

**Evaluating the effectiveness of comprehensive primary
health care in local communities: how do general
practitioners work with and perceive primary health
care services directly funded by government**

Report to SA Health

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Executive summary

Introduction

The South Australian Community Health Research Unit (SACHRU), Flinders University, was contracted by SA Health in 2009/10 to conduct the study **'Evaluating the effectiveness of comprehensive primary health care in local communities: how do general practitioners work with and perceive primary health care services directly funded by government'**. This research study focuses on the links between primary health care (PHC) services directly funded and managed by government and services provided by general practitioners (GPs). It complements research funded under an NH&MRC project grant that is examining evaluation of comprehensive primary health care (CPHC) by working with five PHC service sites in South Australia and one service in Alice Springs¹.

The question addressed by this study is ***"How does fee for service general practice interact with and perceive PHC services that are managed and funded directly by government?"***

Methods

Thirty-two participants were interviewed: 6 Division of General Practice representatives, 18 GPs, and 8 practice nurses. Data were analysed with the assistance of NVIVO software under the themes of the research questions.

Findings

General practice is changing, with more complex conditions requiring more referral, gate keeping and coordinating roles. Practices have expanded to include practice nurses, and in house or co-located allied health services. Divisions have reduced GP isolation and increased opportunities for social and professional contact and interaction.

Links between the GP respondents and the local PHC service were found to be limited. In the instances where GPs, practice nurses, and Divisions had established links with the local PHC service, they were generally very positive about the outcomes of these links. Reported benefits highlight that the difficulties concerning integration of general practice with government-managed PHC services were not due to concerns about patient health outcomes or quality of care, but concerned promotion, communication, and different ways of working.

Analysis of the interviews identified three key enablers for establishing links: 1) active involvement/promotion by the Divisions of General Practice, 2) establishing relationships, communication, and trust, and 3) practice nurses. The three main barriers to establishing links were 1) communication difficulties, 2) access and availability of services and 3) GP perceptions about referral pathways.

¹ The study site in the Northern Territory is outside the scope of this SA Health Funded study.

Discussion and conclusion

Despite the fact that respondents were selected on the basis of their relationship with a PHC service participating in the main study, they still appeared to have limited knowledge of what PHC services were available and how these might be of benefit to their patients.

Where there were links, respondents reported on these positively. Benefits were the ability to share workload and meet demand for services, and to access services for patients that GPs could not provide directly. Diabetes education and counselling were suggested as most valuable.

Factors impacting on closer links between general practice and PHC services were identified as:

- GPs' perceptions of themselves as the central coordinator of care and therefore needing information, if not control, over other health services that their patients use
- Fee-for-service funding that limited GPs' capacity to engage in anything other than individual patient care
- Frequent change of name, staff and programs in PHC services directly funded and managed by government
- Need for PHC services to promote themselves more to general practice
- Overlapping chronic disease programs leading to a feeling of competition
- Uncertainty about the future reform process, with the introduction of Medicare Locals, GP Plus and Federal superclinics, care plans, EPC items and other potential changes

It is important to note that these identified issues do not centre on any concerns about the quality of care or patient outcomes, but on methods of promotion and interaction between services, and the structure of the current health system.

Introduction

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This research study focuses on the links between primary health care (PHC) services directly funded and managed by government and services provided by general practitioners (GPs). It complements research funded under an NH&MRC project grant that is examining evaluation of comprehensive primary health care (CPHC) by working with five service sites in South Australia and one service in Alice Springs². Evaluation of CPHC has been patchy and no studies globally have considered the evaluation of whole service sites and how they fit in with and interact with local networks of services. The NH&MRC study aims to develop a CPHC framework of good practice and then evaluate that framework with reference to two chronic conditions: diabetes and depression.

