

# Victorian Primary Care Partnerships

## Submission to Primary Health Care Advisory Group

*Better Outcomes for People with Chronic Disease and  
Complex Health Conditions through Primary Health Care*

September 2015

---



## Purpose

This submission has been prepared to inform the Primary Health Care Advisory Group of the work that is undertaken by Primary Care Partnerships in Victoria, and to respond to consultation questions put to the sector to gather information that could result in improved outcomes for people experiencing, or at risk of, chronic disease and complex conditions.

Primary Care Partnerships (PCPs) are established networks of local health and human service organisations. They work together to find smarter ways to deliver health services, so the health of their communities is improved. Since they were introduced by the Victorian Government in 2000, PCPs have become a vital component of the Victorian healthcare system.

In the 15 years of operation PCPs have grown significantly, in both size and reputation, as more and more health and social services and community groups join them in the quest to deliver better healthcare outcomes for Victorians. Today, PCPs facilitate partnerships with a wide range of health and social service providers and community groups; and they support collaboration and service integration. Most importantly, they play a key role to enhance the wellbeing of people within our local communities.

There are now [28 PCPs](#) around Victoria that connect more than 800 organisations across many different sectors. This includes: hospitals, GPs, local government, universities, community health services, disability services, problem gambling services, women's health and family violence services, mental health services, sports groups, schools, police and many more.

These diverse organisations are working together to plan around the needs of the community, to share their skills and expertise, and align their efforts. In bringing these health and social service organisations together, PCPs find new ways to collaborate and share valuable learnings, research and information. When it comes to the health needs of the community PCPs also enable more effective integrated planning, and develop the service system through co-ordination and integrated care as well as by making better use of data, evidence-informed interventions and a common planning framework.

PCPs are delivering real results – particularly, better health and social outcomes for community members – at the local level. Indeed, a recent [evaluation report](#)<sup>1</sup> found that PCPs have:

- Improved integrated planning
- Improved service co-ordination
- Increased organisational capacity and learning for health promotion
- Delivered economic benefits and resource efficiencies
- Contributed to healthier communities

The Primary Care Partnership platform is used extensively by the Department of Health and Human Services to roll out new initiatives in the areas of service coordination, integration and chronic disease management. The platform is also pivotal in the delivery of prevention and

---

<sup>1</sup> Department of Health (2011) Primary Care Partnerships: Achievements 2000-2010

health promotion work across Victoria. This submission identifies some of the work that PCPs deliver in chronic disease management and shares some of the learnings from our 15 years of practice in this space. Service coordination has a significant bearing in this respect and we particularly recommend that the PHCAG consider PCP work in this area.

In preparation for this submission, staff from all 28 PCPs had an opportunity to contribute feedback via electronic survey and web based discussion forum regarding different areas of PCP practice and how they interface with chronic disease management and prevention.

This submission includes responses to most of the 23 questions posed by the PHCAG. These can be found below. However, these questions limited to scope of responses and contribution we were able to make. For this reason, we also commend to you our recent submission to the Parliamentary Inquiry into Chronic Disease Management and Prevention which we believe should be read alongside this submission.

## Responses to questions posed by the PHCAG

1. What aspects of the current primary health care system work well for people with chronic or complex health conditions?

In Victoria over the past 15 years there has been significant work to improve service system response for people with chronic or complex health conditions. Much of this work has been led by Victorian Primary Care Partnerships. Integrated chronic disease management is key to PCP work. It fits within the program logic 2013–17<sup>2</sup> which has the following strategy goal:

To strengthen collaboration and integration across sectors by 2017, in order to:

- maximise health and wellbeing outcomes
- promote health equity
- avoid unnecessary hospital presentations and admissions.

It is a requirement that PCP action over 2013–17 is shaped by the following seven guiding principles:

1. Tackling health inequities
2. Person and family centred
3. Evidence-based and evidence-informed decision making and action
4. Cross-sector partnerships
5. Accountable governance
6. Wellness focus
7. Sustainability (including optimal use of technology)

Department of Health (2013) Primary Care Partnership Program Logic 2013-2017.

