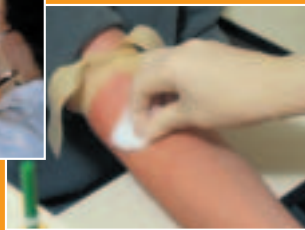


# Study of General Practitioners in Community Health Services Summary Report



Study of General Practitioners in  
Community Health Services  
Summary Report

Published by the Victorian Government  
Department of Human Services  
Melbourne Victoria

June 2002

Also published on  
[www.dhs.vic.gov.au/phkb](http://www.dhs.vic.gov.au/phkb)

© Copyright State of Victoria, Department of  
Human Services, 2002

This publication is copyright. No part may  
be reproduced by any process except in  
accordance with the provisions of the  
Copyright Act 1968.

**Disclaimer**

The views expressed in this report are solely  
those of the responsible consultants and do  
not necessarily reflect the views of the  
Department of Human Services, State  
Government of Victoria.

This study was conducted by Burgell  
Consulting Pty Ltd, O'Leary & Associates  
and The Department of General Practice,  
The University of Melbourne Faculty of  
Medicine, Dentistry and Health Sciences  
during 2000–2001.

Contact details:

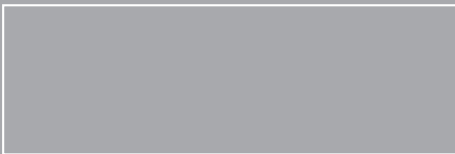
Community Health Policy  
Primary and Community Health Branch  
Department of Human Services, Victoria  
555 Collins Street  
MELBOURNE 3000  
Ph: (03) 9616 8047

(1480402)

# Contents



Executive Summary	1
Introduction	9
Methodology	11
Field Responses Provided by General Practitioners	15
The Community Health Services Profiles	27
Financial Profile	31
Guidelines for Break Even Financial Performance	37
Barriers To Achieving Break Even Financial Performance	41
Information Systems Support for General Practitioners	43
Project Evidence and Conclusions	47
A Review of Related Research and Literature	55



# Executive Summary

## Study of General Practitioners in Community Health Services

A major conclusion derived from the field investigations of this project is that statewide policy and program recognition of the role of General Practitioners (GPs) in Victorian Community Health Services (CHSs) is inadequately defined and supported. The project also acknowledges that Government funders and CHS management are seeking to better specify the service outcomes sought from CHS GP service delivery.

A main reason for the lack of program clarity about this significant field of service provision is that GP service delivery in CHSs is a Commonwealth-funded activity that occurs within a State-funded agency service setting. GP service provision is a CHS discretionary activity undertaken by some CHS agencies in Victoria and because this provision is not State-funded, it usually does not form part of service agreements between the Department of Human Services and CHSs. Also, the policy objectives and program guidelines that normally underpin the Department's funded services in CHS settings do not apply to GP provision. Likewise, the Commonwealth Medicare Program, which funds GPs in CHSs, offers very limited program guidance about the preferred or special roles of GPs in CHSs, with the possible exception of the recently introduced Enhanced Primary Care (EPC) package of reimbursable service items.

GP service delivery work in CHSs:

- (a) Is usually not subject to specific service agreements between CHSs and Commonwealth or State governments.
- (b) Is not underpinned by a targeted set of policy and program guidelines that define the preferred contribution of this group of health professionals. Also, consistent statewide program management information systems have not been put in place to regularly review and measure GP performance in CHS settings.

A lack of program guidelines and associated program monitoring of GP activity in CHSs presented the project with a major methodological challenge. Program performance data that can demonstrate the contribution of GPs in CHSs is either not being collected by CHSs and the Department of Human Services or is not available in accessible forms. As a result, system-wide evidence about the possible unique roles of GPs in CHSs in relation to the Department's primary care policy including the social model of health approach and Primary Care Partnerships (PCPs) is not being readily generated. In response, the project has been required to pursue alternative intensive investigative effort to gather reliable evidence that illustrates the client service impact of GPs in CHSs.

The scenario of limited statewide program definition combined with underdeveloped systems of data collection has acted as a major influence on the way aspects of the project have unfolded and how findings have been interpreted and recommendations prepared.



## Major Findings

The findings set out below need to be qualified by the limitations the project has experienced in gathering field evidence. This issue is addressed in more detail later in the report.

### Clinical Practice Findings

- GP service delivery in CHSs has demonstrated a capacity to meet complex primary care needs of socially disadvantaged groups.
- GPs and other CHS personnel across the survey population have consistently reported that GP client service in CHSs is regularly occurring on a collaborative basis with other CHS health professionals and this collaboration is enhancing the capacity of GPs and health professionals alike to respond to complex client needs.
- CHS GPs are more likely to service greater numbers of non-English-speaking background (NESB) clients and clients who are health card holders than their GP colleagues in private practice.
- GPs in CHSs are more likely to service greater numbers of complex client mental health problems, including schizophrenia and psychosis, than their GP colleagues in private practice.
- GPs in CHSs are more likely to service greater numbers of serious client drug and alcohol problems than their GP colleagues in private practice.
- GPs in CHSs are more likely to see greater numbers of female clients from socially disadvantaged backgrounds who present with sexual and reproductive health needs involving complex biological/social factors than their GP colleagues in private practice.
- GPs in CHSs are more likely to refer their clients to allied health professionals for problems such as, sexual and reproductive health, drug and alcohol, mental health, obesity and foot problems than their GP colleagues in private practice.
- CHSs GPs interviewed by the project reported using client diagnostic and assessment approaches which identified the interaction of biological, psychological and family/community/social influences in determining the problems and needs of the presenting client.
- GPs in CHSs believe current national/international clinical primary care classifications do not adequately capture an understanding of many of the complex client problems they address.
- Working in collaboration with CHS allied health professionals and other community services, GPs in CHSs often respond to domestic violence, homelessness, the impact of unemployment, loss of income and other social problems experienced by presenting clients.

# Executive Summary

- GPs in CHSs located in rural and remote communities where private practice GP bulk billing levels are low, often provide the only affordable and accessible medical service for low income community residents.
- Enhanced Primary Care Medicare Benefits Schedule (MBS) items are at a beginning stage of usage by CHS GPs.

## Cost Focused Findings

- Great variation exists in the cost performance of GP services in CHSs.
- The average financial results per clinical consultation for GP services in CHSs involve a cost of \$30.28 and income of \$29.03 for an operating loss of \$1.25, while across individual CHSs the bottom line varies from a \$18.15 loss to a \$5.16 profit.
- The average financial results per medical Equivalent Full Time (EFT) position for GP services in CHSs involve a cost of \$159,462 p.a. and income of \$151,790 p.a. for an operating loss of \$7,671 p.a. Across individual CHSs, the bottom line varies from a \$71,130 p.a. loss to a \$5,779 p.a. profit.
- GPs in CHSs claim 15 per cent of their MBS reimbursement as long consultations compared with other data suggesting that private practice GPs claim 9 per cent as long consultations. Moreover, client service throughput for CHS GPs is 3.3 consultations per hour compared with available projections for private practice of 3.9 per hour.
- These figures linked to other data collected by the project suggest that, in comparison with private practice counterparts, CHS GPs are likely to spend more time in consultations and they do this because their clients present with greater levels of problem complexity.
- MBS funded GP service provision in CHSs that reflects a 'social model of health' approach and responds to complex client problems should be achievable on a 'break even' financial basis (with the possible exception of delivery to remote communities). Achieving this requires an intentional fostering of effective service interaction between GPs and other health professionals in the CHS. This requires the planned and focused deployment of State program funded resources and infrastructure to support the work of doctors.
- 'Adding value' to GP service delivery is likely to require both a targeted reallocation of existing resources within individual CHS budgets received from the Department of Human Services and some Department pilot support of innovative initiatives.

## Program Development and Service Management Findings

- Survey results drawn from the University of Melbourne's Integration Index for private practice GPs and CHS GPs show that there is little difference between the self-perceptions of both groups regarding the extent to which their own professional practice is integrated.
- The extent to which GPs are involved in the full range of programs/service types delivered by individual CHSs varies statewide. Many CHSs have participation from their GPs in the majority of categories of direct client service that is offered. Some CHSs have little involvement from their GPs in other forms of CHS direct client service delivery.
- On a statewide basis, GP involvement in preventive activities delivered by CHSs, such as population health, health promotion and service development, is infrequent. GPs and others in CHSs have frequently reported a potentially valuable role for GPs to play in CHS multidisciplinary teams in these fields. Currently this role is impeded because MBS funding does not support GPs undertaking non-direct client contact work.
- The level of formalised/structured program collaboration between GPs and other professional staff in CHSs, including the use of common client assessment frameworks and client assessment tools and planned service development meetings, is generally limited.
- Informal collaboration between GPs and other professional staff in individual CHSs is generally frequent and producing skill and knowledge benefits for both groups and enhanced service outcomes for clients. However, for these gains to be maximised, a significantly greater level of formalised/structured collaboration is needed.
- The level of effective collaboration between GPs and other health professionals in CHSs is being impeded because client information systems and performance monitoring arrangements in CHSs are not capturing the extent of common involvement of both groups in service provision to clients.
- The use of the MBS EPC items by doctors in CHSs provide an important Commonwealth funding base to help facilitate collaboration with CHS allied health professionals to deliver social model of health care for clients and to achieve important objectives of the Victorian Government's PCP program.
- CHSs arguably provide the greatest diversity of primary care resources/services of any type of Victorian service agency. Consequently, CHSs are service settings rich with opportunity to achieve the integration of medical and allied health services—a major outcome objective of both the Victorian PCP and the Commonwealth EPC.

# Executive Summary

- GPs services in CHSs will more fully express the PCP objectives of a social model of health if there can be targeting of CHS allied health case management resources to support internal service coordination with doctors for client assessments, care plans and case conferences funded under the EPC items.
- In the context of the PCP, a case exists for the provision of Department funding to CHSs to help achieve improved internal integration of GP and allied health activity in relation to:
  - Service delivery to remote communities where private practice bulk billing levels are low;
  - Responses to complex medico/ social problems of socially disadvantaged client groups including NESB women, refugees, victims of torture, homeless people and long term unemployed people; and,
  - The use of the EPC items to better target socially disadvantaged client groups who have complex needs and the development of integrated client service information systems.
- The project has not found a preferred model for GP engagement in CHSs, salaried and private practice co-location options both have the potential to achieve the outcome objectives for service provision articulated in the PCP program. Likewise, each option can achieve a break even financial performance.
- About half the GPs engaged in CHSs are also engaged in other GP practice settings, such as a local private practice or in hospitals. These multi-setting involvements of CHS GPs help in promoting links between CHSs and GP services based elsewhere in local population catchments.
- The quality of integrated care and the financial performance of GP service delivery in CHSs depends on three main factors:
  - (i) The effectiveness of internal CHS program integration between GP and allied health resources;
  - (ii) The capacity of the CHSs to report and monitor this service integration; and
  - (iii) The development of statewide Department of Human Services guidelines to better define and support CHS GP roles and service outcomes in the context of PCP and other Departmental community health objectives.

## Recommendations

1. Department of Human Services prepare statewide policy and program guidelines to support and develop the effective provision and monitoring of primary care service activity in CHSs, which integrates the allied health and GP resources of the CHS.
2. These policy and program guidelines should clearly define:
  - Client outcome expectations;
  - Collaborative delivery practices between GPs and allied health services;
  - Common client assessment tools for use by GPs and allied health services; and,
  - The client information system infrastructure required for the integration of GP and allied health service activities.
3. In the context of PCP and the social model of health approach, Department of Human Services work with CHSs to strengthen the integration of CHS allied health services with CHS GP activity.
4. This should include other CHS health professionals working closely with CHS doctors to help achieve integration in the following priority target areas:
  - Service delivery to remote communities where GP private practice bulk billing levels are low.
  - Service delivery to socially disadvantaged client groups with complex needs including NESB women, refugees, victims of torture, homeless people and long term unemployed people.
  - EPC service delivery to socially disadvantaged client groups with complex needs.
5. The Department of Human Services work with CHSs to achieve effective integration of GP and other health client service information systems within CHSs based on the implementation features set out in the section of this report entitled Information Systems Support for General Practitioners.
6. That Department of Human Services advocate with the Commonwealth Department of Health and Aged Care to enhance Practice Incentive Payments (PIP) so that they adequately recognise the practice infrastructure demands of GP practices, such as those in CHSs whose focus is upon providing GP services to socioeconomically disadvantaged clients with complex needs in urban, regional and remote communities.
7. That, in conjunction with the actions recommended above, a task group including representatives from CHS GPs and CEOs, Department of Human Services and the Commonwealth Department of Health and Age Care address the following matters of priority:
  - Funding arrangements to support CHS GPs in population health roles with an emphasis on responding to complex needs of disadvantaged communities.
  - The development of formal structures in CHSs to enhance team coordination and sharing of medical and service information.
  - An incentive based career structure for GPs working in CHS settings which offers some diversity in roles including direct client service delivery, population health, service planning and teaching which incorporates appropriate GP remuneration levels and/or engagement arrangements.

# Executive Summary

- The creation within CHSs of accredited general practice vocational teaching posts to provide GP registrars with vocational training experiences in CHS settings. This strategy to be implemented in conjunction with The National Board of General Practice Education and Training (GPET), The Royal Australian College of General Practitioners (RACGP), regional general practice vocational training consortia and General Practice Divisions of Victoria (GPDV).
8. That CHS management uses the Financial Break Even guidelines in this report as a tool to help manage costs associated with CHS GP service delivery.



# Introduction



This report documents an investigation and review of the role of GPs in Victorian Community Health Services (CHSs) conducted by consultants for the Victorian Department of Human Services during the period 2000–2001.

## Project Objectives

The project investigated GP roles in CHSs in relation to the following research objectives agreed between the Department of Human Services, the project team and the project reference group:

1. Establish a statewide profile of GP service activity in CHSs.
2. Conduct a review of professional practice of GPs in CHSs. Including, reviewing the effectiveness of professional practice of GPs in CHSs in relation to claims that these GPs are able to:
  - Effectively address the health/medical needs of clients who have complex needs and/or are socially disadvantaged.
  - Effectively utilise client health need/health risk assessment tools and criteria which are common to a range of health professionals in the local service setting and reflect primary health care/social model of health principles.
  - Effectively engage in teamwork with other health professionals to provide clients with integrated pathways of care (which may include case management arrangements where one professional—GP or otherwise—is assigned a lead worker role).
  - Effectively blend curative and health promotion roles on a regular basis in their day-to-day practice.
3. Based on field evidence gathered and review of other research, develop a preferred practice framework statement for GPs operating in a CHS context.
4. Based on field evidence gathered and other available data, identify indicative benchmark costs for GP service delivery in a CHS context.
5. Identify preferred models for GP employment/engagement or linkage arrangements with CHSs for the delivery of GP services within, or in association with, CHSs.
6. Ensure all project investigations adequately address metropolitan and non-metropolitan needs variations.
7. Based on project conclusions, develop appropriate recommendations about GP service delivery in CHS contexts with reference to Victorian and Commonwealth Government policies.