CPHC is a model of health system organisation that is being promoted by the World Health Organization (2008) internationally and most reform groups within Australia, including the National Hospital and Health Reform Commission (2009) as crucial to the development of a sustainable health system. CPHC can address many community health issues including effective management and prevention of chronic conditions, achieving more equitable access to services and health outcomes and involving communities in planning and managing services. Its focus on equity means it is especially suited to developing population health approaches that include special consideration of the needs of population groups who have worse health status, including low income and Aboriginal and Torres Strait Islander peoples. Despite its apparent promise there remains a critical lack of evidence regarding the effectiveness of CPHC as a health care delivery system. This study will contribute to the understanding of CPHC by informing the development of good practice framework of CPHC services for an Australian context and pioneering evaluation methods to determine the effectiveness of CPHC services in the their local community and service network context.

The research team recognises general practice as an important component of PHC but at the time the NH&MRC grant was submitted engagement with GPs was not sufficiently advanced for them to be included in it. In December 2008, SACHRU investigators met with senior managers from SA Health to brief them on the NH&MRC study. During that meeting, SA Health requested that SACHRU consider broadening the scope of the NH&MRC study to include the perspectives of GPs. This SA Health funded study reflects that request. It allows us to examine PHC from a general practice perspective and will contribute towards the CPHC framework of good practice which is being developed as part of the NH&MRC study.

² The study site in the Northern Territory is outside the scope of this SA Health Funded study.

Research questions and aims

The question addressed by this study is ***“How does fee for service general practice interact with and perceive PHC services that are managed and funded directly by government?”***

In particular this study seeks to understand:

- the current role of general practice within PHC service networks,
- current treatment pathways and health promotion activities associated with two chronic conditions – diabetes and depression,
- the ways in which working with GPs fits into the plans and program logic of PHC services funded by government,
- the perceptions of GPs about the ways in which their work can be made more effective in the context of local networks of PHC services; and
- the enablers and barriers to establishing a more comprehensive PHC system which integrates the work of general practice and PHC services funded by government.

There is an urgent need to strengthen the evidence base for CPHC. This study will demonstrate the important contribution that GPs and general practice more generally can make to the development of effective CPHC models.

Contract with SA Health

Funding was agreed on 4th September 2009 and from September to December details of the contract were negotiated. The final contract from SA Health was received on 8th January 2010 and signed off on 17th March 2010. This delay affected some aspects of the study, in particular the appointment of a dedicated project officer and the application for ethics approval. Application to SA Health was made and approved to extend the project timeline to 30th September to reflect this delay. A further extension was requested in August due to the time needed for recruitment for interviews. The revised reporting timelines were:

29th January 2010 - preliminary report

30th April 2010 - first quarter report

23rd July 2010 second quarter report

16th November 2010 Draft final report

30th November 2010 Final report

Methods

Ethics

Ethics approval for the study was sought and obtained from the Social and Behavioural Research Ethics Committee, Flinders University.

Project Advisory Group

A Project Advisory Group of key stakeholders was established to provide a critical review of the research planning, implementation, dissemination and recommendations. Members were asked to:

- provide advice and review to the research design, data collection methods and analysis
- provide advice on implications for policy and practice and recommendations arising from the study
- assist with dissemination of findings and research transfer
- bring organisational and sector knowledge to the study
- bring broad representation of stakeholder perspectives

This group met three times during the course of the study. Appendix A contains a list of members.

Communication strategy

In addition to the Project Advisory Group as a dissemination mechanism, web-based updates and newsletters have been produced. An update on the project has been distributed in the participating Divisions' newsletters, and other websites.

Participants

The study aimed to interview approximately 36 participants from South Australia comprising of:

- Four GPs and two practice nurses, working in a general practice which either refers to or receives referrals from each of the five South Australian NH&MRC study sites – Port Adelaide Primary Health Care Services; Playford Primary Health Care Services; Inner Southern Community Health Service (to become Marion GP Plus); Aboriginal Health Team, Southern Adelaide Health Service; and SHine SA Woodville Branch; and
- Two representatives from each of the three Divisions of General Practice associated with these areas – Adelaide Northern Division of General Practice, Adelaide Western Division of General Practice and the General Practice Network South.

Recruitment

Participants were recruited via the five study sites, and with assistance from the associated Divisions of General Practice. An item in the three Divisions' newsletters was published in December 2009 to begin the process of engaging general practice. The research team also had discussions with Associate Professor Libby Kalucy, Director, Primary Health Care Research and Information Service, and Professor Michael Kidd, Executive Dean, Faculty of Health Sciences, about methodological issues and the best ways to engage with GPs.

