary care sector and between the acute and primary health care sectors by co-ordinating and engaging with various medical and allied health practitioners and other services at the local, regional and state level. Some examples of the ways in which Divisions achieve these linkages are provided below.

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[1] *Watts I, Hutchinson E, Pascoe T, Whitecross L, Snowden T 2004. General Practice Nursing in Australia; RACGP/RCNA.*

[2] *Wanger E, Austain B and Von Korff M 1996. Organizing Care for Patients with Chronic Illness. The Millbank Quarterly (74) 511-534*

[3] *Sibbald B, Luarant M, Scott T. 2002 Changing task profiles in Saltman A, Rico A & Boerma W (Eds) Primary Care in the Driver's Seat? Organisational reform in European Primary Care.*

- **GP Liaison Officers**
  Many Divisions engage in GP-hospital liaison officer activities which seek to promote patient continuity of care between the primary and hospital sectors and improve GP access to hospital services.

  Example: Ballarat Division of General Practice has entered into a partnership arrangement with Ballarat Health Services (BHS) for a formalised GP liaison service. Under the arrangement, the Division funds a GP Liaison Officer (a GP) and provides associated administrative support. BHS supports regular GP attendance at BHS meetings (primarily at Ballarat Base Hospital). The partnership has enabled improved admission/discharge planning, closer interaction between GPs and salaried medical officers and enhanced GP access to hospital services with particular relevance to their patients eg obstetrics, emergency, aged care and psychology.

- **Shared care programs**
  A number of Divisions engage in shared care programs that entail the coordination of services for patients between the Commonwealth and State health sectors.

  Example: Eastern Sydney and South East Sydney Divisions of General Practice operate a joint antenatal shared care program with formalised links with Sydney hospitals and the NSW South East Area Health Service. The program enables patients to receive alternating and coordinated care between their GPs and hospital clinics. A requirement of the program is that GPs are affiliated with the hospitals and attend relevant hospital services with their patients.

- **Discharge protocol development**
  Many Divisions are involved in discharge planning activities that assist patients to move more seamlessly between the hospital and primary care sectors with subsequent improvements in continuity of care.

  Example: Wide Bay Division of General Practice collaborates with Bundaberg Hospital in a joint funding arrangement to improve discharge planning. The project involves a shared clinical nurse working intensively on systems that support optimum discharge planning between the hospital and GPs.

- **Allied health linkages**
  A number of rural Divisions have promoted links between GPs and allied health providers as part of a comprehensive multidisciplinary approach to service provision under the Commonwealth's More Allied Health Services (MAHS) program. The program has enabled rural Divisions to engage in a fundholding capacity with flexibility to implement services appropriate to the local environment. (See also *item a* below for more details on fund-holding).

  Example: Adelaide Southern Division of General Practice has identified access to mental health support services as a key issue for GPs. As a consequence, the Division has facilitated access to psychological services to support GPs in their management of patients with mental health problems in the rural areas of the Southern Fleurieu and Kangaroo Island regions.

- **Linkages with Aboriginal Controlled Community Health Services (ACCHS)**
  In the primary health care sector, the first point of contact of Indigenous Australians to quality primary health care is either through Aboriginal Community Controlled Health Services (local community controlled health clinics) or mainstream general practice. At the local level, the State level and the federal level, Divisions are developing links with Indigenous health bodies to increase Indigenous access to quality primary health care. In a number of cases, Divisions have assisted local Aboriginal communities to establish their own local health clinics, through the sharing of resources and the provision of health professionals to staff these clinics.

Item a: Examining the roles and responsibilities of the different levels of government (including local government) for health and related services.

It is well recognised that the cost shifting that occurs between state and commonwealth governments regarding health funding ultimately detracts from patient care[4]. It is clear that there is still room for optimisation of the public-private sector interface through better integration of services.

Service integration is a key activity for Divisions and one of the many ways that Divisions support general practice to deliver health outcomes to their local communities. Although predominantly Commonwealth funded entities, Divisions are able to bridge the interface between Commonwealth and State funded services. Divisions have proven to be innovative in securing alternate funding sources to enable optimum general practice support and quality patient care. These scenarios provide an example of how Divisions can overcome the Commonwealth-state issue "on the ground". For instance, in Victoria, primary mental health teams have been developed by the state government to deal with many of the high prevalence mental health disorders through early intervention activities. The teams also assist in health promotion activities to raise awareness of mental health in the community.