Outlined below are the core elements in the project methodology.

## 1. CHS Profile Analysis

Interviews were conducted with CHS managers and senior management teams to gain qualitative and quantitative information on the context, goals and operational issues associated with GP service delivery in CHS settings.

A standardised interview schedule was used. The profile sought to capture information, which included details of: funding sources; client and hourly service costs; client consultation throughput numbers; professional EFTs; and CHS engagement arrangements applying to GP service delivery.

The schedule also sought information about coordinated client care service provision between CHS GPs, CHS allied health workers and other local services including private GPs and Divisions of General Practice. The schedule also asked for information on the number of clients being seen by both GPs and allied health professionals in the CHS, the socioeconomic status of CHS GP clients, and the relative amount of GP involvement in clinical, case management, service planning and health promotion activities.

Managers who were not in a position to meet with the project team were encouraged to complete the schedule and return it for project analysis.

## 2. The Integration Index for General Practice

This instrument was developed by the Department of General Practice and the Centre for Health Program Evaluation at the University of Melbourne with Commonwealth research funds (General Practice Evaluation Program) and has been piloted with several Australian Divisions of General Practice.

The Integration Index is a survey completed by the GP, taking 10–15 minutes. It comprises 70 statements measuring 14 different aspects of integrated practice. These aspects of GP integration were identified by earlier research as constituting the daily practice of a ‘well integrated GP’.

The Integration Index was distributed to all GPs believed to be working in CHSs and the results returned from the survey were used to inform aspects of the research objectives outlined above.

## 3. GP Interviews

The final part of the core methodology involved field interviews with CHS GPs. An interview schedule was prepared which addressed:

- (i) The GP's client practice profile against the national profile for GPs generated from the Bettering the Evaluation and Care of Health (BEACH) study.
- (ii) The GP's use of the EPC items recently introduced to the MBS.
- (iii) Information about a range of other issues about the GPs in CHSs role which had either not been collected in earlier stages of the methodology or required further clarification.

## 4. Supplementary Gathering of Information and Literature Analysis

In addition to the activities described above, the project gathered other field information in various ways. This included follow-up telephone requests for data or data clarification with CHSs, several group discussions with GPs in specific CHSs, a small field trial with GPs in one CHS to assess the extent of allied health collaboration in client service delivery and supplementary visits to relevant sites or organisations. These included specific CHS service locations, GPDV, Department of Human Services program units (including the GP Unit and the Community Health Program Data Unit) and the Victorian Healthcare Association (VHA).

Throughout all inquiry steps, the project was guided by a literature review of relevant national and international research findings, which informed GP community health roles.

### Refinements to the Methodology

In response to results emerging from the Integration Index and Profile Survey stages, the project made some refinements to the methodology.

The Integration Index results showed little difference in practice integration levels between GPs in CHSs and other populations of GPs. This result can be attributed to the small numbers of GPs in CHSs and the small sizes of other GP populations for which the University had trialed the Integration Index and gained results. The lack of role clarity for GPs in CHSs was also a likely contributor to this result pattern.

Secondly, systems and procedures in CHSs for capturing data about GP roles were very underdeveloped. Consequently, adequate information was not available to make confident observations about the work of GPs in CHS settings. This caused the project team, in conjunction with the Department of Human Services, to re-evaluate how the project should proceed in order to gather adequate evidence about GP roles in CHSs. It was therefore decided to intensively interview GPs in all participating CHSs and capture their 'practice narrative' in a structured form.

This approach was undertaken in preference to proceeding with several focus groups of CHS GPs, allied health staff and managers in a process of validating evidence gathered from the earlier project stages.

### Target CHSs and Respondent Levels

The project drew on three principal databases of Victorian CHSs. One was compiled by the VHA for communication with its membership. The other two came from Department of Human Services with one compiled from regional office information and the other via contact data held at central office. To clearly establish those CHSs with a medical service, the team cross-checked the contact databases with:

- (a) Reference group members who had working contacts with CHSs; and,
- (b) The project team's own knowledge of the Victorian community health system.

In addition, the VHA, via a newsletter to all its CHS members, encouraged all centres with doctors to participate in the project and to contact the project team for further information.

## Numbers of CHSs and GPs

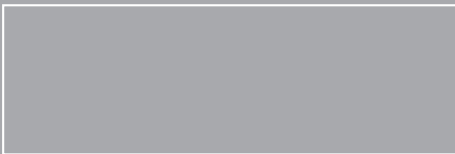
Based on its field investigations, the project concluded that there are 100 service entities in Victoria commonly regarded as generalist CHSs of which 30 engaged GPs during the project. Collectively, these 30 CHSs were estimated to engage a total of at least 118 GPs on a regular basis (excluding locums) and commit through direct employment or private practice co-location at least 29 medical EFT. All 30 CHSs made contributions to the project investigations.

## Gaining CHS and Doctor Participation in the Study

Further to the VHA newsletter, the project team wrote to CHSs CEOs, for the purposes of explaining the project objectives and methodology and requesting their cooperation. Included in this initial correspondence was a letter to each doctor in the CHS together with the Integration Index questionnaire. Doctors were asked to complete the questionnaire and return it.

Two weeks later, the Profile Survey was sent to managers and arrangements were made for follow-up visits by the project group to meet with the CEO and, where possible, the senior GP or practice manager or other senior team members.

Individual interviews were then sought with GP representatives of all CHSs who had agreed to participate in the study. GPs not able to participate in a direct interview were asked to return the completed interview schedule to the project team. This phase also included group discussions with GPs in two CHSs and a small field trial in one CHS.



# Field Responses Provided by GPs



This section summarises responses made by CHS GPs to the aspects of the project methodology that sought to directly engage doctors. It provides a precis of data returns, findings and conclusions for the Integration Index Survey, the GP interviews and several other project components, which consulted directly with CHS doctors.

## Victorian Community Health Centre GP Integration Survey

### 1. Introduction

The GP Integration Index has been developed and validated specifically for the Australian health care setting by a team of researchers from the Departments of General Practice and Public Health at The University of Melbourne. The index has been trialed in two Divisions of General Practice in Melbourne and has been applied in different GP intervention projects. Its properties have further been studied by 25 Divisions of General Practice across Australia.

#### *What is the Integration Index?*

The GP Integration Index is a survey completed by the GP taking 10–15 minutes and comprises 70 statements measuring 14 different aspects of integrated practice. These aspects of GP integration were identified by earlier research as constituting the daily practice of a ‘well integrated GP’.<sup>1 2 3 4</sup>

Contained in the Integration Index are nine aspects of integrated practice relating to GPs’ clinical roles and wider involvement in community health. These are holistic patient

care, GP flexibility, provision of information to patients, attitudes to teamwork, liaison, care coordination, hospital role, community health and health planning and policy. An additional five aspects termed ‘enabling factors’ relate to influential environmental factors and contextual issues. These are GP knowledge of local services, time and funding, practice organisation, personal care domain and information technology (IT). The integration factors can be further summarised into two higher order factors discerning the clinical role from the community health role. These two larger factors are called: Patient Care Management (PCM) and Community Health Role (CHR). Overall, the Integration Index can be seen as a useful tool for describing significant GP roles in the context of a social model of health.

### 2. Survey Procedure

CHSs known to operate a GP service were forwarded copies of the Integration Index survey instrument and all GPs engaged by these CHSs were requested to complete the survey. Seventy-two completed surveys were returned from 19 CHSs, which constituted a useable response rate of 61 per cent.

### 3. Characteristics of Survey Respondents

Of the respondents, 52.1 per cent were male and 47.9 per cent female; 79.2 per cent had graduated in Australia during 1979 to 1989; 93 per cent were vocationally registered; 9.3 per cent were members of a Division of General Practice and 62 per cent were

<sup>1</sup> Southern D., Appleby N., & Young D. (2001), Integration from the Australian GP’s perspective, *Australian Family Physician*, 30(2), 182–188.

<sup>2</sup> Appleby N., Dunt D., Southern D., & Young D. (1999), General Practice Integration in Australia: Primary health services provider and consumer perceptions of barriers and solutions, *Australian Family Physician*, 28(8), 858–863.

<sup>3</sup> Southern D., Batterham R., Appleby A., Young D., & Dunt D. (1999), The Concept Mapping Method: An Alternative to Focus Group Inquiry in General Practice, *Australian Family Physician*, 28(1), S35–S40.

<sup>4</sup> Batterham R., Southern D., Appleby N., Elsworth G., Fabris S., Dunt D., & Young D. (2001) Construction of a GP integration model. (In press: *Social Science & Medicine*)

members of the Royal Australian College of General Practitioners (RACGP).

Forty-three per cent worked solely in the CHS setting while 57 per cent worked in a combination of settings, including the CHS, private general practice and hospitals. Sixty-seven per cent worked more than 30 hours per week; 74 per cent were employees of the practice where they worked; 15.3 per cent were a sole proprietor or partner and 12.5 per cent had other employment status. One type of after hours care service was provided by 76.4 per cent; 16.7 per cent provided two or more types of after hours service and 6.9 per cent provided none.

### Integration Index Scores

The average score for each integration factor from the CHS GPs were compared with earlier surveys of GPs in two Victorian GP Divisions conducted in 1998 and 1999. All GPs within the Divisions' catchment areas had been surveyed.

*Figure 1: Average Integration Factor Scores*

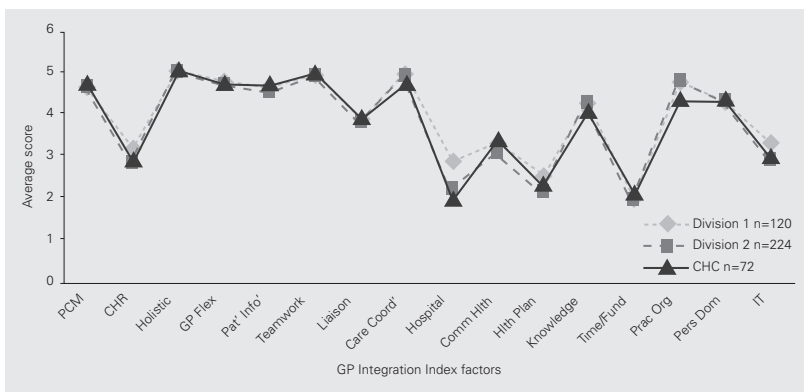


Figure 1 above shows the results pattern for the various Integration Index items for the CHS GP group compared with the GPs from

the surveyed divisions. The results showed essentially no discernible difference between the GPs from the CHS sample and those from the two Division surveys regarding the extent to which they reported their roles as being integrated, based on the survey items.

The results from the CHS GP and Division GP samples involved a total of 416 practitioners, which represents a very small proportion of the Victorian GP population. Also, a number of CHS GP sample respondents might have also participated in the earlier Divisional surveying thus helping to explain the lack of differences detected.

Moreover, during the earlier surveying, both Divisions were engaged in strategic activity, including moves to outcomes-based funding or the conduct of specific integration projects which could have raised a special awareness of integration issues not existing in other parts of the GP population.

Finally, there were major variations in the amount and exclusiveness of work time that CHS GP respondents were actually engaged in the CHS setting. Consequently, these factors could have distorted the extent to which the results from the sample groups reliably indicate comparative integration performance between CHS practitioners and those in private practice.

Taking into account the survey limitations discussed above, it is evident that, for the sample groups involved, GPs' perceptions of how well they are able to work with others does not differ between those working in the CHS setting and those who describe their practice setting as private.

# Field Responses Provided by GPs

## Interviews of GPs in Community Health Services

Thirty-eight doctors in 18 CHSs were either interviewed with a standard schedule or returned responses to the schedule's questions about important aspects of their practice. The interview questions included CHS GPs being asked to compare their patient profile against the national patient profile for Australian GPs documented through the BEACH study. Other questions asked the doctors their take up of EPC items, their usage of computers in everyday practice, the unique health care advantages that they believed derived from GP services being delivered through CHSs and their understanding of holistic care.

A small field trial was also conducted in one CHS that documented the extent to which three GPs collaborated with other health professionals.

In addition, some practice snapshot information was gathered from several CHS GPs about multidisciplinary referrals and approaches to billing for longer consultation items.

## The BEACH Study

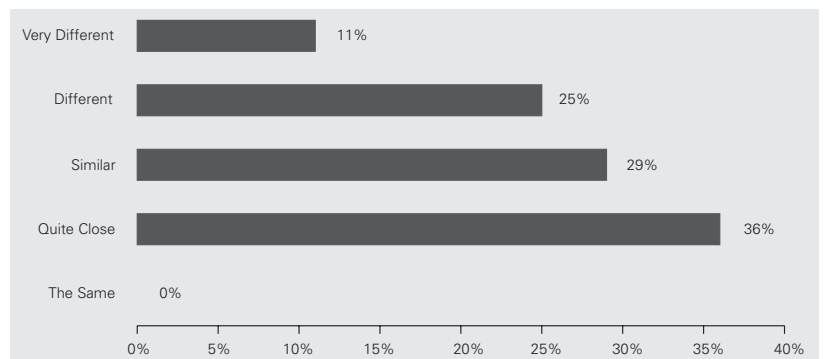
The BEACH Project is conducted by the General Practice Department at Sydney University in conjunction with the Australian Institute of Health and Welfare (AIHW). The BEACH study regularly collects information about the patients seen, reasons people seek medical care, the problems managed and the treatments provided in general practice in Australia.

*Were the patient problems most frequently managed by CHS GPs the same as for Australian doctors in general as reflected in the BEACH Study?*

Thirty-six per cent of CHS GPs considered their profile of top ten most frequently managed patient problems to be different or very different to the BEACH national profile, while the remaining 65 per cent of respondents described their own profiles as similar or quite close to the BEACH study.

The following figure depicts these responses.