PHC sites provided contact information for potential GP and practice nurse respondents and the Divisions assisted in the recruitment process. Nonetheless, recruitment was a slow process and required considerable investment of time. Initial contact was made through a personally signed letter from Professor Michael Kidd and Professor Fran Baum along with a support letter from the relevant GP Division. Contact with practice managers was then made by phone and followed up with a visit to the clinic to introduce the research and invite participation. Follow up phone calls (1 week later) were then made at an agreed time. For many of the interviews a large number of follow up calls was required. A small payment for re-imbursment of time was offered as an incentive.

Interviews

The interview schedules went through a number of drafts and comments from research investigators and the project advisory group. Interview schedules for GPs, practice nurses and GP Division representatives were finalised following the six pilot interviews (see Appendix B).

Participants were interviewed (face-to-face or by telephone as preferred) to gain their perspectives on the research questions. A focus group interview was organised at one practice, where four doctors and one practice nurse were interviewed as a group at their request. With consent, all interviews were audio taped and transcribed.

Analysis

Data were analysed with the assistance of NVIVO software under the themes of the research questions.

Limitations

The research drew on a purposeful sample of general practices that were nominated by the five PHC service sites. These practices could therefore be expected to have a greater awareness of PHC services and stronger links than general practices in the main.

Findings

1. Participants

Recruitment was much more time-consuming and difficult than expected. Effective gate-keeping, particularly in the larger, corporatised practices was the norm. Alternative strategies were developed to overcome this problem. Being able to offer a payment for re-imburement of time was helpful.

Thirty-two participants were interviewed: 6 Division of General Practice representatives, 18 GPs, and 8 practice nurses (see table below).

| Case Study Site | GPs | Practice nurses | Divisional representative |
|--|-----------|-----------------|---------------------------|
| Western Division | | | |
| Port Adelaide Primary Health Care Services | 2 | 1 | |
| SHine SA, Woodville | 4 | 2 | |
| Adelaide Western General Practice Network (AWGPN) | | | 2 |
| Northern Division | | | |
| Playford Primary Health Care Services | 3 | 2 | |
| Adelaide Northern Division of General Practice (ANDGP) | | | 2 |
| Southern Division | | | |
| Southern Area Aboriginal Health Team | 2 | 1 | |
| Southern Primary Health – Inner Southern* | 7 | 2 | |
| General Practice Network South (GPNS) | | | 2 |
| Total | 18 | 8 | 6 |

* A focus group was conducted at one practice, with 5 GPs and 1 practice nurse participating.

Division of General Practice participants

Participants' length of experience in their Divisional role ranged from new (3 months) to 6 years. The participants were three practice support workers - two who mentored and supported practice nurses, and one who focused on chronic disease management, and three managers - a health programs manager looking at physical health programs, a programs manager focusing on mental health programs, and a practice manager /coordinator for practice nurses.

GP participants

The participating GPs had a wide range of length of experience in general practice, from 18 months to 37 years. When asked to describe their patient population, most GPs reported seeing "pretty much everything." A number of GPs found their patient base had evolved in a particular

direction (such as younger patients, more middle aged patients, or elderly patients), due to the demographics in their area, the practice population ageing (reported by one GP to be linked with getting few new patients because of long waiting lists), or patient preference (e.g. some older GPs attracted older patients). Female GPs noted they saw more female patients than male GPs did.

Practice nurse participants

Practice nurses' length of experience in general practice ranged from 18 months to 11 years. When asked about their role, practice nurses identified five key areas:

1. Care plans, chronic disease management
2. Immunisations
3. In-home health assessments on the elderly
4. Wound management
5. Other duties e.g. sterilising instruments, administration, tidying.

When asked how they came to work as a practice nurse in general practice, two mentioned the GP Plus practice nurses initiative. The two most appealing factors cited were not having to do shift work, and working in the community. The lower pay was noted as a negative, however.

