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Australia's systems of primary healthcare

The need for improved coordination and implications for Medicare Locals

Background

In Australia, primary healthcare is largely delivered through two parallel systems: Medicare supported primary care delivered by fee-for-service general practitioners, and state funded and managed community health services.

Methods

Semistructured interviews with 18 GPs to investigate the current links between GPs and local primary healthcare providers.

Results

Barriers to links include: communication and information, access and availability of services, GP lack of awareness and understanding of services provided in the state funded sector, and lack of time to gain information.

Discussion

General practitioners reported dealing with more complex and challenging patients. However, this did not appear to increase their likelihood of engaging with state funded primary healthcare services in case management. Medicare Locals are a once-in-a-generation chance to establish a genuinely coordinated and multidisciplinary primary healthcare sector. To be successful, Medicare Locals will need to bring together two parallel systems of care and improve integration and coordination.

Keywords: general practice; health policy; community health services; integrated delivery of health care

In Australia, primary healthcare (PHC) is largely delivered through two parallel systems: Medicare supported primary care delivered by fee-for-service general practitioners, and state funded and managed community based health services whose formation was shaped by the national Community Health Program of the Whitlam government.¹ Recent measures have facilitated general practice collaboration with other private allied health providers such as diabetes educators, physiotherapists and psychologists through extensions to Medicare funding and divisions of general practice.

Primary healthcare reform in South Australia has focused on the GP Plus Health Care Strategy aimed at increasing collaboration between state run health services and GPs, and prioritising health promotion, illness prevention and early intervention.² Under this initiative community health centres and women's health centres were rebadged as primary care services or GP Plus Health Care Centres. These services employ various combinations of community nurses, allied health workers, social workers and counsellors, health promotion and community development workers and a small number employ salaried GPs. They provide individual and group therapy and support for chronic disease, mental health and other health related issues. South Australian services have been restructured and governance arrangements changed several times in the past decade. In early 2011, all metropolitan PHC services were brought together in one centrally managed region.

Australia is in the process of implementing the National Health and Hospitals Reform. As part of

this reform, the Australian Federal Government is developing Medicare Locals (MLs) aimed at improving PHC at the local level. The first 19 MLs announced in June 2011 were from existing divisions of general practice. Medicare Locals have been welcomed as an opportunity to improve PHC integration between private and publicly funded health providers. However, concerns have been expressed that the proposed changes may focus heavily on the GP part of the system at the expense of interprofessional collaboration and multidisciplinary team care.³ Community based PHC services are to remain state funded and are no longer included in the structure of Medicare Locals.⁴ The removal of PHC services from the structure of Medicare Locals raises further questions about how this may impact on PHC integration and health reform at the local level.⁵

For GPs, health reform presents some challenges. Coordination of patient care is likely to be more difficult as health systems become more complex, leading to decreased patient satisfaction.⁶ Power sharing arrangements such as interprofessional collaboration and shared team care will require negotiation.⁷ To date, these measures have proved difficult to implement in general practice settings.⁸⁻¹⁰

This article reports findings from a South Australian investigation of fee-for-service GP perceptions of local community health services and provides a timely insight into the status of relationships between the two parallel systems of healthcare that currently operate in Australia.

Methods

Eighteen GPs with links to one of 5 metropolitan South Australian PHC services (four directly funded and managed by state government, including an Aboriginal health service and a

nongovernment sexual health service) were interviewed to investigate current links between general practice and local PHC providers.

Recruitment

Purposive sampling of information rich cases was used to gain in depth data.¹¹ Five PHC sites in the Adelaide metropolitan region identified local general practices with which they had links. Practice managers of target practices were contacted to invite GP participation. A practice visit followed to introduce the research. Follow up telephone calls were made to ascertain consent and arrange interviews with GPs. A small reimbursement for participants' time was provided.

Participants were interviewed face-to-face or by telephone as preferred. With consent, all interviews were audio recorded and transcribed.