**Figure 2: Most Frequently Managed Patient Problems Compared to BEACH National Profile**



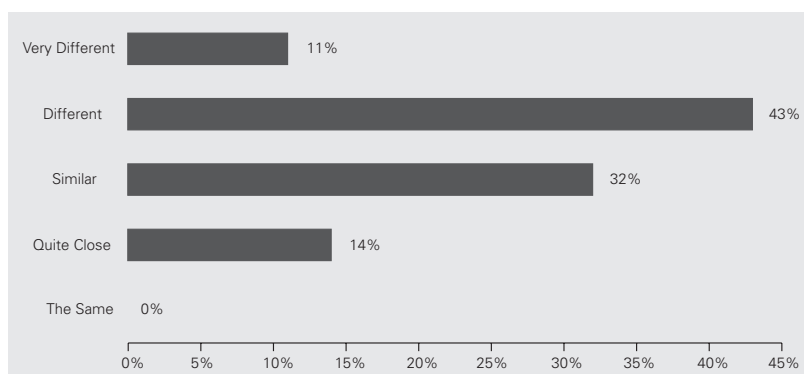
The quantitative and qualitative responses given by CHS GPs to the items on the interview schedule make it clear that the top ten frequently managed patient problems for this group of doctors varies significantly from the Australian profile. The important differences are that the CHS GPs top ten problems included female sexual and reproductive health issues; complex mental health conditions including schizophrenia and bipolar illnesses; alcohol and drug problems; heart disease; and dermatitis and related skin conditions.

Similarly, the CHS doctors indicated that their profile of the top 30 most frequently managed patient problems varied from the BEACH national results by the inclusion of the following items: obesity; management of chronic and complex multi-system conditions; preventive and curative responses to smoking; domestic violence; social support responses arising from the low income or homeless status of patients; problems involving the GP in case management; and travel medicine.

*Were the most frequent reasons given by patients for seeking the help of GPs in CHSs the same as the reasons given for patients visiting Australian doctors in general?*

As outlined in Figure 3 below fourteen per cent of GPs in CHSs considered that the top ten patient reasons given by their patients were 'quite close' to that of the BEACH results and 32 per cent regarded them as 'similar'. Fifty-four per cent believed their patients' top ten reasons to be different (43%) or very different (11%) from the national profile.

**Figure 3: Top Ten Reasons Given by Patients for Visiting CHS GP Compared with National Profile**



CHS GPs believed that the top ten reasons given by patients for seeking their help differed from the national profile by inclusion of the following reasons: patients reporting experiences of complex mental illness; female patients referring to sexual and reproductive health problems; patients indicating they had drug and alcohol related health conditions and included demands for detoxification or methadone treatment; patients complaining of insomnia; patients feeling weak or tired; and patients complaining of shoulder problems.

Doctors in CHSs also indicated that the top 30 most frequent reasons given by patients for seeking their help varied from the national pattern by the inclusion of 'dizziness' as a reason given by NESB groups; 'not feeling well' and 'sore feet'. CHS GPs also believed that 'anxiety' as a reason for their patient's presentations should be given more prominence in their top 30 patient reasons than reflected in the national profile. Moreover, while the BEACH results showed that 'general check up' was a top 30 patient reason, CHS GPs believed that their patients were inclined to be more specific about the particular health problems or conditions they wished the doctor to check.

*What were the most common problems addressed by CHS GPs which required allied health referral in comparison with the national profile of Australian doctors?*

Four per cent of CHS GPs believed their practice profile was 'the same' for the top ten most common problems involving allied health referral as for Australian doctors in general. Forty-three per cent of CHS respondents considered their practice to be 'different' (29%) or 'very different' (14%) from that shown in the national profile for this aspect of practice.

## Field Responses Provided by GPs

For their top ten problems involving allied health referral, CHS GPs more frequently referred the following problems for allied health assistance than did their counterparts in the wider Australian GP community: female sexual and reproductive health problems which required counselling, complex mental health problems, alcohol and drug problems, obesity and foot conditions. Also the following problems were included in the list of top 30 problems referred for allied health assistance by CHS GPs but not reflected in the same listing category for the wider GP community: incontinence, aged care assessment, domestic violence, homelessness and income support.

### *Does the international clinical classification system used by the BEACH study effectively capture the types of problems dealt with by GPs in CHSs?*

CHS GPs believe that the clinical classification system used by the BEACH study did not fully capture many of the challenging problems this group of doctors continually responded to. These included complex multi-system conditions with interacting physical, psychological and social components, such as frail aged problems, sexual and reproductive health issues, alcohol and drug addiction, physical illness of people with intellectual disabilities, homelessness and domestic violence. Also, these doctors considered that the classification system did not adequately address problems presented by NESB patients; complex mental health issues, service coordination needs; and check ups for specific, ongoing or chronic conditions.

## Other Characteristics of Patients seen by CHS GPs

### *Age and Gender*

While the project was unable to get consistent or detailed data on the age and gender characteristics of patients seen by doctors in CHSs, respondents to the interview schedule provided some indicators of the relationship of their patient profile to the BEACH national results. This included results showing that 79 per cent of GPs in CHSs indicated that their age and gender patient profile was different to that shown in the BEACH study.

### *Health Card Holders*

All CHS GPs indicated that their patient profile for health card holders was different to the BEACH profile. Those GPs who were able to indicate a percentage, placed health care card holders as constituting nearly 100 per cent of their patients. This is a significant difference from the BEACH percentage of 47.3.

### *NESB*

Ninety-three per cent reported their patient profile differed from the national picture for NESB patients. The majority of services indicated that their NESB patient percentage was significantly higher than BEACH but a small number of rural services reported they saw less.

### *Aboriginal and Torres Strait Islander (ATSI) Patients*

Seventy-one per cent of CHS based doctors reported their patient profile for ATSI varied from the general pattern for Australian doctors. Some services see many less ATSI patients than BEACH and others many more. This pattern related to each service's geographic location in areas of concentration of ATSI communities in Victoria.

## CHS GP Service Delivery in Comparison with National GP Profile Data

Responses by CHS GPs reviewing their patient profile data against national GP profiles gathered through the BEACH study, indicate strongly that in comparison with GPs in the wider Australian community, CHS GPs uniquely focus on providing services for socially disadvantaged patients with complex needs. CHS GP services have a strong service orientation towards NESB communities, ATSI communities, low income households including those receiving social security support, homeless people and other groups in society prone to being marginalised. Moreover, in responding to disadvantaged groups, CHS GPs address complex patient needs and problems involving physical, psychological and social factors. These include complex mental health issues, drug and alcohol addiction and misuse, domestic violence, sexual and reproductive health issues and conditions arising from limited lifestyle opportunities including cardiac illness and obesity. CHS GPs are also more likely to refer to allied health professionals when addressing these needs and problems than are GPs in the wider Australian community.

## Enhanced Primary Care Package

### *Take up Levels of the EPC Items*

The EPC items were introduced in November 1999 and CHS GPs were asked to indicate their take up levels for these based on their usage of the items during 2000. The GPDV April 2001 newsletter reported that as of 28 February 2001 the take up levels for all EPC items was 46 per cent of all GPs for

Victoria and South Australia, 41.5 per cent for Queensland, 40 per cent for Tasmania, 38 per cent for Western Australia and 36 per cent for New South Wales.

### *How frequently during the project investigation period did CHS GPs undertake an EPC individual patient health assessment?*

The total of the sample that had undertaken an EPC individual patient health assessment was 58 per cent, while 42 per cent had never done so.

### *When CHS GPs undertook an EPC patient assessment how frequently was this done in collaboration with at least one allied health professional from the CHS?*

Twenty-five per cent of CHS GPs always undertook an EPC individual patient assessment with at least one allied health professional and 46 per cent never did.

### *How frequently did CHS GPs undertake or contribute to an EPC patient care plan?*

Eleven per cent indicated they undertook or contributed to an EPC patient care plan at least fortnightly, 61 per cent never did.

### *How frequently did CHS GPs undertake or contribute to an EPC patient care plan in collaboration with at least one allied health professional from the CHS?*

Eighteen per cent always undertook or contributed to an EPC patient care plan in collaboration with at least one allied health professional from the CHS and 50 per cent never did.

# Field Responses Provided by GPs

## *How frequently did CHS GPs undertake or contribute to an EPC case conference?*

Seven per cent of respondent CHS GPs undertook or contributed to an EPC case conference at least fortnightly, and 61 per cent never did.

## *How frequently did CHS GPs undertake or contribute to an EPC case conference in collaboration with at least one allied health professional from the CHS?*

Twenty-five per cent of CHS GPs always undertook or contributed to an EPC case conference in collaboration with at least one allied health professional from the CHS and 54 per cent never did.

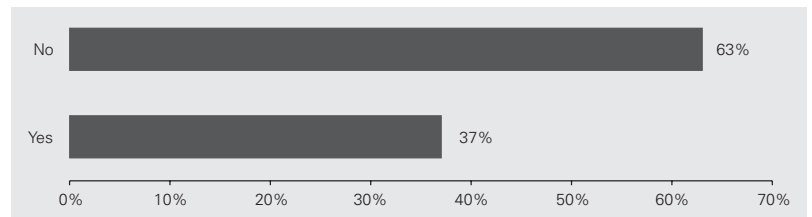
## *Conclusions about EPC Take Up*

Respondent replies show that at the time of project investigations, CHS GPs rate of take up of EPC items was at a similar level to private practice GPs in Victoria.

## **Computer Usage by CHS GPs**

As shown in Figure 4 below, only 37 per cent of CHS GPs in the respondent sample routinely used a desk top or laptop computer to record and retrieve patient information, the majority of GPs (63 per cent) did not. In response to another interview schedule question, 41 per cent of GP respondents indicated that they routinely used a desk or laptop computer to access databases to assist in making assessment or treatment decisions while 59 per cent did not. In summary, most CHS GPs were found not to be regularly using a computer.

**Figure 4: GPs' Computer Use To Record and Retrieve Patient Information**

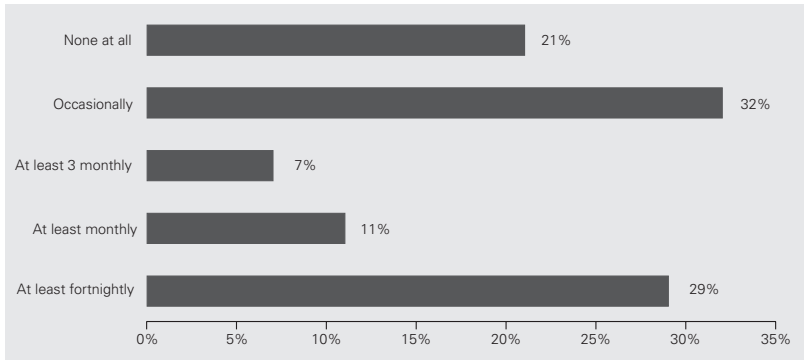


## **Collaboration with Allied Health**

### *How frequently do CHS GPs participate in a planned multidisciplinary team meeting with allied health professionals working in the CHS?*

As shown in Figure 5, 29 per cent of CHS GPs indicate that they participated in a planned multidisciplinary team meeting with allied health professionals working in the service at least fortnightly. Eleven per cent of GPs indicated that they participated at least monthly, seven per cent at least three-monthly and 32 per cent occasionally. Twenty-one per cent of CHS GPs did not participate at all in a planned multidisciplinary team meeting with allied health professionals working in the CHS. Although other project data points to extensive collaboration between CHS GPs and allied health professionals, these results confirm conclusions arising from the project's CHS profile analysis that GP collaboration with other staff occurs mainly at the informal rather than formal levels.

**Figure 5: Frequency of Planned Multidisciplinary Meeting**



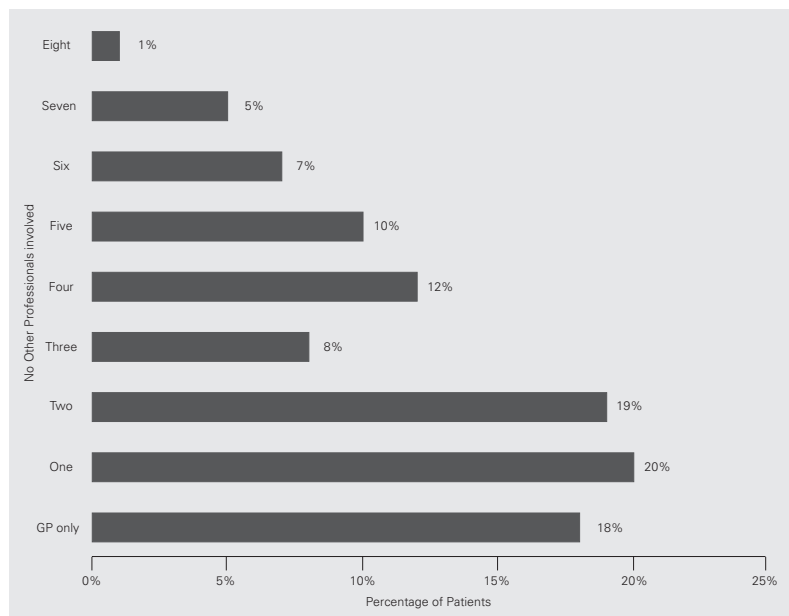
**Allied Health Collaboration for Patients Seen by CHS GPs**

A small field trial study was undertaken in one CHS to ascertain the level of referral and collaboration between CHS GPs and allied health professionals in the CHS or

surrounding community. This trial study was conducted over a two-week period. Three GPs participated and 106 patient consultations were involved. The study tracked the number of professionals with which each patient was involved. The results of the study provide proxy indicator information about the extent of multidisciplinary collaboration by CHS GPs and the level of complexity of the patient problems addressed by CHS GPs.

Figure 6 below shows that the majority of patients had more than one health professional involved. These results indicate high levels of interaction between GPs and other professionals.

**Figure 6: Level of Complexity of Patient Problems and Involvement of GPs and Allied Health Professionals**



# Field Responses Provided by GPs

## Length of Consultations

A small group of CHS GPs agreed to document MBS item numbers for a period of six days to provide additional information on the consultation profiles of this group of doctors. Three doctors from the same CHS were involved.

As shown in Figure 7 to the right, the long consultation items of 36 and 37 represented 19 per cent of the profile. This compares with the information in the financial section of this report showing that, on average, these items represented 15 per cent of the consultation profile for CHS GPs and 9 per cent for GPs in the wider Australian community. These results provide further evidence that CHS GPs provide relatively more long consultations than do their private practice colleagues.

