

Comments on AGPN discussion paper: blueprint for primary health care organisations

This paper

AGPN has developed a discussion paper about divisions evolving into primary health care organisations, as suggested in the National Hospital and Health Reform Commission's report. ¹AGPN seeks agreement from the Network so that they can negotiate with government about the next steps. This will be the subject of discussion at the Divisions' Network meeting for Chairs and CEOs on 4th November in Sydney.

This paper summarises some key points in the AGPN blueprint, some of the points made at the Victorian forum discussion, points about PHCOs agreed by GPV's working group and board, to suggest responses to AGPN's blueprint about:

- Number of PHCOs – does AGPN's *Blueprint* set number too low?
- Criteria for boundaries – needs to include LGAs and cross-border catchments; and prioritise patient flows
- Need for clarity about PHCOs' main aim to determine the right strategies, membership, governance etc.
- PHCO functions – is there too much emphasis on direct service delivery at the expense of other roles?

AGPN blueprint

The government reports² have only very broad statements about the PHCO's purpose, roles etc. and suggest that each would cover a population of approximately 250,000-500,000 but that other factors would also be taken into account in determining size and boundaries. The lack of detail about purpose and roles, or the relative priority that will be assigned to quite different purposes (e.g. improving access and reducing inequity; better management of chronic conditions; increasing the focus on prevention; or improving quality, safety, performance and accountability³) mean that there are many different ways of interpreting what PHCOs will do, who will be in them, and what divisions will need to do in order to become PHCOs or remain membership-based organisations in a new environment where PHCOs exist.

AGPN suggest different potential pathways that divisions could decide to pursue (p.8), including:

- Evolving into a PHCO and setting up the new entity quickly
- Partnering with other GP Networks and potentially other organisations to set up the entity
- Become a service provider engaged by their regional PHCO or other funders, if they win funding contracts
- Become a member-funded GP support organisation
- Negotiate to transfer some/all of their human capital and infrastructure into a local PHCO and operate as a "spoke" of the PHCO.

AGPN proposes a set of PHCO characteristics (p.10) and proposes (p.33) that 44-55 PHCOs will be responsible for:

¹ *Towards a blueprint for partnership-driven health reform and innovation through Australian Primary Health Care Organisations.*

² The [National Health & Hospitals Reform Commission](#) (see esp p. 205; & p.103) and the [Draft National Primary Health Care Strategy](#) (see esp. p.13). You can find links to these and other relevant documents at www.gpv.org.au; policy & consultation; health reform 2009.

³ These are the four 'priority directions for change' listed in the Draft National Primary Health Care Strategy. p.11.

- planning and development
- workforce development and support
- health service development and delivery and
- population health and community development.

CEOs' and Chairs' input on this is sought under AGPN's question 1 (p.9), which asks if the model (on p.10 & p.33) is broadly acceptable, and (at Q.3) what issues need we need to think through more carefully. Some of these issues are below.

Victorian Divisions' Discussion

The forum meeting (18th September, attended by 26 Victorian divisions) attempted to put aside definitional issues about purpose and roles, partly because of the uncertainty about them (they are being negotiated by governments now) and partly because at the previous forum, divisions had already expressed their wish to continue most of their current areas of work, as well as to broaden their roles, including focusing more on the wider primary health care sector. Instead, the forum allowed time for discussions between neighbouring divisions about geographic scenarios for the size, shape and boundaries of new PHCOs, including discussion of who they would need to work with to form them⁴ and a discussion about what criteria should be used to determine the size and shape of PHCOs. The message from Victorian divisions in general was that in principle they were ready and willing to work with others to take up roles as PHCOs and to make necessary changes to their boundaries whilst recognising that there is not yet a shared understanding of PHCOs' main purpose and functions.

PHCO functions

Division board members and CEOs heard a presentation (by Libby Kalucy) that summarised possible functions of a PHCO:

- supporting collection and monitoring of local population health data
- planning and coordinating services
- supporting prevention activities
- allocating resources for health service delivery
- reflecting on system effectiveness and relative cost-effectiveness
- informing decisions on allocative efficiency across the broader health system

with an indication of how each relates to divisions' experience to date. While divisions have some experience with some of these roles, in other areas they have limited experience, and in some areas, none so far. (Please see the slides – especially # 12 onwards - at

www.gpv.org.au/files/downloadable_files/Policy/Forums%20for%20Victorian%20divisions/PHCOsandDivisions.ppt)

AGPN's blueprint proposes a different set of PHCO functions at p.23. GPV has some concerns about the combination of 'purchasing and brokering services', 'commissioning, changing or developing new services (change management)' 'providing services to fill gaps' and 'direct service delivery or brokerage of a full range of locally relevant PHC services' given that there is little indication that PHCOs' main role is likely to be about service delivery. (This is discussed further below.) Also, there is comparatively little emphasis on coordinating care, including with hospitals (as well as with specialists, and with other primary care providers), which remain important areas to address if we are to achieve a better patient journey.