[http://docs2.health.vic.gov.au/docs/doc/5E35B44E161AF5C8CA257ACF00762128/\\$FILE/PCP%20Program%20Logic%202013-17\\_FINAL\\_v02.pdf](http://docs2.health.vic.gov.au/docs/doc/5E35B44E161AF5C8CA257ACF00762128/$FILE/PCP%20Program%20Logic%202013-17_FINAL_v02.pdf)

---

<sup>2</sup> Department of Health (2013) Primary Care Partnership Program Logic 2013-2017.

[http://docs2.health.vic.gov.au/docs/doc/5E35B44E161AF5C8CA257ACF00762128/\\$FILE/PCP%20Program%20Logic%202013-17\\_FINAL\\_v02.pdf](http://docs2.health.vic.gov.au/docs/doc/5E35B44E161AF5C8CA257ACF00762128/$FILE/PCP%20Program%20Logic%202013-17_FINAL_v02.pdf)

Timely access to appropriate services is the key to ensuring better outcomes for people with chronic or complex health conditions; right care-right time-right place. In Victoria, Primary Care Partnerships (PCPs) are voluntary alliances of local health and human service organisations who come together to strengthen relationships across sectors in order to maximize health and wellbeing outcomes. They work together to find smarter ways to deliver health services, so the health of their communities is improved. PCPs also enable more effective integrated planning, and develop the service system through co-ordination and integrated care as well as by making better use of data, evidence-informed interventions and a common planning framework.

A recent [evaluation report](#)<sup>3</sup> found that PCPs have:

- Improved integrated planning
- Improved service co-ordination
- Increased organisational capacity and learning for health promotion
- Delivered economic benefits and resource efficiencies
- Contributed to healthier communities

Department of Health (2011) Primary Care Partnerships: Achievements 2000-2010

Within local PCPs, all work is underpinned by core service coordination principles as outlined in the Victorian Service Coordination Practice Manual<sup>4</sup>:

- Central focus on consumers
- Partnerships and collaboration
- The social model of health and the social model of disability
- Competent staff
- Duty of care
- Protection of consumer information
- Engagement with a broad range of service sectors
- Consistency in practice standards

VictorianServiceCoordinationPracticeManual2012,

[http://www.health.vic.gov.au/pcps/downloads/sc\\_pracmanual2.pdf](http://www.health.vic.gov.au/pcps/downloads/sc_pracmanual2.pdf)

Service coordination benefits include

- Improved access to assessment and coordinated shared care/case planning clarity regarding who is involved in service provision and what their responsibilities are to meet the consumer's goals
- Reduced duplication of assessments and services as well as identification of service gaps
- Documented practice standards for the elements of service coordination including; initial contact, initial needs identification and shared care/case planning, providing a common language between services

---

<sup>3</sup> Department of Health (2011) Primary Care Partnerships: Achievements 2000-2010

<sup>4</sup> Victorian Service Coordination Practice Manual 2012,

[http://www.health.vic.gov.au/pcps/downloads/sc\\_pracmanual2.pdf](http://www.health.vic.gov.au/pcps/downloads/sc_pracmanual2.pdf)

- Improved consistency and quality of consumer information through the use of common tools such as **the Service Coordination Tool Templates which have increased efficiency by combining over 300 different versions of templates.**

While there is still much work to do in these areas, PCPs provide an existing platform from which to deliver integrated chronic disease management programs and improve systems, processes and partnerships to achieve better outcomes.

2. What is the most serious gap in the primary health care system currently provided to people with chronic or complex health conditions?

a) In your area?