## Community Health Service Advantages

*What are the unique health care advantages arising from having GP services delivered through Community Health Services?*

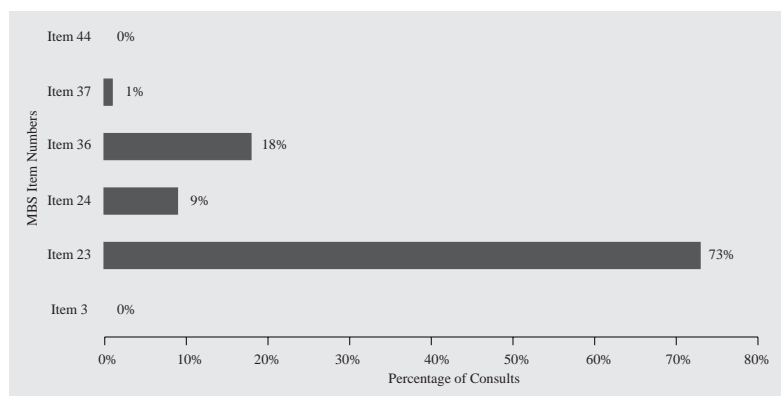
CHS GPs were asked to respond to this question. A summary of the dominant themes arising from their answers is set out below.

### *Multidisciplinary Collaboration*

Many responses pointed to the advantages of the multidisciplinary CHS environment as a preferred setting for the delivery of GP services. The strengths of this environment included:

- The ability of medical services to respond more effectively to complex patients' needs by readily drawing upon a wide range of additional knowledge and skills.

*Figure 7: Consultation Profiles of CHS GPs*



- An enhanced ability for medical services to holistically address patient needs and problems that involved interacting physical, psychological and social factors.
- An enhanced ability to provide coordinated or case managed patient care that required inputs from a variety of health professionals.
- An enhanced capacity to monitor and review the effectiveness of treatment provision to individual patients.
- The capacity to implement speedy and effective allied health referrals.
- Better opportunities for effective professional development and growth in professional expertise based upon sharing of knowledge between GPs and other health professionals.
- The creation of a team setting that was supportive of all members and provided high levels of professional stimulation.

### *Quality of Patient Consultations*

Many CHS GPs reported that the CHS setting enabled them to have much more time with individual patients. These longer consultation opportunities greatly improved the effectiveness of GP intervention especially in response to complex needs. Longer consultation times helped patients to

relax, which resulted in improved patient assessment and better capacity for the doctor and patient to reach a shared understanding of care or treatment goals.

### *Connections with the Local Community*

A significant theme arising from responses related to the advantages that the CHS setting provided for doctors to connect with the surrounding community. The networks established by the CHS gave GPs improved knowledge of and access to a range of local community resources for the benefit of patients. GPs also indicated that the CHS setting increased their awareness of being part of the local community, including a sense of obligation or accountability to it.

### *Affordable Medical Services*

Most CHS GPs believe that the CHS setting, with its emphasis on a bulk billing approach to charging for services, provided surety that low income individuals and families in the CHS catchment had access to affordable GP services.

### *Accessible Provision for Rural and Remote Communities*

A related theme to the above concerned the delivery of accessible medical services to rural and remote communities. Several CHSs had very consciously planned and established GP services in localities where there was no other local medical provision. Without the CHS GP presence, residents in these areas usually had no alternative but to make often long return travel visits to see a doctor. Moreover, most of these rural and remote localities were within population catchments characterised by private GP services with low levels of bulk billing. Consequently, CHS GP provision in these communities addressed the twin access

barriers to effective care of geographic isolation and low household income.

### *Culturally Sensitive Provision*

Many answers claimed the CHS setting enabled GP services to be more culturally sensitive than counterpart provision in private practice. The combination of comparatively good access to interpreters, longer consultation times and access to ethnic support workers employed by the CHS or neighbouring services had enabled CHS GP services to respond effectively to the needs of culturally diverse communities. CHS GPs believed that particular client groups whose needs were unlikely to be met as effectively through private GP provision included: refugees; asylum seekers; victims of torture; NESB women including those presenting with culturally sensitive sexual and reproductive health or family relationship issues; and ageing clients from NESB communities, including those experiencing confusion or dementia.

### *Responses to Complex Needs*

A very strong theme emerging from CHS doctors' referred to the effectiveness of CHS GP services in addressing a range of other complex patient needs in addition to cross-cultural factors described above. Issues such as family violence, complex mental illness, alcohol and drug misuse or addiction, homelessness and household poverty, where an interplay of physical, psychological and social problems were experienced by patients, were examples of complex needs that CHS GP services were seen to address more effectively than private GPs.

### *Role Diversity of CHS GPs*

Despite restrictions of Medicare funding, many CHS GPs referred to opportunities in

## Field Responses Provided by GPs

their day-to-day practice for blending clinical based curative work with population health/preventive, health promotion and service planning responsibilities. The diverse service types delivered by CHSs enabled doctors to contribute their medical expertise within multidisciplinary teams at a range of points on the health care continuum. Also, CHS GPs had scope to specialise in particular clinical fields, such as drug and alcohol, mental health and family violence areas. The same opportunities were not as readily available in GP private practice.

### *Client Satisfaction*

GP responses also referred to clients being afforded strong respect within the process of CHS GP service delivery. The CHS setting was welcoming of clients. Moreover, CHS operating philosophies sought to empower clients as equal partners with GPs and other health professionals and emphasise client rights. CHS doctors saw these factors as tangibly enhancing the level of satisfaction that CHS clients experienced of GP service provision.

### *Concerns Expressed*

A significant number of CHS GPs, when noting the advantages of medical provision within the CHS setting, also referred to frustrations connected to the erosion of these services. An important theme referred to GP services in the CHS not being properly recognised because they fell between State and Commonwealth policy responsibilities and consequently did not get adequate infrastructure or supplementary funding support in comparison with other CHS service types. As a result, these services were under pressure to become totally self-funding. This forced them into increasing patient throughput, reducing consultation times

and consequently threatening their capacity to address the complex needs of disadvantaged groups.

## Conclusions

The responses of CHS GPs about the advantages of GP services in CHS settings strongly confirm earlier project evidence showing that CHS GPs have a priority orientation to service disadvantaged groups with complex needs.

### **A Representative Sample of Responses from CHS GPs**

GPs described their understanding of holistic client care and the extent to which their own practice contributes to such care:

- Looking at the person as a whole individual rather than addressing individual symptoms.
- While the CHS helps achieve holistic care, average consultation times of only 10–15 minutes limits engagement with the patient and family members (especially for elderly patients).
- Provision of care to the total person.
- Providing a continuum of care from curative to preventive/developmental services.
- A bridge between individual patient care and broader public health.
- The CHS is beginning to move in this direction by linking individual patient initiatives to wider cardiac prevention programs, school health education and municipal public health planning.
- Seeing the patient's biology in a fully integrated and connected way, not just parts.
- Understanding the patient in their family and community setting.

- EPC offers a new potential to achieve some holistic directions with MBS support
- Assisting clients to take control of their health and social/emotional status.
- Provision of a multifaceted health service aimed at the individual's physical, emotional, mental and social needs.
- This care is aimed for in the context of one-on-one patient involvement and other team activity in the CHS.
- Holistic care recognises that, in addition to notions of disease, social, emotional, psychological and environmental factors contribute to health status and must be considered in patient assessments and health interventions.
- Such care involves assessing and managing client problems in reference to their personal, social, psychological, cultural, spiritual and educational background.
- Allied health back-up and good referral links to other community services along with NESB culturally sensitive support helps GP service delivery in the CHS to be holistic.
- Looks at the whole person, what they are and what is going on around them. Aboriginal approaches to health care are a good pointer as the health of the community determines the health of the individual.
- It addresses family patterns or causes of illness or disease and takes into account the potential of the family to provide support when devising a patient treatment plan.
- Holistic care must look at the interrelationships of various symptoms on the individual to gain a total picture of needs and treatment requirements.
- It requires an intimate knowledge of the local community if it is to be done well.
- It requires time, for example, a PAP smear consultation may lead into problems with marriage/family relationships which require sensitive exploration.
- See the relationship of body, mind and spirit.
- Understanding the impact that emotions such as bitterness and resentment can have on the body's biology.
- Not confining attention to disease, but looking at wellness issues and actively addressing preventive risk factors for prevention purposes.
- A focus on enabling the client to take control of their life.
- Blending clinical activity with population health/development activities including municipal investigations or neighborhood screenings as well as building partnerships with other professionals in health development teams in local settings to address such issues as heart disease or community nutrition.
- The CHS gives opportunity to fulfill holistic care goals.

The responses from individual CHS GPs addressing their understanding of holistic care are consistent with the way the social model of health concept has been articulated by the Department of Human Services in the PCP publications: *"Integrated Service Planning: Interim Guidelines—Primary Care Partnerships"*; *"Primary Care Partnerships: Selecting and Accessing Population Data—An Information Resource"* and *"Primary Care Partnerships—Community Health Plan Template."*

The responses do not, however, provide consistent evidence about the extent to which CHS GPs believe the concept of holistic care is reflected in their everyday service delivery.

# The Community Health Services Profiles



## Agency Profile Summaries

A Profile Survey Questionnaire was sent to CHSs for completion by centre managers. In addition, interviews were held with GPs, managers and other CHSs research sources.

The Profile Survey Questionnaire targeted quantitative and qualitative data collection in ten key areas of service operations. The findings of this investigation are summarised below.

## Relative Disadvantage Ranking of CHS

The Index of Relative Social and Economic Disadvantage for the Australian Bureau of Statistics (ABS) Social and Economic Indices for Areas (SEIFA) framework ranks postcodes by a number of criteria that indicate disadvantage. The ranking is from 1–623 Victorian postcodes. A low rank number indicates high relative disadvantage, a high rank number indicates low relative disadvantage.

The majority of CHS GP service delivery locations are in relatively disadvantaged localities. Most Victorian CHSs with GPs (27 of the 30) have service locations within the third (207) of Victorian postcodes with the greatest levels of social and economic disadvantage. Fourteen of these service locations are in the 50 most disadvantaged postcodes, five are in the ten most disadvantaged postcodes and one service delivery

location is in the State's most disadvantaged postcode. The majority of CHS GP service delivery locations are in relatively disadvantaged localities.

## Medicare Bulk Billing Rates

High Medicare bulk billing levels in a geographic area is often interpreted as an indicator that affordable medical services are available in the locality.

Five CHS GP service locations are found in rural localities where bulk billing occurs at a rate of less than 55 per cent of all Medicare claims. These CHSs are clearly responding to a barrier placed on the affordability of GP services for many low income groups caused by the majority of GPs in these localities charging patients a co-payment for service provision.

## CHS GP Engagement Arrangements

Twenty CHSs engage salaried GPs, seven CHSs engage GPs on a private practice co-location basis and two CHSs draw on both arrangements.<sup>5</sup>

## GP Numbers in CHSs

It is estimated that at least 29.4 medical EFT is committed to GP delivery in CHSs. This translates into at least 118 GPs regularly engaged in Victorian CHSs.<sup>6</sup>

<sup>5</sup> Partly because limited information was provided by some CHSs about the way they engaged their GPs (which in turn was due in some measure to restrictions about the accessibility of confidentiality linked remuneration information) and partly because of some technical issues involved in making distinctions between an employee and a contractor in a medical setting the project has classified engagement arrangements into two basic categories of employee and private practice co-location. The defining characteristics of these categories are that in an employee situation the CHS directly receives Medicare reimbursement money and then distributes a payment to the GP,

while in a private practice co-location situation the GP directly receives the Medicare reimbursement (and then depending on local arrangements may make service payment to the CHS for such items as accommodation rental, reception and administrative/client records support.

<sup>6</sup> Difficulties were encountered in getting full details in several private practice co-location settings. The information is an estimate of GP numbers engaged in Victorian CHSs. In the main this information is concerned with GPs who are regularly engaged in CHSs and does not address locum appointments.

## **Formalised Practice Frameworks for Quality Assurance in CHS GP Service Delivery**

As can be seen from the following analysis, quality assurance systems and frameworks for GP service delivery in CHSs are underdeveloped. The project has concluded that the lack of formalised policy recognition of GP service provision in CHSs arising from the function being a Commonwealth funded activity located in a State funded service delivery context is the major reason why formalised quality frameworks are not in place.

### **Patient Eligibility Criteria**

Most respondent CHSs do not have client eligibility criteria. That is:

- The extent of written client eligibility criteria is limited.
- A majority of respondent CHSs do not have mission documentation that directly addresses their GP services.
- A little over half the respondent CHSs have written service objectives connected to GP provision.
- More than half the respondent CHSs do not have outcome/performance measures for GP provision—a small number have detailed measures.

### **Clinical and Management Information Systems**

A variety of clinical and management information systems are in place with SWITCH being dominant. However these systems do not integrate GP services and other forms of client service offered by the CHS.

## **Standardised Client Needs/Diagnostic Classification System**

Most respondent CHSs do not have standardised systems in place for this purpose. The qualitative responses show that GPs in CHSs are responding to some very high needs/complex needs groups. There was a general lack of quantitative data held or easily accessible for analysis.

### **Profiles of GP Clients Compared to Other CHSs Clients**

Quantitative information on comparisons between the client profiles of GP services and other services offered by CHSs was very limited. However, qualitative information suggests that the social and demographic profiles of GP clients and clients receiving other CHSs services are similar.

### **Percentage of Total Client Numbers in the Centre Seen by GPs Only**

There is a large range in the percentage of clients in each CHS who are seen by the GP service but not seen by other CHS services. This ranges from 5–50 per cent of GP clients based on estimates provided by CHSs.

# The Community Health Services Profiles

## **Common and Standard Client Assessment Framework Used To Assess All Clients**

Within CHSs the use of common/standardised client assessment frameworks across all service types offered is not frequent. Consequently, the use of client assessment frameworks common to GP and other types of CHS service delivery is not prevalent.

## **Common Client Assessment Framework Used**

The Home and Community Care (HACC) derived Client Information and Referral Record (CIARR) framework is the most prevalent assessment tool reported, although this appears not to be used in a substantial way in GP services. The RACGP assessment framework is the most frequently reported framework in use for CHS GP service delivery.

## **Extent to which a Standardised Case Management Framework Applies to the Delivery of GP and Non-GP Service Delivery**

A small number of CHSs have a standardised case management framework in place for GPs and allied health professionals in the CHS.

## **Evidence that CHS GPs Are Meeting Complex Clients Needs, which Cannot Be Adequately Met by Private GPs**

The qualitative responses point to a picture of GPs consistently responding to marginal/disadvantaged groups with complex needs. Client information systems, however, are currently not capturing this complexity.

## **GP Involvement in Range of Service Types Provided by Each CHS**

The number of service types offered in each CHS (based on the CHS's local description of service types) ranged from 10–46 types. The level of GP activity in these service types varies enormously from one CHS having GPs participating in 94.4 per cent (17) of service types offered to another with its GPs participating in 6.5 per cent (3). Most GP activity occurs in the direct client services band of activities, followed by the health promotion, screening and risk reduction band of activities. Finally, the service system planning/development and coordination band and the professional and community training services band both have fairly equal and low levels of GP participation.