⁴ The presentation with some maps showing geographic scenarios for PHCOs in Victoria is at: http://www.gpv.org.au/files/downloadable_files/Policy/Forums%20for%20Victorian%20divisions/20090918_presentation_SmallGroupDiscussionIntroduction.ppt

Groups also considered supporting population data for each LGA, PCP catchment and possible PHCO.

Stakeholder views

Libby Kalucy also described some of the reactions of other stakeholders in the health sector, who have expressed concerns about divisions becoming PHCOs. Stated concerns include:

- the likelihood that PHCOs would always have a medically dominant approach rather than act as equal partners
- the current governance arrangements whereby only one component of the primary health care sector is represented, and where there is no representative community governance
- that it may be unlikely to achieve fundamental culture and attitudinal change, as business and operational processes are well entrenched across the Network.

It is important that divisions think about these points of view in order to come to the table and find ways of working productively with other partners to form the new organisations.

Discussion points about the governance model for PHCOs, whether they should be membership-based and who their members would be are at p.27 of AGPN's document. Victorian divisions & GPV have expressed concern about retaining general practice engagement in PHCOs, this having been one of the successes of the Divisions' Program, which has provided a platform through which to improve links between general practice and the rest of the service system as well as improve the quality of general practice services, for improved health of the community. GPV has also advocated for building on the range of existing partnership arrangements and adopting an inclusive approach to planning PHCOs rather than one focused exclusively on general practice. There has been no detailed statewide discussion by divisions of governance and membership of PHCOs to date.

Number of PHCOs

The discussion among groups of neighbouring divisions about geographic scenarios for PHCOs in Victoria was very much an initial discussion, but it did suggest that at the very least there would need to be 13 PHCOs in Victoria – 5 in rural areas and at least 8 in metro areas. (It should be noted that three of these, in the north-west metropolitan area, have populations of over 500,000 – including two with 537,000 and 562,000 already – and given projected population growth, this may give PHCOs too big a catchment population very quickly.)

AGPN's blueprint suggests possible numbers of PHCOs at p.25. We would point out that the reports suggest that the number of PHCOs in Australia is between 43 and 86⁵ and that it may be premature for the Network to suggest as few as 46-51 (or even 45-55 as on p.33)) With its other partners, the Divisions Network would probably find it easy to persuade the government to fund fewer PHCOs, should there be a case to reduce the number; it will be harder to mount a successful case to increase the number. Following clarification of the purpose of PHCOs, detailed mapping will take time – as AGPN agrees, it is about far more than population numbers. It is also worth noting that the NZ PCOs (till now) have served much smaller population sizes (81 have been established since 2002⁶ for a national population of 4.3 million⁷ making the mean PHCO population approximately 53,000) as well as having more narrowly defined aims.

⁵ Based on total Aust population in 2008, (21,432,000 in ABS cat. No 4102.0, Australian Social Trends, Data Cube – Population, released 30 June 2009)/500,000 = 42.8; or /250,000 = 85.7.

⁶ NZ Ministry of Health, Primary Health Care FAQs <http://www.moh.govt.nz/moh.nsf/indexmh/phcs-pho>

⁷ Estimated resident population 4,335,296, October 2009, www.stats.govt.nz/methods_and_services/population_clock.aspx

Criteria for boundaries

Groups also discussed the criteria for determining boundaries of PHCOs. Obviously there needs to be a clear statement of the organisations' purpose and roles before this can be done properly, but the groups took the criteria developed at the time of the Review of the Divisions Program, and used by the Review Implementation Committee, as the basis for discussion.⁸ This set of criteria were generally thought to be very useful, with feedback from most groups confirming that local government areas should be the basic building blocks; that a criteria about patient flows to other services, including hospitals, should be given high priority; and that local communities' own alignments and existing relationships with communities and services should take precedence over consideration of state borders.

Most of these points – with the exception of LGAs and the need for catchments crossing state borders– are included in AGPN's blueprint at p.24, under two listed criteria. It may still be useful to refer to the full list of criteria, to ensure comprehensiveness and we should also ensure that the criteria re patient flows to other services is given high priority.