In North East Victoria, this state initiative has merged with a local rural division. This merged team combines federal allied and mental health funding with state funds from North East Victorian Division of General Practice and North East Health Wangaratta. The teams are co-managed and governed by a business MOU between the Division and NE Health. The result is a united team which delivers better mental health outcomes in more areas with less duplication of resources. The mixed funding has additional benefits in that it increases access not only to care but also to a greater variety of services, so making the advantages of multidisciplinary care more readily available to health consumers.

The appeal of approaches such as this is that they help provide integrated primary health care services without requiring high level political interactions and change "from above". Rather, they show how local level collaboration and cooperation can act to utilise combined state and federal funds so that services can genuinely "sing from the same song-sheet" to provide the goal that all share - improved patient health outcomes.

This idea can be extended to consider a more generalised fund-holding function for Divisions. Divisional fund-holding of pooled funds from different levels of government and other agencies provides a further opportunity to overcome the state-commonwealth divide "on the ground". As Divisions know their local practices and know their communities, it also allows those funds to be better targeted to meet local need.

Example: Brisbane North Division of General Practice is currently trialling a collaborative, coordinated care approach to patients with chronic illness. GPs work in a team with their practice staff and a community nurse service coordinator to manage patient care and coordinate access to other allied health workers and services in the hospital and community setting. Fund-holding by the Division is an important component of the project as it allows funds pooled from commonwealth (Medicare) and state sources to be used flexibly to purchase services for people most at risk. To date, this has resulted in 96% of patients in the trial receiving multidisciplinary care plans and has substantially increased patient access to allied health and other community support services.

Item c: Considering how and whether accountability to the Australian community for the quality delivery of public hospitals and medical services can be improved[5].

In the primary health care sector, accountability for quality service delivery already exists and a continuous quality improvement approach is encouraged. Improvements in accountability for

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[4] *Marcus D. 2000 Prospects for Managed Health Care in Australia Parliament of Australia Parliamentary Library http://www.aph.gov.au/library/pubs/rp/1999-2000/2000rp25.htm#is Website last reviewed Sept. 2001.*

[5] *NB. This item has been interpreted as mainly referring to hospitals and the acute care sector.*

Divisions are currently being advanced through the implementation of a quality framework for Divisions where performance indicators for future funding will be introduced. Furthermore, to ensure the establishment and maintenance of proper governance and administrative processes within Divisions, all Divisions will be required to undertake accreditation. A number of Divisions are currently accredited and all Divisions, SBOs and ADGP will be required to be accredited within the next few years.

Divisions also engage in research activities, often in partnership with Universities. This type of collaborative activity encourages the quality delivery of medical services as it both enables the research agenda to be informed by people "at the coal face" and also assists in the translation of evidence into practice.

Within general practice itself, the Royal Australian College of General Practitioners (RACGP) maintains high standards of practice through accreditation processes and Continuous Professional Development (CPD) which is rolled out to practice staff through Divisions. Core competencies are also being developed for practice nurses, given their increasing role in general practice, as well as for other practice staff.

Despite the current workforce shortage, it is imperative that evidence-based, quality health service delivery is maintained in all sectors of the health system. The funding of collaborative health services research which can be directly applied to both service delivery and policy development will also help in this area.

Item e: Whilst accepting the continuation of the Commonwealth commitment to the 30% and Senior's Private Health Insurance rebates, and lifetime Health Cover, identify innovative ways to make private health insurance a still more attractive option to Australians who can afford to take some responsibility for their own health cover.

Broadening private health insurance to cover out-of-hospital care to include, for example, the co-payment portion of general practice consultations has been suggested in a number of forums as a means of making private health insurance attractive to more Australians[6]. However, such an idea would need to be pursued with caution both to avoid introducing a two tiered system of health care and to avoid the potential for an over-inflation of private health fees without a resultant increase in quality care.

Another approach that might make private health care more attractive to both insurers and those seeking cover is for private insurance to offer more preventive health cover. This could include packages of multidisciplinary care for those with a family history or other risk factors of disease as well as "wellness" checks undertaken within general practice.

Promoting further uptake of private health insurance more broadly will continue to be difficult however whilst access to private hospital and other facilities in regional, rural and remote Australia remains limited or does not exist[7]. Even if a *primary health care only* cover was introduced, it still disadvantages those in rural / remote areas where access to general practice and the allied health workforce is restricted. Addressing health workforce issues and inequality in access to health services across Australia must be a first step to increasing the likelihood of a greater uptake of private health cover.

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[6] *Australian Government Department of Health and Ageing 1999. Innovative Health Care Trial Launched http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-mediarel-yr1999-gt-gt99035.htm*

[7] *Lokuge B, Denniss R and Faunce T. 2005 Private Health Insurance in Regional Australia. eMJA 182 (6):290-293*