## **Linkage Arrangements with Other Professionals within the Local Community**

The predominant external linkage arrangements include Divisions of General Practice and PCPs, followed by Shared Care programs and then co-location arrangements with other services in the CHS, including the Division of General Practice and private GPs.

## Reasons Why CHSs Engage GPs

- (i) To address GP shortages in the local area.
- (ii) To better provide holistic and multidisciplinary care from the CHS.
- (iii) To provide affordable and accessible GP services especially in remote localities.
- (iv) To enable intensive and adequate service provision to high needs groups which many private GPs cannot do as well because of financial pressures to maintain high patient throughputs and because they do not have the same access as CHS GPs to allied health provision.

## Additional Comments

A consistent theme that emerged is that CHSs need additional funding support to facilitate the integration of CHS allied health services with CHS GP services and that funding capabilities to achieve this have been eroded over a number of years.



## Methodology

The Profile Survey Questionnaire sent to CHS managers included a major section, which sought detailed costing information. Relevant cost data was assembled from survey items, which addressed GP Service Locations and Hours, GP Service Financial Profile, GP Service Resource Profile and a Consolidated CHS Financial Overview. Thirteen of the 30 CHSs that had engagement with the project provided comprehensive cost data.

A preliminary comparative analysis of financial and activity data provided to the project was carried out between services to determine a reasonable range of unit cost data and the upper and lower 'outliers' for follow-up and clarification. This also included cross-validation of reported costs and income relative to reported activity measures (such as the number of EFT medical personnel and the number of medical consults) as a way of ascertaining the 'reasonableness' of data gathered.

Surveys returned indicated the following accounting practices in respect of GP services:

- Profit and loss financial reports are prepared on an accrual accounting basis. The GP services are treated as business units. Separate cost centres are maintained for each service location for the majority of GP services.
- The majority of centres do not charge out depreciation of medical plant and equipment, office plant and equipment/furniture and fixtures.
- No building depreciation charges are reported by any centre.

Most centres have indicated that they believe GP business units are adequately charged for equipment and purchase of medical plant and equipment. Half of the centres indicated that GP services were not adequately charged for the use of premises as no internal rent is charged to provide any capital return on Centre's assets. Two of the three CHSs that operated private practice/co-located GP services and also provided detailed cost data have indicated that the non-charging of rent and indirect business support costs acts as a financial subsidy for attracting co-located private GP services to their sites.

## Overview of GP Costs and Income

Table 1 on the following page summarises the key cost components and sources of income for 1999–2000 from the 13 CHSs returning comprehensive cost data. Ten of these CHSs provided a salary-based GP service and three provided private co-located GP services.

## Conclusion Regarding Financial Viability

Table 1 shows an aggregate statewide operating deficit of \$270,600 from the 13 salaried GP services (cell M1). The figures show that at an aggregate level for all 13 CHSs, the total income received is \$5,352,000, rounded to \$5.35M (cell L1). This is greater than the sum of medical staff costs (cell A1), service support costs (cell B1) and other operating expenses (cell C1), which in round figures total \$5M. The statewide financial return for the 13 CHS is greater by \$0.35M than the aggregate of all direct personnel and operating costs, including service-support costs.

**Table 1: Summary of Key Cost Components and Sources of Income for 1999–2000**

1999–2000 Operating Results for CHS_GP Services	Salaried GP	PP Co-location GP	TOTAL GP	Row Identifier
<i>Column Identifier</i>	<i>Column 1</i>	<i>Column 2</i>	<i>Column 3</i>	
	\$'000	\$'000	\$'000	
Medical Staff Costs <sup>7</sup>	\$3136.7	169.0	3305.7	A
Service Support Costs <sup>8</sup>	1319.2	285.3	1604.5	B
Other Operating Expenses <sup>9</sup>	551.5	74.6	626.1	C
Indirect Business Support Costs <sup>10</sup>	615.2	5.5	620.7	D
<b>Total Costs</b>	5622.6	534.4	6157.0	E
Less Income:				F
Medical Benefit Schedule (MBS) Receipts	4685.8	179.4	4865.2	G
MBS Income Sharing	0.0	96.7	96.7	H
Practice Incentive Grants	329.7	9.3	339.0	I
Third Party Client Service Fees	144.1	0.8	144.9	J
Other	192.4	235.8	428.2	K
<b>Total Income</b>	5352.0	522.0	5874.0	L
<b>Net Loss</b>	(270.6)	(12.4)	(283.0)	M
Number of Agencies	10	3	13	
Number of GP Services	13	4	17	

Aggregate indirect business support costs are \$615,200, rounded to \$0.62M (cell D1). After accounting for all other cost categories, aggregate income for the 13 CHSs meets 56 per cent (\$0.35M) of the total indirect business support costs of \$0.62 M. This produces an aggregate technical gap between costs and income of about \$0.27M if a decision is made to include indirect business support costs in the charging formula for GP services.

The average actual operating deficit or surplus per medical EFT for each service for the data set is a loss of \$7,671 from an

average total cost of \$159,462 per medical EFT and average income of \$132,894 MBS and \$151,791 total GP income per medical EFT. This is equivalent to a loss of \$1.25 per consultation from an average \$30.28 total GP cost per consultation, \$24.97 MBS income per consultation and \$29.03 total income per consultation. A significant observation is that the three rural services providing detailed financial data reported high operating costs, including average medical personnel costs of \$109,960, \$118,400 and \$119,186 respectively per medical EFT.

<sup>7</sup> Medical Staff Costs, including employee on-costs. These costs include all salaried and sessional medical staff payments, payments for locum service and employee on-costs such as superannuation, workers compensation and other salary costs.

<sup>8</sup> Service Support Costs, These costs are associated with non-medical support staff costs, inclusive of employee on-costs and who have hands-on responsibility in the overall delivery of GP service at the centre. This included general practice managers, nurses, receptionists and medical records

<sup>9</sup> Other Operating Expenses. These include both expenditures which are directly incurred by the medical practice

(e.g. medical and surgical supplies and equipment, printing and stationary) as well as other indirect expenditure charged out against the Business unit by the Centre. Indirect expenditure refers to charged-out shared costs associated with the provision of accommodation (fuel, light and water, telephone, domestic cleaning, security, building repairs and maintenance etc) and excludes business support costs.

<sup>10</sup> Indirect Business Support Costs - These are internal charges made by the Centre to recover costs of centralised support services provided, such as corporate management, financial services, recruitment and payroll services, information technology etc.

## Consultation Patterns

CHS GP services reported, on average, 2.3 to 3.7 consults per hour per medical EFT and an average of 5,463 consults per annum medical EFT. The project has drawn on Health Insurance Commission (HIC) data that suggests that for all Victorian GPs, the State average is estimated to be 6,455 consults per annum per full workload equivalent (FWE) doctor, which translates to 3.9 consultations per hour. Fifteen per cent of client contacts made by CHS GPs are long consultations compared to a projected national average for all GPs of 9 per cent. The project believes that the lower client throughputs per hour and the greater use of long consultations by CHS GPs, compared to wider projections for all GPs, are indicative of GPs in CHS servicing a more complex and demanding clientele than GPs in private practice.

## Viable GP Services

The analysis has confirmed that financially viable CHS GP services are currently operating. Based on other data gathered by the project, it is clear that these services are delivering to areas with low socioeconomic status and are also reflecting a social model of health in their practice orientation. Significantly, the analysis also shows that financial viability can be achieved with relatively low numbers of GPs (<2 EFT) and larger numbers of GPs (>6 EFT).

Table 2 on the following page profiles some key cost, income and activity indicators for these viable services. It can be seen from the table the importance of non-MBS income as an income supplementation to achieve break-even results.

The two smaller practices reported average cost per consultation of around \$31.00, while the larger service was \$26.19. Average total cost per medical EFT ranged from \$139,670 to \$162,235 and non-salary costs (operating and indirect business support costs combined) represented 20–22 per cent of total costs. These services demonstrate that GP provision in community health settings can be financially viable while yielding social model of health outcomes.

There is some variation in the way CHSs have treated their indirect business support costs. Nevertheless, based on the range of costing data assessed, the project has formed the conclusion that CHS GP service provision can be managed to achieve a break even financial result while effectively addressing the needs of disadvantaged clients with complex needs. The exception to this conclusion is likely to be some rural services outreaching to remote communities where additional cost pressures caused by travel and distance may not be fully recoverable regardless of the type of service management arrangements in place.

*Table 2: Profile of GP Services with Operating Surpluses*

Profile	CHS 1 Small	CHS 2 Medium	CHS 3 Large	Data Set Average
<b>Staffing Profile</b>				
No of Medical EFT	1.75	3.5	6.26	
No of Support EFT	0.86	0.71	0.97	0.89
<b>Financial Profile</b>				
Total GP Service Cost per Medical EFT	\$139,670	\$162,235	\$157,655	\$159,462
Total MBS Income per Medical EFT	\$120,881	\$138,382	\$139,342	\$132,894
Practice Incentive Grant Income per Medical EFT	\$14,555	\$16,980	\$10,720	\$9,352
Other Income per Medical EFT	\$8,246	\$9,620	\$13,372	\$9,545
Average Number of Consults per EFT	4457	5301	6020	5463
Total Cost per Consult	\$31.34	\$30.60	\$26.19	\$30.28
Total Income per Consult	\$32.24	\$31.12	\$27.15	\$29.03
Surplus per Consult	\$0.90	\$0.52	\$0.96	-\$1.25
<b>Cost Structure Profile</b>				
Medical Personnel Costs	60%	60%	55%	56%
Service Support Costs	20%	20%	24%	24%
Other Operating Costs	9%	9%	6%	6%
Indirect Business Support Costs	11%	11%	16%	11%
<b>MBS % Mix Profile</b>				
Short Consults	1%	1%	0%	1%
Standard Consults	59%	77%	81%	77%
Long Consults	24%	19%	10%	15%
Prolonged Consults	7%	2%	0%	1%
Various, including Procedures	9%	1%	9%	6%

The two smaller practices reported average cost per consultation of around \$31.00, while the larger service was \$26.19. Average total cost per medical EFT ranged from \$139,670 to \$162,235 and non-salary costs (operating and indirect business support costs combined) represented 20–22 per cent of total costs. These services demonstrate that GP provision in community health settings can be financially viable while yielding social model of health outcomes.

There is some variation in the way CHSs have treated their indirect business support costs. Nevertheless, based on the range of costing data assessed, the project has formed

the conclusion that CHS GP service provision can be managed to achieve a break even financial result while effectively addressing the needs of disadvantaged clients with complex needs. The exception to this conclusion is likely to be some rural services outreaching to remote communities where additional cost pressures caused by travel and distance may not be fully recoverable regardless of the type of service management arrangements in place.

## Conclusions

CHSs should be in a position to deliver MBS-reimbursable GP services on a cost break even or small surplus basis including services associated with the new EPC MBS items.

This is likely to be the case for practices with three or more full-time doctors with nursing support. This 'complementary medical team' approach provides effective leverage to capitalise on MBS and non-MBS income, such as Practice Incentive Payments and GP immunisation program payments.

GP practice, which reflects strong collaboration with allied health staff in CHSs, should be sustainable while still enabling GP service delivery to operate on a break even or surplus level. This strong collaboration is likely to pay off financially in light of the EPC package.

This project has not found evidence that specific models of GP engagement in CHSs offer unique or dominant cost advantages (that is, salaried, sessional contract or private co-location). The critical success factor for cost-effective outcomes appears to be the extent to which program management systems, which monitor and improve the quality of service activity, are in place.

GP business planning is an important cost and income driver, determining the financial viability of activities. Where CHSs want involvement by their GPs in health promotion, service planning or other activities which are not MBS-reimbursable (for example, diabetes outreach), GP time investment needs to be treated as an internal charge against the other program(s) rather than a non-recoupable cost to the CHS GP program.



# Guidelines for Break Even Financial Performance



Findings and observations from the project's cost analysis and other studies indicate that a GP service in a CHS is likely to achieve a break even financial result where the following conditions can be maximised.

## Resource Sharing and Reducing Indirect Costs

Project analysis suggests the critical mass threshold appears to be around 3.00 EFT per service. The achievement of this critical mass begins to optimise the distribution of overheads across individual practitioners in the service. It also acts to reduce costs connected to locum and staff substitution arrangements. Where unplanned temporary staffing vacancies or absences do occur, gaps in service delivery can often be at least partly covered by distributing some client demand to other GPs in the CHS and thereby maintaining effective service continuity. Also, other types of locum recruitment can often be expedited by drawing from the existing pool of GP staff in the CHS. The attainment of the critical mass threshold by a CHS assumes that there is sufficient client demand for at least three medical EFTs in the CHS's catchment.

## Reducing Business Overheads

The extent of CHS corporate overheads being charged against a CHS GP service will ultimately determine the bottom line result. Currently CHSs tend to charge out corporate services to their business units and service streams in standard proportion to the CHS budget or EFT share for each unit. As medical salaries are, on average, higher than other service staff, the GP unit is likely to be charged a relatively higher sum for

overheads than other business units while its demands for corporate services are not necessarily greater. An equitable user-pay and arms-length charge-out arrangement to the GP service, which reflects its actual usage level of corporate services, should be negotiated by each CHS. Also, where other CHS units require GP services for activities such as health promotion or population health planning and the like, the GP service unit should clearly charge out its time to the other unit. Such arrangements will help prevent overheads and expenditure associated with the GP service from becoming cost inflated.

## Allied Health Staff as part of GP Service Delivery

Nursing and other allied health staff provide a cost-effective practice integration support role to GPs. This support can help sustain high volume client throughputs while reinforcing the quality and effectiveness of service delivery. The MBS income-generating capacity per doctor can increase significantly without directly proportionate increases in nursing and other allied health costs when this professional back up is strategically exercised to support GP service delivery.

For instance, some CHSs have exploited increased income opportunities arising from participation in the GP immunisation program and the associated use of nurses. This Project's observations suggest that CHS GP service effectiveness and income generation can be increased by using CHS nursing/allied health staff in the delivery of MBS EPC items.

The planned use of a CHS's allied health staff to carry out such tasks as client home assessments and case management

coordination can improve the quality of the client outcomes intended from EPC items dealing with client assessments, care plans and case conferences. Moreover, the wise use of allied health support resources will help to maximise client throughput and thereby increase MBS hourly income derived from these items.