The ongoing challenge for PCP work in Victoria is addressing long established fragmented care, poor communication and duplication in the primary health care. Gaps identified by PCP members include effective care coordination, shared care planning, case conferences and the ability to communicate efficiently and effectively via secure and reliable technologies. In some cases, inadequate staff training and poor understanding of local service systems is a barrier to timely and effective assessment and communication. This poor understanding of local service systems outside of their own often leads a time poor, resource constrained workforce to function in ever decreasing circles – avoiding interagency liaison and case conferences, repeating assessments “because its quicker than chasing up the referrer”, completing unnecessary or out of date referrals, or not referring at all. GP practices, cited as integral to primary care, often feel the most disconnected and unable to participate in collaborative work.

b) Nationally?

3. What can be done to improve the primary health care system for people with chronic or complex health conditions:

a) In your area?

Strengthening patients' ability to self-manage their condition is the most promising way to achieve greater value in care for people with long term conditions. Collaborative relationships between clinicians and patients working together to create and implement personalised care plans are key to encouraging better self-management. People who are well-informed and well-supported are more likely to make healthy lifestyle choices; they tend to adhere better to medication regimes, they make informed and personally relevant decision about their treatment and they use less health care. Empowering patients may be the most effective way to manage demand, as well as being an essential component of good chronic disease management. Consumer and community empowerment is one of the PCPs key three domains in its program logic for 2013–17.

Better coordinated care is needed to support care plans and the PCPs are working to improve this under a second key domain - Early intervention and integrated care.

b) Nationally?

4. What are the barriers that may be preventing primary health care clinicians from working at the top of their scope of practice?

Barriers to clinicians trying to innovate in this area include the challenge of coping with multiple competing demands, lack of acknowledgment of the psychosocial and interpersonal demands of working with complexity, a feeling of being hidebound by policies, procedures and regulatory requirements, the lack of a dedicated team to support quality and change, and negative or defensive reactions from colleagues.

There is a constant risk of trading quality for quantity and accuracy for timeliness.

PCPs identified a number of additional barriers to more effective work including:

- “information fatigue”, being pulled into too many meetings, constant information and updates and little time to process, reflect and reply.
- approaches that operated in silos and difficulties getting broader catchment and / or regional agreement.

Most of the challenges identified related in some way to resourcing issues. Many professionals from within PCPs noted frustrations with lack of time allocation to follow through on activities, lack of staff skill and knowledge in understanding how to tackle the upstream determinants of chronic diseases and lack of resources that would enable follow through on activities and ideas generated by partnerships.

5. As described in Theme 1 of the Discussion Paper, a ‘health care home’ is where patients enrol with a single provider which becomes their first point of care and coordinates other services.

Do you support patient enrolment with a health care home for people with chronic or complex health conditions?

The principle of a health care home is sound however, in practice a number of questions arise such as, “who coordinates care?” This often becomes a point of consternation with practitioners sometimes expressing views such as “We aren’t funded to do that, my title is not Care Coordinator, we’re the 3<sup>rd</sup> service they’ve come to: why should it be us?” The need for skilled clinicians to assume this co-ordinating role is critical to assist both the consumer but also the services involved. Case managers may assume this role in some programs.

In addition such a system must allow for and enable patient choice including the choice to seek second opinions. Without strong systems and protections in this area, people with low health literacy and poorer health outcomes may find their disadvantage exacerbated.

We particularly commend the work of Coulter, Roberts and Dixon (2013) in this area and reinforce their focus on individual empowerment, without which such a system is unlikely to achieve health equity and other desired outcomes.

“The House of Care –

- a coordinated service delivery model focused on care planning and support for people with long term conditions ). The house is a metaphor for the supports that need to be put in place to deliver more proactive, personalised and better coordinated care. The model has a particular focus on primary care professionals, but has wider implications for the broader health and care workforce.
- it explicitly places the person at the heart of the delivery system. A central aim of this model is individual empowerment. People who have the knowledge, tend to lead healthier

lifestyles, make informed and personally relevant decisions about their treatment and care, are more likely to adhere to treatment regimes, experience fewer adverse events and use less costly healthcare.”

Coulter A, Roberts S, Dixon A, 2013. *Delivering better services for people with long term conditions: building the house of care*. London: King’s Fund.