Ethics approval was granted by the Flinders University Social and Behavioural Research Ethics Committee.

Interviews

A semistructured interview guide was developed with input from the project advisory group, and piloted with two GPs. Interviews sought GP perceptions about the extent and nature of links with local PHC services, barriers and enablers of linkage, and the potential impact of health reform.

Analysis

Transcribed data were thematically analysed¹² by the research team with assistance of NVivo software. Emerging findings were discussed and themes negotiated and agreed upon in regular team meetings. Interpretations were checked with the project advisory group, which comprised key stakeholders including representatives from SA Health, divisions of general practice and GPs.

Results

This article reports GPs perceptions regarding the role of general practice, changes to practice and links with state government funded and managed PHC services. A full report of the study may be accessed online.¹³

Participant characteristics and general practice role

Eight female and 10 male GPs participated (*Table 1*). Total general practice years varied from 1–42

years (mean=21). Years in current general practice situation varied from 1–36 years (mean=12). Seventeen GPs graduated in Australia, one GP graduated overseas. All participants practised in a shared or group practice.

General practitioners were asked to describe their day-to-day practice role and if this had changed over time. Although most GPs reported that they dealt with 'pretty much everything', many believed their patient base had evolved in a particular direction (eg. younger patients, middle aged, elderly patients) depending on local demography, aging practice population, or patient preference.

Other changes included changes to practice set up, changing role and practice focus, and patient characteristics. General practitioners reported being less isolated than in the past, with increased social and professional contact and more team practices. General practitioners perceived their role as the central coordinator for patient care and were concerned that the role of the family GP may be declining. Most GPs believed that they were now seeing patients with increasing multimorbidity and complex medical

problems and an aging patient demographic. They also saw more patients for referrals, prevention and chronic disease management.

GP links with local primary healthcare service providers

We explored any formal (referral) or informal links that GPs had with local PHC services. Formal links were defined as a direct referral from the GP to local PHC service providers. No formal links with local PHC services were reported in this purposive sample. We found most GPs had limited links with, or awareness of, the services provided by their local PHC service. General practitioners who had established some level of connection reported this had come about through either previous personal contact with local PHC service staff, positive patient feedback, or the PHC service being recognised as a longstanding provider of a specialised health/community service (eg. sexual health). Occasionally links were made through a third party such as referrals made for a GP's patient by another health provider:

'Look, I think that's probably an area that I wouldn't organise direct referral but an area I'm

Table 1. General practice characteristics for study participants

| Participant | Gender | Practice type | Total GP years | GP years in current practice situation |
|-------------|--------|---------------|----------------|--|
| GP 1 | F | Shared | 22 | 20 |
| GP 2 | M | Shared | 31 | 10 |
| GP 3 | F | Group | 19 | 7 |
| GP 4 | F | Group | 2 | 2 |
| GP 5 | M | Group | 1 | 1 |
| GP 6 | M | Shared | 16 | 15 |
| GP 7 | F | Group | 8 | 2 |
| GP 8 | F | Group | 42 | 36 |
| GP 9 | M | Group | 28 | 28 |
| GP 10* | M | Group | 18 | 5 |
| GP 11 | F | Shared | 15 | 7 |
| GP 12 | M | Group | 30 | 30 |
| GP 13 | M | Group | 8 | 6 |
| GP 14 | M | Group | 26 | 16 |
| GP 15 | M | Group | 30 | 10 |
| GP 16 | F | Group | 37 | 10 |
| GP 17 | M | Group | 14 | 9 |
| GP 18 | F | Group | 32 | 9 |

Practice type: shared = two GPs; group = three or more GPs; * = graduated overseas

aware it does happen is with preschoolers and speech therapy – and that's an area certainly that I've had communication to and from [local PHC service].' [GP 6]

Difficulties forming links with local primary healthcare services

A number of difficulties in forming links with their local PHC services were reported by the GP participants. A lack of communication between the two sectors was noted as a concern by GPs:

'... the biggest level of concern is that if people are getting health advice from many different sources, if there isn't good communication then it means that the essence of who a person is and what their needs are can become diluted somewhat.' [GP 6]

Information sharing problems were perceived by GPs in terms of the lack of feedback from local PHC providers also working with their patients:

'Correspondence. It is, I do think it is a negative impact, because typically in my world when I refer someone to a colleague, I generally will get feedback from that colleague as to what they've done and what their plan is so that you can at least have an update in your records of what the plan is so you're working as a team, not as an individual with everyone doing different things – then you don't know what they've done and what I'm due to do next.' [GP 3]

Access and availability of services was often perceived by GPs as complex and liable to lack of uniformity and frequent change:

'Yeah, just the lack of uniformity with how to make an appointment depending on what service and what site.' [GP 11]

Practitioner specific issues also emerged such as lack of awareness and understanding of services provided in the PHC sector and GPs lack of time to pursue such information:

'Because sometimes – I may have even gotten information but you don't realise – you don't have the time to sit and read through it...'. [GP 13]

Ensuring continuity of care emerged as central to GPs in determining patient referrals and was linked to GPs perception of their role as the central coordinator for their patients' care:

'I still think the GP is probably – whether you call them team leader or team coordinator, is the patient's main coordinator, navigator, treater, so you can navigate the patient through the system

which they need to be... so GPs still should be – if you don't want to call them leaders, but at least coordinators of primary health.' [GP 12]

'What I believe that we are able to provide in our role here is a continuity of care to individuals and their families... I see my role as being someone in a position to know my patients and their needs and to be able to work with my patients and the services that are available to ensure that those needs are met.' [GP 6]

However, ensuring continuity and coordination of care also emerged as a barrier to linking outside the GPs' established referral pathways:

'I'd normally stick to people that I've used in the past and happy with and stick to them.' [GP 13]

Generally, GPs' referral pathways had evolved over time as trust was built with individual providers, establishing closer working relationships:

'I spend the time that I think is necessary, and that's the way I like them treated. That's the way I'd like to be treated. Then okay, you've got that one person in one specialty or allied health area that you trust and respect and you know you can use, and then if I'm referring for a lot of years, I've got an idea.' [GP 12]

General practitioners reported a conservative approach to making referral links with other health providers. While medicolegal obligations were often cited, this also emerged as an issue of trust:

'I think a lot of the conservatism of the general practice population is mainly by medicolegal pressure which is in the other direction. And I have no trouble taking responsibility for the staff that I know, that I've worked with, that I've trained but if I don't know them and I don't trust them, I will not take responsibility for them.' [GP 14]

Improving links with local primary healthcare services

Avenues for improving links between GPs and local PHC services were explored. Key factors were improving communication and the means by which information is accessed and shared between the two provider groups. General practitioners stated patient feedback was an important source of information for referral decision making:

'Well a big one is patient feedback, if I referred someone to somewhere, and they come

back to me and say I didn't like it because then that will make me question whether that's a good place to send people, so patient feedback is a big one, time to get in, so if there's long waiting periods that would make it less likely for me to refer there.' [GP 10]

The lack of individual professional relationships and direct access to local PHC service providers emerged as a major barrier to developing further links between the two sectors. General practitioners suggested improvements such as online access to local PHC service information and patient referral forms, better promotion of services by PHC providers directly to GPs and better feedback from PHC service to GPs:

'... if they made themselves better known that could be helpful and then I guess I'd have to think of them, that's the second thing, because they can be well known and then you come and see a patient, because it's busy and you just tend to do what you've always done, and then after you think 'oh I could've sent them to see so and so', and I just didn't think because I did what I always do, and then the third thing is that you do need to have some feedback and build up a relationship.' [GP 1]

Divisions of general practice appear to have improved the flow of information to GPs. Primary healthcare service information was most often provided to GPs through divisional support to individual practices. In some areas, GPs reported that their division provided a system that enabled faster processing of GP referrals for services required from other health providers:

'... but for example with [division] we fax them the referral, and then they fax back quite quickly that they've received it, and that it will be x number of weeks wait, and then they'll contact the patient directly so there is a system there.' [GP 11]

Discussion

Despite GPs perceptions that they were dealing with more complex and challenging patients this does not appear to have increased their likelihood of engaging with state funded PHC services in case management. Problems were often related to the lack of communication and information sharing between the two sectors. No evidence of individual professional relationships between GP participants and PHC service providers were

found. Divisions of general practice appear to have the capacity to improve links with the state funded PHC services through their relationship with general practices in their locality.

Our findings are similar to two studies conducted 15 years ago which found few links between the systems of fee-for-service primary care delivered in general practice and state government funded and managed PHC services.^{14,15} These studies also described practice and organisational cultural differences between the two systems and are supported by others in the Australian context.^{9,16,17} Findings here suggest that, while divisions of general practice have increased awareness and links between the two sectors, there is still a surprising lack of contact between them. This study drew on a sample of GPs nominated by state funded PHC services and we would, therefore, expect them to be among the GPs most aware of those services. Yet there was little evidence of coordination of care for patients between general practice and local publicly funded PHC services. General practitioners expect to be the main coordinators of care and they do recognise the potential benefit of multidisciplinary teamwork for their patients. We found however, that there were no formal structures to encourage this teamwork. Collaborative teamwork is difficult to achieve in the absence of concerted efforts and structures to encourage it, given the strong culture of clinician centeredness that exists in primary care.¹⁸ Greater communication and trust will need to develop between the two systems than we found exists at present.¹⁹

Our findings have some important implications for the establishment of MLs.²⁰ The expectation in the Council of Australian Governments (COAG) agreement that MLs will '...reflect their local communities and healthcare services in their governance, including consumers, doctors, nurses, allied health and state funded community health providers...'.⁴ suggests an expectation for collaboration and teamwork. In line with recent changes to the reform agenda the COAG agreement further states 'the parties agree that both Medicare Locals and state funded health and community services will work cooperatively to achieve these objectives in each local community'. To be successful MLs will need to bring together two currently parallel systems of

care and integrate and coordinate their work so that patients experience seamless care. This will be particularly hard to achieve if the MLs are simply seen as a rebranding of current divisions of general practice.

Findings suggest a number of strategies that may be beneficial for MLs in this regard. First, closer integration of services will require an understanding of the organisational history and culture that have, hitherto, kept the two sectors largely separate. Second, a major barrier to forming links found in our research was the GPs' lack of awareness of their local PHC services. Successful integration will require coordination of information sharing by MLs to ensure GPs are aware of available state managed PHC services and programs. Third, we suggest MLs develop avenues to bring GPs and state managed PHC service providers together to establish shared expectations around coordination of care and communication that meet the needs of both sectors' cultures and to build relationships and trust.²¹

Medicare Locals are planned to have a broader scope than divisions and this will enable them to reach out to state managed PHC services to ensure the two sectors work together to provide increased benefits for all members of the community. For example, fee-for-service GPs have limited scope to undertake population wide disease prevention and health promotion programs compared to the state funded and managed sector.²² The roll-out of federally funded health promotion programs through MLs should be encouraged, building on the expertise of the local state funded services.

Limitations should be considered for interpreting the study findings. Findings reflect the experiences of GPs in metropolitan areas of Adelaide, South Australia. The study's generalisability is limited by the use of a purposive sample. Research using different techniques may yield further clarification. Findings are strengthened by supporting literature from other Australian research.^{9,10,16}

Implications for general practice

Medicare Locals will be a once in generation chance to establish a genuinely coordinated and multidisciplinary PHC sector. If this opportunity is to be realised then MLs must build on the evidence of why the two PHC sectors have found

it hard to work together in the past and apply this evidence to designing organisational processes that supports reform in both sectors for the benefits of patients, practitioners and the health of the community.

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