Recent field studies undertaken by a Monash Division of General Practice project examining nurse and other professional back-up to private GPs in an EPC context, reinforces this conclusion. The studies have shown that income potential can be lifted by up to 19 per cent p.a. by drawing on nursing or allied health support (See *“Supporting GPs in Enhanced Primary Care: Identifying A Role for Divisions and Practice Nurses”*).

## Reorganisation of Consultation Throughputs

The project survey indicated the number of consultations being provided by CHS GPs is between 2.3 to 3.7 per hour. This compares to the State average that is estimated to be 3.9 consultations across all GPs in Victoria.

Project analysis shows that the break even revenue target for CHS GP services is in the range of \$157,300 to \$174,800 p.a. per full time medical EFT, consulting for 46 weeks of the year. Most CHSs would need to set a consultation target of around \$90 to \$100 per hour to achieve the break even figure. (The break even target is largely dependent on the actual total cost per medical EFT and the extent of other non-MBS income.)

In order to attain the annual break even revenue target, CHS GP services should have a minimum throughput of around three consultations per hour, that is, an average of 20 minutes per client.

Achievement of this threshold level is still possible for CHSs while offering a suitable percentage of longer consultations to viably address complex client needs, which require more time than the 20 minute average. Table 3 is a summary of revenue projections based on various consultation mix scenarios and the actual spread of client consultation duration based on the MBS item categories of short, standard, long and pro-longed consultations.

*Table 3: Revenue Projections Based on Consultation Mix Scenarios*

Consultation Mix*				Ave Mins Per consult	No of Consults Per Hr	Hourly MBS Income	Annual MBS Income*	Reference Table
Short	Standard	Long	Pro-longed					
8%	65%	27%	0%	18.5	3.2	\$99.84	\$174,518	Scenario 1
5%	59%	36%	0%	20.7	2.9	\$97.16	\$169,844	Scenario 2
4%	67%	24%	4%	19.8	3.0	\$90.16	\$157,596	Scenario 3
5%	57%	32%	6%	21.7	2.8	\$85.52	\$149,486	Scenario 4
5%	59%	29%	7%	22.2	2.7	\$81.12	\$141,795	Scenario 5
5%	68%	16%	11%	24.0	2.5	\$65.75	\$114,931	Scenario 6

# Guidelines for Break Even Financial Performance

Scenario 3 is one example of achieving a revenue target of \$90 per hour for a practice involved in consultation mix of 4 per cent short, 67 per cent standard, 24 per cent long and 4 per cent prolonged. A high hourly revenue outcome is achieved by ensuring that there is a reasonable spread of consultations across each MBS item. This enables an optimal number of consultations being delivered in the hour without compromising the length of service provision in response to patient needs. This is illustrated by comparing revenue outcomes in Scenario 5 and Scenario 6.

## Monitoring MBS Claims

Several MBS claim related monitoring functions, if adequately addressed by CHSs, should help contribute to the financial viability of their GP services. These are:

- Monitoring the effectiveness of doctors in appropriately identifying the MBS item numbers they claim against for each consultation. There is some evidence to show that MBS income may not be maximised because legitimate higher income item claims available for some client contacts are not being adequately recognised in lodging claims. For example, contacts over 20 minutes are being logged as standard rather than long consultations.
- Minimising the extent to which MBS claims are rejected due to the use/ recording of incorrect/invalid Medicare numbers.

(NB Three services analysed by the project who were found to have 3–5 per cent operating deficits are likely to have the potential to turn their performances into a break even result solely through the improved monitoring of MBS claims.)

- Ensuring that CHS practice managers and service planners have access to HIC returns provided to individual doctors—these reports summarise MBS items claimed and other client related profile data. This information has a valuable application in interpreting the progressive costs of service provision and other aspects of service activity yet it is not being adequately fed into the planning processes of most CHSs.

## The Importance of Non-MBS Income

A range of supplementary income sources is potentially available to CHS GP services. These include General Practice Incentive Payments, for example, for immunisation, IT, after hours, various training grants, health service planning grants from Commonwealth and State sources and methadone prescriber support assistance. Project collected cost data indicates that where CHS GP services can attract other income to supplement MBS revenue, their financial viability and break even potential is markedly enhanced. Many of these supplementary income sources have a crucial role in helping to cover the costs of important non-client contact GP service planning and coordination activity, which is not directly claimable from MBS sources.



# Barriers to Achieving Break Even Financial Performance



## Small CHS GP Services

Small CHSs are not able to distribute their minimum fixed cost burdens across a sizeable group of active GPs to achieve lower costs per doctor. Consequently, their marginal operating costs per practitioner are generally high and break even financial performance is very difficult to achieve. For instance, a CHS providing a sole practitioner service for one or two sessions per week is unlikely to generate income that matches the overheads applying to each client service transaction.

## Complex and Time-Intensive Caseloads

CHS GP services which respond only or mainly to complex client problems requiring long or prolonged consultations are unlikely to generate sufficient hourly MBS to break even financially.

Types of complex problems that often require GP client contacts of over 20 minutes (and should regularly attract long or prolonged MBS consultation reimbursement) include: sexual reproductive health advice and other services to NESB people, complex alcohol and drug problems (including methadone support), responses to victims of torture or asylum seekers, responses to complex mental health problems, such as schizophrenia and psychosis, and responses to multifaceted domestic violence.

Where GP service delivery is skewed to mainly addressing complex problems which require more than 20 minutes contact time, client throughput and MBS income per hour will be lower than for GP services responding to a variety of problems that involve a mix of shorter and longer client contact periods. (Table 3 helps illustrate this point).

## Remote Service Delivery

A number of Victorian CHSs are providing GP services to remote rural communities. Delivery arrangements usually embrace provision of outposted clinics in remote settings of several weekly sessions with a low level EFT base and often a sole practitioner. These outposted settings are considerable distances from larger towns and provisional population centres. The services may also incorporate other features such as GP community liaison and some home visiting.

Service provision is cost-intensive because reception and infrastructure overheads are distributed against one or very few practitioners. Travel costs are high for practitioner's return trips, outreach visits, delivery of medical consumables and pathology transports. Disruptions to client contact service delivery when staff are on holiday or sick leave, professional development, or involved in non-client contact service activities, such as service coordination and population health initiatives, are more difficult, and therefore more costly, to cover through locum recruitment or staff substitution than is the case for services based in larger population centres.

## Business Model for Cost-Effective Performance

Larger CHSs that develop a business and budget planning model to effectively manage the cost drivers outlined above should be able to:

- (a) Consistently deliver a social model of health orientated medical service for disadvantaged groups whose health needs include a mix of complex and non-complex problems, *while*
- (b) Ensuring the financial viability of the service.

Remote delivery services, other small services and services specialising in responses to complex client problems involving mainly long consultation times, are unlikely to break even financially. By applying a business and budget planning model, which deliberately anticipates and manages key cost drivers, these services should consistently show lower operating deficits than otherwise would be the case.

## Best Practice Elements

Several of the better financially performing GP CHSs have demonstrated some of the following best practice elements in financial management and accountability:

- Development of an optimal practice income strategy and budget plan relative to the CHS's medical staffing complement, practice setting and client needs profile. A GP service revenue budget is usually determined in consultation with the CEO and other management team members and then used as an important tool to help facilitate the negotiation with each doctor of practice targets, preferred areas of service delivery specialisation and a remuneration package.
- Assignment/appointment of a practice manager with a key operating performance review function in monitoring/managing appointment bookings, incidences of did-not-attend, waiting lists and rosters. In this context the appointment bookings for each medical staff are designed to align with their minimum performance targets. For instance, unforeseen long consultations with non-urgent medical problem may be rescheduled for a second consultation, which should generally provide a higher level of MBS income per client as well as eliminating unnecessary waiting room congestion.
- Monthly monitoring of MBS income raised by each doctor that is assessed against each practitioner's expenditure and income targets.
- Monthly monitoring of overall income and costs for the business unit.

# Information Systems Support for General Practitioners



This section discusses the project's investigations concerning client information systems supporting GP service delivery in CHSs. The findings also embrace the integration of GP client information with client data applying to the other services offered by CHSs. The project concluded that significant systems development is needed to ensure effective GP client information management arrangements are in place in CHSs and a series of action recommendations have been identified to achieve this goal.

## Background

The Project did not set out with a primary focus on investigating IT issues relating to GPs in CHSs. It became apparent during field work that the level of IT integration and data availability within CHSs varied substantially. With the exception of a small number of CHS GP services, data capability was non-existent or at low and generally unsophisticated levels.

In general, HIC information is not used in a systematic way to help review and evaluate GP service provision.

A small number of centres do use SWITCH to manage basic GP client information, such as name, address and age, but it is not used to record and track cross-referral patterns between GPs and other professionals.

There is limited use of SWITCH to support GP service provision in CHSs, however SWITCH has considerable capability to richly report client data about GP service delivery. This capability lies mainly dormant at a statewide level but includes opportunities for extensive report customisations for program review or management purposes and for achieving a creative

interconnectedness with other software packages used for medical services.

Provision for targeted training, advisory and pilot support to CHSs is warranted to effectively exploit the potential of SWITCH and other CHS software to fully report the role of CHS GP services. A series of demonstration projects should be established statewide to create information models and working templates that:

- (a) Illustrate the operational potential of existing software.
- (b) Accurately showcase the diversity, integration and unique contribution of GP in CHSs.

A significant barrier to better integration and documentation of GPs service data in CHSs derives from the low number of CHS GPs who have access to computers on their desktop and to networking and integration with other data collection facilities in community health.

Training time does not generate income and it has been difficult for many GP services to allocate sufficient time and budgets for training. The lack of professional development time is felt keenly by GPs in CHSs.

The better integration of service activity data in a CHS will allow for a more formalised and systematic identification of clients who require assessment, care plan or case conference services covered in the EPC MBS items. Increased use of EPC services will enable higher quality client care, including strengthened multidisciplinary support to clients, and attract greater per hour MBS income to the CHS.

CHSs potentially offer a model environment for the integration of GP and allied health

services as sought in Department of Human Services PCP objectives, as both types of service can be placed under the one roof and a single overall management structure. If the Department wants to encourage CHS GPs in this model, then significant IT support for GPs in CHSs and concomitant training will need to be undertaken.

CHSs that offer GP services can be a powerful example to other local services and private practitioners. These CHSs demonstrate how service integration goals, which link together GPs and other professionals for client assessment, care planning and record keeping, can become an everyday practice reality.

The GPs who work in CHS are often the same GPs who work in private practice. Gains and advances achieved in CHSs with GPs will stand a very strong chance of being adopted in private practice because practice innovation achieved in one setting will more readily flow to the next when the one practitioner is active in both environments during their working week.

Experience and knowledge of PCP issues can be taken into private practice by CHS GPs. In turn, accurate information about practical issues dealing with PCP implementation and service integration can be brought back to the CHSs, including how CHS allied health services can better link with private GPs.

## Key Findings

- Improved IT and systems will greatly assist in maintaining the financial viability of GPs in CHSs.
- There is no systematic statewide collection of data providing adequate baseline information about the activities of GPs in CHSs, and little consistent collection of client data on the activities of GPs within individual CHSs.
- The lack of systematic data collection has contributed to a lack of understanding of the contribution and complexity of the roles of GPs in CHSs.
- The lack of integrated data systems for GPs in CHSs means that significant grass-roots information about existing and emerging health issues is not available to primary care planners.
- Demands placed on GP services within CHSs to be self-funding from mainly Commonwealth MBS/HIC sources have resulted in the IT infrastructure, software development and, particularly, training for GP IT services being separated from systems development in State-funded services delivered by CHSs, lagging behind technology and data set improvements for other Department of Human Services services.
- With adequate IT training, GPs in CHSs are willing to utilise electronic data and decision making systems to achieve greater integration with other services.

# Information Systems Support for General Practitioners

## Recommendations

1. That the Department of Human Services support pilot demonstration projects to integrate general practice and community health client service data. Pilot projects should aim to provide working demonstration models and easily used templates that, as a priority, can 'bolt on' specialist medical software and other IT applications to the core community health client information system within CHSs (SWITCH). As a number of CHSs use other systems, in addition to SWITCH, as data collection and management tools for core Community Health Program purposes, flexibility should be applied by the Department when making pilot project approvals to enable exploration of a wide range of achievable linkages between various software applications able to capture GP and/or allied health client data.
2. An audit should be undertaken prior to any pilot projects being approved to ascertain the current status, use, hardware and software dimensions, and levels of integration between client data systems within those Victorian CHSs delivering GP services.
3. Pilot project selection criteria should include a weighting in favour of projects that directly involve GPs and are able to promote service integration for private practice GPs.
4. Department of Human Services should support targeted IT training for CHSs with GPs services to increase the skills base within CHSs and GPs.



# Project Evidence and Conclusions



## Introduction

This section reviews the evidence emerging from the project's field investigations in relation to the research objectives and questions. Conclusions are then drawn and recommendations made.

## Project Research Objectives

**1. Establish a Statewide Profile of GP Service Activity in CHSs** and, subject to data availability, identify funding sources, employment/engagement/linkage arrangements, EFT/personnel numbers, numbers of clients seen, eligibility criteria for client service, client characteristics/profiles, job specifications/recognised professional roles, service costs and management reporting procedures applying to general practice conducted within or in association with all Victorian CHSs.

### Commentary

The management, program performance and integrated client information systems in place for GP service delivery in CHSs are very underdeveloped. Previous sections have addressed in detail these problems and their underlying reasons.

Within the limits of CHS data capacities, the earlier sections dealing with the Integration Index, finance, the profile analysis, the GP interviews, and the examination of information systems have provided a comprehensive statewide 'window' into the operation of CHS GP services, as sought by this objective.

**2. Conduct a review of professional practice of GPs in CHSs**

### Commentary

This and the following objective are addressed together below.

**3. Review the effectiveness of professional practice of GPs in CHSs** in relation to claims that these GPs are able to:

- Effectively address the health/medical needs of clients who have complex needs and/or are socially disadvantaged.
- Effectively utilise client health need/health risk assessment tools and criteria that are common to a range of health professionals in the local service setting and reflect primary health care/social model of health principles.
- Effectively engage in teamwork with other health professionals to provide clients with integrated pathways of care (which may include case management arrangements where one professional, GP or otherwise, is assigned a lead worker role).
- Effectively blend curative and health promotion roles on a regular basis in their day-to-day practice.

### Commentary

The project brief specified that the investigation of general practice in CHSs should be placed within a social model of health framework.

The project team, in partnership with the Department of Human Services and the reference group, agreed that the criteria above define a social model of health for the purposes of this project.