- Yes
- No
- Prefer not to answer

6. Do you support team based care for people with chronic or complex health conditions?

- Yes
- No
- Prefer not to answer

7. What are the key aspects of effective coordinated patient care?

PCPs identify the 8 key aspects of effective coordinated patient care as

- Patient and carer engagement
- Leadership
- Service and care model design
- Workforce (role design, skills, capacity)
- Information and Information Technology
- Financial and Contractual Mechanisms
- Culture
- Governance

8. How can patient pathways be used to improve patient outcomes?

The most critical element to improving patient outcomes through patient pathways lies in the meaningful inclusion of patients in decision making (*Developing Pathways: using patient and carer experiences* <https://www.networks.nhs.uk/nhs-networks/smart-guides>) This must be a key priority for improving the care of people with chronic and complex conditions. Health practitioners have limited potential to impact on health outcomes given the tiny percentage of time they have with patients relative to all other activities that person undertakes in their life. Failure to engage, include and empower patients in decision making will ultimately prove most costly and less effective than when patients are more active in this way.

If localised effectively patient pathways can provide a clear and consistent mechanism for ensuring that people receive appropriate and consistent care and support. They can also be

individualised to reflect specific specialised needs of various communities. Documentation of pathways ensures that gaps are more readily identifiable and it assists various services/disciplines to clearly articulate the nature of their service what they are able to provide and what they are not able to provide and any requirements they may have to effective and efficient service provision. Well defined pathways can also be used to clearly and consistently outline to clients the ways in which their care will be managed, i.e. the flow of activity and by whom. This may assist patients in being more confident about asking questions and seeking clarification about anything they were unsure of.

At present there is a lack of regional and state clinical pathways for specific disease processes. Clinical pathways and associated disease processes are homogenous and hence minimal. Whilst there are some examples of pathways e.g. NICE pathways UK <http://pathways.nice.org.uk/>, Map of Medicine <http://mapofmedicine.com/>, NPS Medicine Wise <http://www.nps.org.au/> , regionally there appears to be little consistency amongst service providers.

The Peninsula Model is one local example where Health Pathways map of medicine has been adopted. <http://www.peninsulamodel.org.au/map-medicine-care-pathways-project-update>. This kind of consistency is required at minimum regional level regardless of what provider is chosen. This is an area where PCPs believe that PHNs can play an active and leading role.

*Patient pathways* are nationally or regionally standardised, evidence-based multidisciplinary management plans which identify an appropriate sequence of clinical interventions, timeframes, milestones and expected outcomes for a patient group.

9. Are there other evidence-based approaches that could be used to improve the outcomes and care experiences of people with chronic or complex health conditions?

PCP work is evidence based and we refer particularly to the key lessons for the successful adoption of coordinated care taken from *Providing integrated care for older people with complex needs: lessons from seven international studies* January 2014 Nick Goodwin, Anna Dixon, Geoff Anderson, Walter Wodchis [http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/providing-integrated-care-for-older-people-with-complex-needs-kingsfund-jan14.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/providing-integrated-care-for-older-people-with-complex-needs-kingsfund-jan14.pdf)

#### **System level**

- Provide stimulus through funding or other means to support the development of local initiatives to improve care for this group of people.
- Avoid a top-down policy that requires structural or organisational mergers.
- Remove barriers that make it more difficult for localities to coordinate care, such as differences in financing and eligibility.

#### **Organisational level**

- There is no single organisational model or approach that best supports coordinated care.
- The starting point should be a clinical/service model designed to improve the care that is provided rather than an organisational model with a pre-determined design.

#### **Functional level**

- Success appears to be related to good communication and relationships between those receiving care and the professionals and managers involved in delivering care.
- Greater use of ICT is potentially an important enabler of coordinated care, but does not appear to be a necessary condition for it.
- Building relationships to support coordinated care requires time to build social capital and foster



trust.