GPV working group

GPV's Health Reform Working Group met for the first time on 28 August and again on 2 October. The working group recommended to the board that GPV take a leadership role in the development of a model of PHCO that will suit the circumstances of Victoria's primary health care sector and enable all players to have a role in its future development. The board supported the working group's proposal and agreed that:

- boundaries of PHCOs should be based on function not on geography or population alone, and take into account patient flows and pre-existing relationships in the local area between service providers and between organisations including divisions, PCPs, community health services, hospitals, etc.
- GPV should advocate via the General Practice Network Leadership Group (GPNLG) that it is best to take a 'state by state' approach to the formulation of PHCOs, given the differences between state jurisdictions and different pre-existing relationships with other government and peak organisations in each state and territory.
- the first step in working towards a Victorian model is to build on the range of existing partnership arrangements that Victorian divisions have, and the approach taken by GPV needs to be inclusive to avoid alienating key stakeholders, particularly state government departments.
- the shift towards creating PHCOs must be a gradual 'evolution', as these organisations will be very different in their roles and functions to existing divisions of general practice and will require very different skills sets to manage.

Discussion

Scope and function – what's the main aim?

It would be helpful to have some clarity about whether the main focus of PHCOs should be to address disadvantage, to increase access and outcomes for marginalised populations and those whose needs do not tend to be best met by a private business model of primary care. Or whether,

⁸ The criteria were finalised in July 2005 by The Structural Efficiency Working Group – a sub-committee of the Review Implementation Committee (RIC). The RIC was established in 2004 to advise the Australian Government of implementing the Government Response to the Review of Divisions. They are published in the Commonwealth of Australia's 'Future Directions: your toolkit for implementation' and are summarised in GPV's background paper to September 2009 forum.

on the other hand, the primary focus should be to improve quality of the care that is delivered through general practice, where the vast majority of the population access primary medical care. Or whether it should be to collect and analyse population health data, to plan more effectively to address health needs on a regional level (which would include analysing general practice data). Or whether it should be to help primary care settings (including general practice) to focus more on prevention. Or whether it should be to better manage chronic disease in the general community (with the added benefit, of great interest to government, of reducing the rate of increase in demand for hospital services). Although these are not all mutually exclusive aims, the strategies to achieve each one are likely to be quite different. If PHCOs are to address the problem of Australia having no systematic way to ensure quality in primary care, will they have a role in monitoring and/or trying to improve the quality of services delivered in service sites within its catchment area; or will they be concerned only with the quality of services they deliver themselves?

The meeting organised by UNSW's Centre for Primary Health Care & Equity, APHCRI and others on 21st October, attended by a wide range of stakeholders including AGPN and SBOs, made very clear the need for a shared understanding about which problem(s), in order of priority, PHCOs should be trying to solve. To be effective, the PHCO will need to have very clear aims. While these remain unclear, there are a wide range of legitimate but completely incompatible views about the next steps – membership, governance, responsibilities, etc.

Scope and functions – deliver some services/all services? or build capacity of other services?

The government reports do not suggest that the primary purpose of PHCOs would be service delivery. This point has been reiterated by the Chair of the NHHRC, Christine Bennett at the August CEOs and Chairs meeting, and recently, again by Warren Snowdon, Minister for Indigenous Health, Rural and Regional Health and Regional Services Delivery, at the VHA conference, where he said that in his view PHCOs would be purchasers not providers of services.

AGPN suggests that PHCOs have a role in service delivery (p.19, 21-22) and also suggest that if a division decided not to become a PHCO, a major remaining role would be to deliver services, under contract to a PHCO.

Victorian divisions have experience with delivering or brokering services to meet some gaps in service delivery, with programs like MAHS and ATAPS. GPV has advocated that it is appropriate for divisions to deliver services in this way, where they complement and link to existing general practice care, but not to set up a separate, competing service delivery infrastructure, which would risk duplication, inefficiency and poor continuity of care for patients, by failing to link back to the usual general practice. This position has been supported by Victorian divisions. The major primary care service delivery structures in Victoria exist outside divisions, in private general practice, private allied health services and community health services.

If one of the problems with the current service system is that there are multiple providers and the system is fragmented, then adding in yet another provider is unlikely to help. There may be worth in having the PHCO concentrate on planning, coordination, commissioning and improvement activities, rather than get distracted by direct delivery. It is also worth noting that in the UK, PHCOs are moving away from attempting to both purchase and provide the services necessary for an area.⁹

⁹ Department of Health, 'Transforming community services: enabling new patterns of provision,' January 2009. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093197