An evaluation of the effectiveness of CHS GP practice against these criteria now follows:

*Effectively address the health/medical needs of clients who have complex needs and/or are socially disadvantaged.*

Results from the GP interviews, supported by anecdotal responses from the profile survey, show that CHS GPs are consistently responding to the complex needs of disadvantaged groups. Based on a comparison of the project results with the national GP client profile of the BEACH study, CHS GPs respond to disadvantaged clients and their associated complex needs with much greater priority and frequency than do GPs in private practice settings.

In particular, GPs in CHSs are more likely than their GP colleagues in private practice to:

- Serve greater numbers of NESB clients and clients who are health card holders.
- Serve greater numbers of complex mental health problems including schizophrenia and psychosis.
- Serve greater numbers of serious client drug and alcohol problems.
- Serve greater numbers of female clients from socially disadvantaged backgrounds who present with sexual and reproductive health needs involving complex biological/social factors.
- Serve the medical needs of low income residents of remote communities where Medicare bulk billing rates are low by ensuring the provision of accessible and affordable GP care.
- Respond to domestic violence, homelessness, the impact of unemployment, loss of income and similar client social problems.

Most GPs in CHSs serve Victorian communities that have relatively high levels of social and economic disadvantage as shown by the analysis of CHS locations by ABS SEIFA rankings.

The GP profile information returned with the Integration Index survey shows a response rate of 47.9 per cent from female doctors. This figure can be used as a proxy indicator of the number of female GPs in CHSs. The AIHW GP database for 1998–99 showed that approximately 33 per cent of GPs billing Medicare in Victoria were female. Based on this information it can be reasonably assumed that there are proportionately many more female doctors in CHSs than generally found in private practice. This strongly suggests that CHS GP services are likely to be much more sensitive and responsive to women's needs than is the case for private practice GP services.

*Effectively utilise client health need/health risk assessment tools and criteria which are common to a range of health professionals in the local service setting and reflect primary health care/social model of health principles.*

Project evidence shows that the use in CHSs of standardised client needs and assessment tools, which are common to a range of health professionals including GPs, is quite undeveloped. However, a review of GP interview responses dealing with the concept of holistic care shows that most practitioners interviewed about this approach to care expressed a sophisticated understanding of the complex interplay of bio-medical, psychological, social, and cultural factors which impact on a client's health status. Moreover, they sought to apply these insights in their own professional practice.

# Project Evidence and Conclusions

*Effectively engage in teamwork with other health professionals to provide clients with integrated pathways of care (which may include case management arrangements where one professional, GP or otherwise, is assigned a lead worker role).*

Field investigations show that, generally, there are no formalised case management arrangements between GPs, and allied health professionals in CHSs or health professionals (including GPs) in the local community.

However, it can be reliably demonstrated statewide that, in most CHSs with GPs, collaboration and joint problem solving about client service delivery between GPs and other professionals is usually informal, occurs very frequently and adds much value to client outcomes. This is based on:

- (a) The practice experiences of CHS GPs recorded at interview,
- (b) The professional collaboration tracking trial the project undertook in one CHS, and
- (c) The profile survey information including the extent of GP participation in the various service types of CHSs and qualitative responses dealing with inter-professional service linkages.

## **Benefits of GPs to CHSs and Other Providers of Services**

The evidence points to a reciprocal process where the pooling of medical and other health disciplines' knowledge productively occurs for client assessment and client care planning purposes. Also, timely and effective cross-referrals of clients between GPs and other professionals routinely happens as a result of the close working

relationships that have been achieved between both groups.

Managers have also confirmed that having GPs in CHSs enables allied health professionals to be offered medical and clinical support for their clients. They can have an immediate assessment of the health concerns of their clients and provide feedback to them.

This collaboration is greatest with allied health professionals based in the CHS and is one of the main justifications given by GPs and CHS management alike for the provision of GP services in CHSs.

Project information has also revealed an increasing trend for CHS GPs to engage in direct client service and other forms of collaboration with professionals outside the CHS. This is being achieved through connections with organisations or networks such as local Divisions of General Practice, PCPs, Royal District Nursing Service (RDNS) and local government.

The Integration Index returns showed that 57 per cent of respondent CHS GPs also worked in other settings, including private practice and hospitals. This indicates that many CHS GPs are professionally integrated with other GP practice settings. It can be reasonably expected that such integration flows in two ways, that is, the experience of the GP in the CHS is introduced into other service delivery settings in which they work and the GP brings their experiences of other settings into the CHS environment.

CHS GPs, like their colleagues in private practice, are in the early stages of understanding and applying the potential of the MBS EPC items for adding value to client

service outcomes through strengthened assessment and interdisciplinary activity. An important opportunity seems available to CHSs to effectively implement the vision of improved client care, which is reflected in the EPC goals. This relies on the creative integration of CHS GPs and allied health roles. Given that both GPs and other professionals are under the one roof, CHSs are in a position to lead and model the emerging professional practice associated with the EPC items.

*Effectively blend curative and health promotion roles on a regular basis in their day-to-day practice.*

The analysis of GP participation in the various CHS service types indicates that GPs are much more involved in direct client service activities than they are in curative activities, such as health promotion/screening/risk reduction activities or service system planning/development and coordination activities. Responses from both GPs and CHS CEOs indicate that the major restriction placed on GPs taking a greater preventive and population health focus in their work derives from these responsibilities being ineligible for Medicare or significant practice incentive funding. Nevertheless, GPs and CHS management believe that a valuable role should be played by CHS GPs in these fields and funding options to make this possible should be strongly investigated.

**4. Develop a preferred practice framework statement for GPs operating in a CHS context based on field evidence gathered and review of other research including:**

- Target or priority clients and local community/population needs serviced.
- GP professional roles and functions.
- Benchmark principles for team work and coordinated client care linkages with allied health professionals and other GP's in the CHS or local community.
- Minimum data gathering sets for reporting GP client service and other activity.

**Commentary**

It has not been possible to develop a preferred practice framework, due to:

- (i) The data limitations the project encountered in generating quantitative evidence about roles of GPs in CHSs, and
- (ii) GP activity in CHSs currently occurring through a variety of organisational arrangements and without a clear policy mandate or endorsed program objectives from the Department of Human Services.

**5. Identify indicative benchmark costs for GP service delivery in a CHS context based on field evidence gathered and other available data.**

**Commentary**

Previous sections provide this benchmark information.

**6. Identify preferred models for GP employment/engagement or linkage arrangements with CHSs for the delivery of GP services within or in association with CHSs.**

## **Commentary**

The project has established that GPs in CHSs make a unique contribution to medical service delivery in Victoria by responding to the complex needs of disadvantaged client groups. This unique contribution occurs in both GP salaried and GP private practice co-locations.

These settings also include several sub-varieties of the two main approaches. The project is unable to identify any preferred engagement arrangement. After reviewing the available evidence, the project team has concluded that the effectiveness of CHS GP performance is primarily dependent on:

- (i) Client assessment and case management integration support to effectively link the roles of GPs and allied health professionals, and
- (ii) Information systems that adequately track and help create the client service pathways necessary to achieve such GP and allied health integration.

These critical success factors can be readily implemented in either salaried or private practice co-location settings, providing the program infrastructure support is made available to achieve this.

## **7. Ensure all project investigations adequately address metropolitan and non-metropolitan needs variations.**

### **Commentary**

The project has embraced 13 non-metropolitan and 17 metropolitan CHSs and reviewed practice needs in a variety of geographical settings.

## **8. Based on project conclusions, develop appropriate recommendations to Department of Human Services about GP service delivery in CHS contexts with reference to Victorian and Commonwealth government policies.**

This project review is timely, as it has highlighted a range of current issues facing GPs in CHSs. Based on this study, the project team believes that GPs in CHSs have a unique role to play in the current health care system.

## **Delivering a Social Model of Health and Responding to the Opportunities of PCPs**

The project has clearly established that GPs in CHSs deliver a social model of health because they:

- (i) Respond to the complex needs of disadvantaged clients.
- (ii) Apply a holistic approach to client assessment and care planning, which incorporates biomedical, psychological, social and cultural factors impacting on client health status.
- (iii) Frequently collaborate on an informal basis with allied health professionals to deliver integrated care.

GPs in CHSs are ideally suited to deliver care to health care cardholders and those with chronic illnesses, drug and alcohol problems, recent refugees and people who are homeless or from NESB. As noted, GPs interviewed in the study claimed that they see more complex cases than those listed in the BEACH study and their claims were substantiated by the higher MBS claims of long consultations and fewer consultations per hour. The methadone case studies provided by GPs from one CHS illustrated the complexity of their clients' problems.

Because of their predominant locations in disadvantaged areas, CHS GPs in conjunction with CHS allied health professionals, can provide affordable (including full bulk-billing) primary care services to their local populations. They are potentially in a position to strongly extend their collaboration with local services external to the CHS by exploiting the emerging integration opportunities arising from the PCP alliances facilitated through Department of Human Services.

## Barriers to Achieving the Role

There is lack of recognition and definition for the role of GPs in CHSs. This project believes this has arisen because CHS GP services are mainly Commonwealth-funded yet they are based within a State-funded service setting. Usually CHS funding and service agreements with Department of Human Services have not embraced the role of CHS GPs. However, the effective integration of Commonwealth-funded CHS GPs with Department-funded CHS allied health services is an important Department of Human Services objective inherent in its social model of health approach and the PCPs program.

The unique contributions of CHS GPs are not being fully realised because of their ambivalent positioning between State and Commonwealth health responsibilities.

The lack of recognition and definition in GP roles has continued to be widespread despite the existence of a Victorian community health centre doctors' contract and award for salaried GPs in CHS settings.

As a consequence of a lack of policy and program clarity about CHS GP services:

- These services have been poorly developed and formalised tools and program frameworks to guide their effective integration with allied health services in CHSs and in other local services.
- Targeted CHS allied health case management support is not adequately available in the CHS setting to enable the contribution the GP makes with a client to be brought together in a coordinated manner with the contribution other services in the CHS can make in responding to the same client's needs.
- The resource investments required by CHSs to adequately promote integration of their Department of Human Services funded allied health services with their GP service activities, including involvement by CHS GPs in the MBS EPC program to address the complex needs of disadvantaged groups in urban, rural and remote settings, are not adequately recognised.
- CHSs are not being supported adequately to establish effective client information systems which help facilitate GP and allied health integrated client service delivery.
- Commonwealth funded GP practice incentive payments are not providing sufficient practical support to GP services in CHSs to address complex needs of disadvantaged groups.

## Recommendations

1. Department of Human Services prepares statewide policy and program guidelines to support and develop the effective provision and monitoring of primary care service activity in CHSs, which integrates the allied health and GP resources of the CHS.
2. The policy and program guidelines should clearly define
  - Client outcome expectations
  - Collaborative delivery practices between GPs and allied health services
  - Common client assessment tools for use by GPs and allied health services
  - The client information system infrastructure required for the integration of GP and allied health service activities.
3. In the context of PCP and the social model of health approach, the Department of Human Services to work with CHSs to strengthen the integration of CHS allied health services with CHS GP activity.
4. This should include other CHS health professionals working closely with CHS doctors to help achieve integration in the following priority target areas:
  - Service delivery to remote communities where GP private practice bulk billing levels are low.
  - Service delivery to socially disadvantaged client groups with complex needs including NESB women, refugees, victims of torture, homeless people and long term unemployed people.
  - EPC service delivery to socially disadvantaged client groups with complex needs.
5. The Department of Human Services work with CHSs to achieve effective integration of general practice and other health client service information systems within CHSs based on the implementation features set out in the Information Systems Support section of this report.
6. That Department of Human Services advocate with the Commonwealth Department of Health and Aged Care to enhance PIP payments so that they adequately recognise the practice infrastructure demands of GP practices such as those in CHSs whose focus is upon providing GP services to socio-economically disadvantaged clients with complex needs in urban, regional and remote communities.
7. That in conjunction with the actions recommended above, a task group including representatives from CHS GPs and CEOs, Department of Human Services and the Commonwealth Department of Health and Aged Care address the following matters of priority:
  - Funding arrangements to support CHS GPs in population health roles with an emphasis upon responding to complex needs of disadvantaged communities.
  - The development of formal structures in CHSs to enhance team coordination and sharing of medical and service information.
  - An incentive based career structure for GPs working in CHS settings which offers some diversity in roles including direct client service delivery,

population health, service planning and teaching and which incorporates appropriate GP remuneration levels and/or engagement arrangements.

- The creation within CHSs of accredited general practice vocational teaching posts to provide GP registrars with vocational training experiences in CHS settings and that this strategy be implemented in conjunction with The National Board of General Practice Education and Training (GPET), the RACGP, regional general practice vocational training consortia and GPDV.

8. That CHS management use the Financial Break Even guidelines set out in this report as a tool to help manage costs associated with CHS GP service delivery.

# A Review of Related Research and Literature



## Background

This brief summary of the literature consists of two sections. The first section contains an overview of the generic concepts of integration and collaboration, two key philosophies that underpin the CHS model. The second section provides an overview of the Australian literature on the history, development and utility of CHSs.

## Integration

Primary health care, that is health care that is directly accessible to the public and seeks to promote their wellbeing and meet their physical, social and psychological health needs, is a complex activity. The multiplicity of community needs is matched by the range of people and structures, which come together to meet those needs. The Alma Ata Declaration (WHO, 1978) explicitly states that primary health care should involve 'in addition to the health sector, all related sectors and aspects of national and community development' and that it required 'maximum community and individual self reliance and participation in its planning, operation and control'. Above all, the Declaration indicates that primary health care should be participative and empowering to the people and communities it serves, offering them respect and shared decision making rather than seeking to control them. Professionals should be operating collaboratively with communities as well as with each other.

The move of traditionally secondary care activities into the primary care sector, for example hospital at home schemes, early discharge programs and not so minor day surgery, brings GPs into contact with another range of service providers. Two patterns

of working seem likely to become more prevalent. Firstly, primary care staff (not just GPs) will have expertise in assessment and initial treatment in a range of areas and will collaborate and integrate with specialist services as necessary. For example, in looking at the needs of a teenager diagnosed with diabetes, they will ensure links to local specialist groups and also make connections to education staff, consider family impact and voluntary agency support. They will also filter out services inappropriate to an individual's needs. The approach taken may be similar to care management in social services, where one worker, usually a social worker, is responsible for coordinating all the relevant services—from voluntary agencies, from social services and health care—to meet each individual's assessed needs. Organisations such as Carelink can potentially assist this process.

Secondly, as population health becomes a higher priority, practice based on the principles of public health and community development will be extended. Primary care practitioners are becoming central to decision making about service provision. This requires skills not only in patient contact, but also in the analysis of local health needs and decision making about how these should be tackled, feeding into locality-based primary care groups. Such a model is exemplified by the Primary Care Groups in the UK and the emerging PCPs in Victoria.