### **Professional level**

- Professionals need to work together in multidisciplinary teams or provider networks – generalists and specialists, in health and social care.
- Within teams, professionals need to have well-defined roles, and work in partnership with colleagues in a shared care approach.
- In most of the case study programmes, care co-ordination was being delivered alongside rather than by primary care physicians. This suggests that patients with complex needs that span health and social care may require an intensity of support that is beyond what primary care physicians can deliver.

### **Service level**

- A number of common elements in the design of the care process at a service level appear to be important. These include:
  1. holistic care assessments
  2. care planning
  3. a single point of entry
  4. care co-ordination
  5. the availability of a well-connected provider network that can facilitate access to the necessary support, particularly for self-management.

### **Personal level**

- All case studies had a specific focus on working with individuals and informal carers to support self-management.
- Continuity of care and care co-ordination to meet individuals' specific needs is important and highly valued.
- Personal contact with a named care co-ordinator and/or case manager is more effective than remote monitoring or telephone-based support.

## **THEME 2, INCREASED USE OF TECHNOLOGY**

10. How might the technology described in Theme 2 of the Discussion Paper improve the way patients engage in and manage their own health care?

The National Health Services Directory (NHSD) is a key resource within this area it has been expanded from the Victorian Human Services Directory and is now nationwide. It underpins directories such as Nurse on Call, the better health Channel and Connecting Care among others. It is on-line and is regularly updated by agencies. PCPs encourage all member agencies to populate and update the NHSD. The Department of Health and Human Services encourages use of the NHSD but it would be helpful to issue stronger directives in this regard and provide funding and or incentives to make it more accessible and increase the functionality and develop this technology further

11. What enablers are needed to support an increased use of the technology described in Theme 2 of the Discussion Paper to improve team-based care for people with chronic or complex health conditions?

E-health as a domain is now moving beyond secure messaging into the complex area of shared care planning. Being able to access, contribute and use 'live' documents in partnership with consumers and service providers is something we need to strive for.

One of the lessons from experience is the need to ensure that information-sharing is

supported by appropriate information governance and equally is not hindered by overly zealous interpretation of the rules on information governance. (Chris Ham, Nicola Walsh March 2013 [http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/making-integrated-care-happen-kingsfund-mar13.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-integrated-care-happen-kingsfund-mar13.pdf)).

Care coordination is greatly enhanced where there are high levels of IT connectivity which comply with the National E-Health Transition Authority (NEHTA) Standards. There are a number of electronic client management systems that enable better connectivity for supporting services. S2S and Connecting Care are the ones that are used by the majority of PCP member agencies in Victoria. S2S and Connecting Care enable secure messaging between agencies. s2s also has the capacity to have an interactive shared support plan between agencies supporting a consumer. PCPs are well placed to assist local health providers to become more e-referral literate and recommend

**1. Implement the Service Coordination framework across all funded health agencies and resolve issues with connectivity to ensure secure and efficient practice in relation to all aspects of service coordination:**

- The Commonwealth should collaborate with the Department of Health and Human Services (Vic) and other State authorities to ensure that all future upgrades to referral processes (such as the SCTT tools) are included in software products and that interoperability exists between secure messaging platforms. Furthermore, future developments should occur in consultation with vendor providers' development teams to enable implementation of the upgrades in a timely manner.
- Continue to support the ongoing development of platforms to enable interoperability of CMS in future developments that align with NEHTA standards.

**2. Ensure a well trained and competent workforce**

- Implement minimum compulsory training standards for all existing staff in privacy and confidentiality and the transfer of client information. This should include information about secure messaging.
- Ensure that Service Co-ordination is included within the curriculum at university to all medical, health and social students with some detail about the secure messaging, privacy and systems.

**3. Invest sufficient resources to ensure that all agencies can meet best practice standards in relation to service coordination**

- Resource and strengthen existing partnerships and platforms. New initiatives should not be introduced independently of existing structures, as it can be counterproductive to create new partnerships, governance structures and organisations.
- Consider promoting and enhancing co-location arrangements so that more workers from different disciplines can be seen from one location thereby decreasing the need for consumers to juggle multiple appointments in different locations.

12. How could technology better support connections between primary and hospital care?

*Refer to questions 10 and 11*

13. How could technology be used to improve patient outcomes?

PCPs are watching digital developments in the UK's NHS with interest including ideas such as -

- Patients able to book appointments online. This may also include the capability to inform patients if an appointment is actually needed. Depending on presenting conditions there may be more appropriate services to meet the patient's needs.
- Integrated and interoperable working with other agencies, for example GPs to be able to access child and adult records held in DHHS systems, specifically to inform diagnosis and safeguarding.
- GPs visiting patients at home, care homes, or other care settings, having access to systems they would have if they were in their own practice building. This could include:
  - Full access and ability to update patient records in real time
  - Ability to prescribe medicines electronically and either print a ticket or text/email a confirmation, to initiate a dispensing instruction to the pharmacy of the patient's choice.
- GPs able to visit or offer appointment times to patients from other general practices with the ability to view their records, write to the patient record and issue electronic prescriptions, subject to information sharing agreements across shared care models.
- Exploring the benefit of clinical decision support and links into Nurse On Call as a 'pre-primary care' triage service.
- Nurse On Call and Out Of Hours providers able to access and update the patient's primary care medical record, subject to patient's consent.
- Nurse On Call and Out Of Hours providers able to access and view the patient's summary care record and/or full coded record.
- Patients able to view their full coded medical record, including the option for them to download their record into third party applications, where required.
- Installing Wi-Fi and other enabling infrastructure in practices, allowing patient access to online services (e.g. repeat prescriptions, online appointment booking) from their own mobile devices.
- Telecare and healthy living apps which enable patients to monitor and manage their health or live independently without having to visit their GP surgery as often.
- Patients able to provide information prior to seeing the GP to aid pre-referral diagnosis and maximise effectiveness of patient-GP face time.
- Telehealth devices made available to patients to test and undertake diagnostics then upload to GP for consideration.
- Offering a 'click and collect' or 'click and deliver' service for repeat prescriptions (e.g. patient orders repeat prescription online, GP signs off in electronic prescription service, pharmacy dispenses and patient either collects or pharmacy delivers), all trackable online by the patient.
- Enabling new channels for consultations with a GP, e.g. via telephone, email, webcam or instant messaging, where this is deemed to be appropriate and clinically safe.

## **THEME 3, HOW DO WE KNOW WE ARE ACHIEVING OUTCOMES?**

14. Reflecting on Theme 3 of the Discussion Paper, is it important to measure and report patient health outcomes?

- Yes
- No
- Prefer not to answer

Why do you say that?

Setting specific objectives for coordinated care, and measuring and evaluating progress toward these objectives is essential to monitor effectiveness. A common weakness is the failure to move beyond high-level aspirations to agree specific objectives for coordinated care. In practice, these objectives need to encompass a variety of dimensions of care including user experience, service utilisation, staff experience and the costs of delivering care. [http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/making-integrated-care-happen-kingsfund-mar13.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-integrated-care-happen-kingsfund-mar13.pdf)

The difficulty is, while there is often lots of data collection, routine extrapolation and useful application doesn't often occur.

15. How could measurement and reporting of patient health outcomes be achieved?

- Further consideration is required as to how 'patient health outcomes' are defined.
- Combine objective measures with patient experience
- Improved quality of life indicators for some conditions
- Greater access by health planners to hospital data from EDs and other programs
- Improved data systems that enable sharing of de-identified data.

16. To what extent should health care providers be accountable for their patients' health outcomes?

Given that most care is undertaken by patients and their support networks (95% cited at a recent PCP forum), providers should be knowledgeable and mindful of factors outside their control that influence patient health outcome. Perhaps being accountable for patient and carer's experience could be relevant, and being accountable for what matters to patients i.e.