## Reasons for Integrated Primary Health Care

The National Health Priority Areas lend themselves to concerted action. The GP Strategy Review (1998) emphasises collaborative working. It also outlines chronic care management as a key management role for GPs. Other areas for primary care collaboration include:

- Health promotion, especially primary prevention, community development and local public health work. This work involves wide networks of other colleagues. Health visitors, school nurses and occupational health staff are perhaps the main players, but again GPs are expected to play a greater role.
- Chronic disease management (for example, asthma, diabetes and arthritis care): primary care is increasingly becoming a key provider in this area. GPs, together with pharmacists, assume much of the day-to-day support and monitoring of these patients, liaising with hospital staff, social workers and others on a regular basis. (In the UK, practice nurses and specialist nurses in primary care also play a role.)
- Care of older people—primary care staff are increasingly coordinating and providing ‘seamless care’ to older people with substantial health and social needs, in collaboration with social services and voluntary agencies. They will also need to draw on a wide range of local expert resources. This work has been encouraged by the MBS items for health assessment, case management and care planning introduced under the EPC Initiative.
- Care of people with long term mental illness, especially people with anxiety and depression. Changes in the role of community psychiatric nurses (CPNs) are placing additional pressure on GPs and other team members, such as practice nurses and health visitors. This is an area where new roles might develop to fill the gap.
- Sifting and management of self-limiting and minor health problems, together with the identification and referral of serious health problems. This area of practice is probably one of the most rapidly expanding, with some GPs working in Accident and Emergency (A&E) departments. In other countries, nurse practitioners and specialist nurses see patients in minor injury centres (Glasman, 1993) and in out of hours centres.
- Provision to marginalised communities or groups, especially those for whom traditional care is not accessible. There is considerable potential for the development of new roles with marginal groups, including finding effective ways of bringing them into decision making.

## Collaboration

The need for collaboration is noted in recent government documents. For example, the NSW Nurse Practitioner project report sees collaborative planning, practice and evaluation as ‘the foundation of relationships across professional boundaries’ (NSW Department of Health, 1999). It offers the scope for achieving mutual goals. Iles and Aulick (1990) emphasise the need for collaboration rather than domination in inter-professional relationships. They delineate the prerequisites of mutual goals,

# A Review of Related Research and Literature

clear roles and procedures and cooperative interpersonal relationships. Psychological theory clarifies that the decision making process requires cooperative, assertive behaviour from involved parties (Ruble et al., 1976).

## History

This decade has seen an increasing move towards a primary care led health service. Influencing systemic factors include the move of services into community settings and a broader service range enabled by technological advances. Societal influences include increased consumer demand and changing demographic patterns. This changing pattern, plus continued fiscal constraints, necessitates service integration, both within and across agencies. Hence the 1990s have seen the development of shared and coordinated care arrangements, culminating in the recent PCP program. Joint action can occur to differing degrees (Harris, 1991). While there are number of potential benefits to collaboration (Walker et al., 1997), the development of collaborative networks across care sectors is by no means cost neutral (Swerissen, 1997).

Integration of primary care services has been a key policy objective of both Commonwealth and State Governments. The National Strategy for General Practice (1991) aimed to increase GP involvement in health promotion, planning and continuity of care. Divisions of General Practice were set up to support GPs in working together and throughout the health care system. This includes enabling more collaborative working with other health professionals. In addition, the State-based organisations, the Support and Evaluation Resource Units and

the Rural Workforce Agencies have a role in providing infrastructure support to Divisions and to GPs.

Primary care services provide the following: identification and assessment of early stage health problems, management of common health problems, health promotion and illness prevention and ongoing supportive care (Australian Community Health Association, 1990).

## Community Health Services Definition

The community health service is a State-funded model for the delivery of general primary care. Community health services consist of multidisciplinary teams of salaried health professionals and are, by and large, funded and managed by State governments and/or their regional health services. GPs have been employed mainly in CHSs in Victoria and South Australia and to a lesser extent in Queensland, Tasmania and other States and Territories. Their employment arrangements vary from independent fee for service private practice through to salaried staff members. GP integration as part of the multidisciplinary team varies.

## Role of the GP

Although not all CHSs provide a medical service, GPs do work in such settings to varying degrees. The potential for GPs to collaborate with allied health professionals in the CHS setting will be explored below.

## Extent of Use

The CHS model largely operates in Victoria and South Australia. In New South Wales, although private GPs working in liaison with CHSs was piloted with some success (Saltman et al., 1993), elsewhere a proportion of GPs have actually been based in CHSs, largely as salaried employees. There are no recent national figures on either the number or distribution of CHSs across Australia or the number of GPs working from them. In 1993, there were approximately 23,500 staff based in 4,760 CHSs (Australian Community Health Association, 1993). State/Territory expenditure on CHSs ranges between 6–18 per cent (Fry and Furler, 2000). CHSs are not distributed in a comprehensive way to all communities. Rural services often experience shortages of allied health workers including physiotherapists, speech pathologists, social workers and mental health workers (National Rural Health Alliance, 1997). Some large urban services also have difficulties in meeting the needs within their limited supply (Western Sydney Area Health Service, 1995). In Victoria, it has been estimated that of the 100 CHSs, 30 run some type of medical service with 118 GPs, many of whom are part time.

## For What and with Whom

CHSs were established in the 1970s with the aim of integrating teams of health professionals to respond to local needs (Sax, 1992). They were located mainly in areas of socioeconomic disadvantage where there were gaps in medical services. The philosophy of the CHS is to operate within a social model of health. The implication for medical practice in this setting is that GPs can provide a holistic service to people with multiple social and physical problems in

conjunction with allied health professionals. It also offers the GP an opportunity to become more involved in health promotion and community development activities. The extent to which this has occurred has been questioned.

## Community Health Program Goals

The goals of community health are:

- Universal access
- New methods of service delivery
- Strengthening community action for health
- Creation of supportive local environments for health
- Encouragement and support for self help. (Owen & Lennie, 1992)

In principle, GPs working in CHSs portray the maximum degree of integration and communication between general practice and community health care. There is scope for a holistic approach to care. This can be exemplified by antenatal obstetric shared care in such settings (Isaac, 1986).

There is some evidence that CHS-based GPs are more likely to refer to allied health professionals, but this finding was based on self-reporting of the GPs in the study (Montalto et al., 1994). Montalto and colleagues (1994) set out to explore whether CHS doctors in the early nineties were reflecting the original intentions of their role. They interviewed 46 such GPs, the majority of whom were salaried. They tended to be younger, female, working part-time and less experienced than other GPs. Perhaps as a result of these characteristics, almost half intended moving on from the post within the next five years. While there were benefits from teamwork and the nature of employment, there were difficulties with

# A Review of Related Research and Literature

management and loss of professional autonomy. In line with the philosophy of CHSs, 76 per cent were involved with community health promotion activities, but clearly there is scope for this proportion to be higher, in line with the National Health Strategy (National Health Strategy, 1993). One barrier to involvement in health promotion is the pressure to increase throughput to support non-funded activities of the CHS. There are no signs of this receding.

While this study made no comparison between the activities of CHS-based GPs and their peers in private practice, a later report did so (Montalto et al., 1995). The responses of 39 CHS-based GPs were compared to those of GPs enrolled in the Australian Morbidity and Treatment Survey (Bridges-Webb et al., 1992). The CHS-based GPs were more likely to report offering counselling and advice and to refer to allied health professionals. Wijkkel's (1986) finding of fewer specialist referrals or greater rates of repeat prescribing (Jacob et al., 1984) were not corroborated in these Victorian GPs, but lower rates of home visiting (Jacob et al., 1984) were.

Studies conducted in the mid-nineties by the South Australia Community Health Research Unit (SACHRU) indicated the high level of patient/consumer support for the care received from CHSs that employ GPs as part of the multidisciplinary team. In particular, patients tended to rate the medical care experience there as more satisfactory than that received from private, fee for service practitioners (Warin et al. 1998).

Walker and colleagues (1997) have also drawn attention to the scope that CHSs have for liaising with other organisations to

provide integrated care. Their study, albeit with only four CHSs, suggested that much of this potential remained to be met. In summary, from the evidence available, it is not clear the extent to which these opportunities are realised in practice.

## Impact of CHSs and Barriers to Their Evolution

Over time, the CHS philosophy has become more prevalent within mainstream general practice with the establishment of the Divisions and Projects Grants Program in 1991. Many Divisions were employing their own allied health professionals, such as physiotherapists, podiatrists and dieticians for health care cardholders and pensioners. The proportion of GPs that fully bulk-billed their patients in urban areas also increased so much so that GPs in CHSs were in competition with other bulk billing private practice clinics nearby.

Another recommendation in the General Practice Strategy review also had an impact on CHS GPs—that all GPs were encouraged to adopt a population health, preventive medicine approach and to integrate better with allied health professionals and hospitals. Thus, the distinction between the fee for service model and CHS services became less apparent in the 21st century. At about the same time, CHSs had a budget cut and even though GPs in CHSs were salaried, they have always charged their services to Medicare and this was known as a pseudo-salaried arrangement. The fee for service structure has also impacted on medical services in CHSs as management put the pressure on GPs to see more patients in order to be financially viable.

The health promotion sessions were all abandoned and there was no time for community development work and the remuneration and working conditions of CHS GPs were indistinguishable from those of GPs in private practice. In several places, medical input has become unviable and the number of CHSs providing medical services has diminished. A large number of CHS GPs left in disenchantment with the erosion of the philosophy of the community health movement.

The CHS model offers the opportunity for GPs to collaborate in a more integrated fashion with other health care providers, with whom they are co-located. The question remains whether the setting engenders greater collaboration than elsewhere in the primary care setting. For instance, the Divisional Program, developed during the 1990s, has expanded GPs' opportunities via a number of activities. Programs such as after hours services have extended consumer access to GPs. Rural Divisions can now supply more allied health services to their GPs who can work closely with them to meet their clients' needs. The need for the CHS model as a separate entity may have diminished.

Swerissen and colleagues (1998) recently investigated the extent to which Divisions and CHSs work in partnership. As previously reported by Harris (1991), perceptions of each other's roles and conflicting ideologies acted as barriers to collaboration. In addition, the report highlights constraints such as lack of funding, rivalry, different geographical boundaries and GP time constraints and perceived lack of interest. The majority of Divisions thought it inappropriate for GPs to be based in CHSs.

Although the Primary Healthcare Research and Information Service (Department of General Practice, Flinders University) data on Divisions projects suggest that a number are involved in community health initiatives, these do not always involve liaison with allied health professionals. There was some joint work, largely on specific projects. The authors confirm that better relationships will be required for planning and service development. Some saw a need for protocols, rather than relying upon informal referrals. Both sides were less than satisfied with the current situation, but generally felt that relationships were gradually improving. There was also some debate about the extent to which partnerships existed with individual GPs, as distinct from Divisional representatives. In all, there was a need to create opportunities for greater collaboration.

## References

- Australian Community Health Association (1993), *A focus on people*, cited in Fry and Furler, 2000 op cit.
- Bridges-Webb, C., Britt, H. & Miles, D. et al. (1992), Morbidity and treatment in general practice in Australia 1990–1991, *The Medical Journal of Australia*, 157, S14–S15.
- Commonwealth Department of Health and Family Services (1998), *General Practice: Changing the Future through Partnerships*, Report of the General Practice Strategy Review Group Canberra, Commonwealth Department of Health and Family Services.
- Fry, D. and Furler, J. (2000) General Practice, Primary Health Care and Population Health Interface. In *General Practice in Australia: 2000*, Commonwealth Department of Health and Aged Care, Canberra.
- Isaacs, D. (1986) Shared Antenatal Care: An Alternative, *Australian Family Physician*, 15, 927–931.
- Jacob, A. & Anderson, R. A. (1984), A Move to a Health Centre: The Effect on Home Visiting, Repeat Prescribing and Patient's Choice of Transport, *Journal of Royal College of General Practitioners*, 34, 381–385.
- Montalto, M., Dunt, D. & Young, D. (1994), True believers? Characteristics of General Practitioners in Victorian Community Health Centres, *Australian Journal of Public Health*, 18, 424–428.
- Montalto, M., Adams, G., Dunt, D.R. & Street, A. (1995), Differences in Work Activities Between Private and Community Health Centre General Practitioners, *Medical Journal of Australia*, 163, 187–190.
- National Health Strategy (1992), *The Future of General Practice*, Issues Paper No 3, Commonwealth Department of Health, Housing and Community Services, Canberra.
- National Health Strategy (1993), *Pathways to Better Health*, Issues Paper No 7, National Health Strategy, Melbourne.
- National Rural Health Alliance (1997), *Workshop Reports and Communiqué: Strengthening Partnerships in Your Rural Community*, National Rural Public Health Forum, October 1997.
- Saltman, D.C., Sengoz, A. & Spencer-Herrera, L. et al. (1993), Community Health and Medical Practitioners Scheme: Providers Evaluate a Pilot Program of Integration of Services, *Medical Journal of Australia*, 159, 246–248.
- Sax, S. (1989), Organisation and delivery of health care, *The Politics of Health: The Australian Experience*, Gardner H(Ed), pp 225–251, Melbourne, Churchill Livingstone.
- Swerissen, H. (1997), How Should We Organise Community Health Services? *Australian Journal of Primary Health - Interchange* 3, 6–15.
- Walker, R., Mitchell, S. & Wright, M. (1997), Inter-organisational Relationships of Community Health Centres, *Australian Journal of Public Health*, 3, 18–28.
- Warin, M., Baum, F. & Kalucy, L. (1998), *'Not Just a Doctor': Community Perspectives on Medical Services in Women's Community Health Centres.*, SA: Flinders University, SACHRU.



Western Sydney Area Health Service (1995),  
*Review of Community Health Services*,  
Westmead Hospital, Sydney.

World Health Organisation (1978),  
Declaration on Primary Health Care, *WHO  
Chronicle*, 32(11), 409–430.

Wijkkel, D. (1986), Encouraging the  
Development of Integrated Health Centres: a  
Critical Analysis of Lower Referral Rates,  
*Social Science Med*, 23, 35–41.

## **Bibliography**

Dougan, B., Fry, D. & McMaugh (1999),  
*Collaboration in Primary Health Care: Case  
Studies of Divisions of General Practice and  
Community Health Services Working Together*,  
Royal Australian College of General  
Practitioners, Melbourne.

Swerissen, H. et al. (1998), *Community Health  
and General Practitioners: Partnerships in Care*,  
Primary Health Care Research and  
Development Centre,  
Latrobe University, Melbourne.