- Feeling informed and being given options
- Staff who listen and spend time with me/patients
- Being treated as a person, not a number
- Being involved in care and being able to ask questions
- The value of support services, for example patient and carer support groups
- Efficient processes (Robert, Cornwall, Brearley et al 2011)

17. How could health care provider accountability for their patients' health outcomes be achieved?

see Question 16

18. To what extent should patients be responsible for their own health outcomes?

PCPs adopt a social determinants of health approach to understanding health outcomes and contributing factors. We acknowledge that many factors influence good health are beyond patient control. For this reason, we must avoid language and systems that might blame individuals for poor lifestyle choices and health outcomes. It is important to start from the core belief that all people are entitled to and desire good health. The health system will achieve the best outcomes when people are empowered and resourced to achieve this. For this reason, the word “responsible” may be considered problematic in that it may lead to blame and stigma of those who fail to make “healthier lifestyle choices” or adhere to medications regimes or other instructions given by health care providers.

19. How could patient responsibility for their own health outcomes be achieved?

See question 18

#### **THEME 4, HOW DO WE ESTABLISH SUITABLE PAYMENT MECHANISMS TO SUPPORT A BETTER PRIMARY HEALTH CARE SYSTEM?**

20. Theme 4 of the Discussion Paper discusses different payment mechanisms. How should primary health care payment models support a connected care system? Some PCPs believe that capitated payments are a better way to fund health services, however the formula on which health services are cash-flowed needs to ensure equity across all sizes of services/and service types, rather than population statistics. For example some smaller health services offer a similar range of services to larger nearby services, and rural people will travel to smaller service providers to avoid waiting lists. The formula would need to allow for a “bonus” system rather than a penalty reaction should services exceed targets through genuine service demand.

Rural recruitment and retainment of workforce is a substantial concern for smaller rural services and guaranteed funding (in advance) allows for confidence when health service workforce planning is undertaken.

In other consultation processes, PCP members also highlighted areas where the Medicare payment system fails to reward and encourage best practice and quality improvement in chronic disease prevention and management. In particular, access to best practice care may be limited for patients due to current Medicare funding arrangements that restrict rebates for services for allied health. These are subject to referral rules in which the number of services and treatment requirements are pre-specified by the GP. Group therapy is not covered and therefore the benefits of shared experience between patients receiving the same types of restorative or supportive services, is not possible. Group therapy is often an efficient delivery mode for exercise based rehabilitation programs (e.g.: Heart Failure restorative programs). In addition, the current referral process does not support a multidisciplinary team approach, requiring separate referrals to each service provider, which is duplication and repetition for the referring GP

GPs are cited as integral to primary care yet their links with community based outpatient programs and health professionals, in our experience, could be improved. Predominantly in private practice they work on a business model and it appears financial incentives are main driver. Often GPs have 'in-house' AHPs via CDM MBS and CHS now utilise CDM MBS to fund some of their AHPs (requiring high through put). There was a distinct culture between private and public sector, and why you chose to work in one vs other, however this is becoming blurred and to the detriment of community based out patient services.

Results from work currently under way in the UK to explore an outcomes-based contract for frail older people may be relevant. A critical requirement for success will be the willingness of different commissioners to work together to support the emergence of integrated care, a task that has been made more difficult by the fragmentation of the population-based budgets, formerly controlled by primary care trusts, to clinical commissioning groups, the NHS Commissioning Board and local authorities.

21. Should primary health care payments be linked to achievement of specific goals associated with the provision of care?

- Yes
- No
- Prefer not to answer

Why do you say that?

In our consultation process for this submission, some PCPs felt that targets or remuneration KPI's would ensure that direct service provision funded resources are not absorbed into hospital operations. Clinicians remain client focused, however the fee vs care debate regarding similar MBS models is an ongoing one, with no easy answer as individual client needs are difficult to "cap".

22. What role could Private Health Insurance have in managing or assisting in managing people with chronic or complex health conditions in primary health care?

PCPs do not have a uniform opinion in this area.

23. Do you have anything you would like to add on any of the themes raised in the Discussion Paper?