Some of the practice nurses had received training upon starting in general practice – one week or a number of training days over several weeks. Other nurses relied on on-the-job training, with some receiving training or mentoring from another practice nurse, or being supported by a practice nurse in another practice. The practice nurses also had access to ongoing training through Divisions of General Practice in particular topics, such as cardiovascular health, asthma, and diabetes.

2. Changes to Roles

Practice Nurses

The relatively new practice nurse role was reported by GP and practice nurse participants as reducing the workload for GPs. It enabled chronic care plans to be done 'in house' where the GP still has control and oversight of the patient's condition and treatment, as reported in the following example:

"I think the use of practice nurses is really important so they can spend more time on doing a lot of the routine stuff and we can spend more time talking to the patients...I get quite a lot of care plans myself, but it's doing the pre care arrangements, finding the podiatrists that suit the patient, phone numbers, contacting them and then getting acceptance back." GP

Practice nurses felt both GPs and patients find their services useful. Having a practice nurse may also encourage patients to attend for chronic care plan reviews because practice nurses generally have a good relationship with patients and are able to spend more time with them than their GP:

“We definitely reduce their [GP] workload so that they can get on with the job that they need to do and also being an advocate for patients, because I think the patients feel they can talk to a nurse better they can actually talk to a doctor.” Practice Nurse

Another practice nurse described her role thus:

“We have more time to spend with people than their GP will, so we can do a lot of the background work, we can do their baselines, we can find out whether they need to have updates on their blood tests, any other tests, so that when they go in to a doctor, that information is all ready and he can go through it and get someone healthy” Practice Nurse.

However, it was suggested by one practice nurse participant that some GPs don't use the practice nurse role effectively – circumscribing their role to routine immunisations for example. Medicare item numbers were also perceived to influence and limit what practice nurses can do, as were legal issues with regard to duty of care for patients:

“I suppose it all depends which GPs you get, because obviously there's GPs around here I mean they'd be very supportive, and others I mean by the time you're trying to get practice nurses into practices, it's like the slippery end of the slope you put them there, and it's like 'God, they want to take somebody's blood pressure and urinalysis today, and they'll want to do scripts and whatever the next week', and you don't want to do that, you know nurses don't want to be doctors, they just want to do what they can do to help the patient, to be educators and all that sort of stuff, but GPs get a bit funny like that...” Practice Nurse

GPs

Participants described a number of changes in general practice. These include changes in practice set up, patient characteristics, and changing role and focus. The advent of Divisions has acted to bring GPs together for education and workforce development and information dissemination; and to increase evidence based practice, discussion with colleagues, and community links. GPs reported being much less isolated than previously having more social and professional contact with other GPs:

“In the past I think many years ago there was a GP here, a GP there and everyone was on their own, and there was almost like competition...And with electronic type stuff you can get things more quickly. I think we're closer together. A lot more GPs know more GPs than they did before, and yeah, I think people have grown up or GPs have grown up. Plus they've been using allied health more than in the past, which they don't have the time for everything themselves. So there's a place for all of us in the whole treatment continuum of patients.” GP

GPs generally reported seeing more complex cases and elderly patients. This was seen as being exacerbated by the increase in large corporate clinics where patients attend for simple things like a sickness certificate or a repeat prescription. However, when a patient has a complex issue and they want a longer consultation they are more likely to attend their regular GP. One GP explained:

“Because I think there’s more of a push towards these big clinics which become much more impersonal and I don’t know, I just find that a bit sad... a GP needs to be in touch with who’s doing what to which patient. Once you take them out of the loop, things get duplicated, elderly people get confused pretty easily, specially once they start getting chronic problems. I just think the whole ... it’s changed.” GP.

GPs reported that patients are more educated and demanding and that referral to a specialist is often expected. While it was believed important for the GP to retain the coordinating role, further changes were expected as this GP elaborated:

“Well I think that the provision of primary health care remains the important part of what a GP does, and I think my allusion before to knowing a patient, to providing that continuity and to coordinating the care that I think they may need remains central to our focus, but the way that it happens is changing and I think that the type of conditions we’re seeing change, our patient’s expectations change and the framework within which we work is changing” GP.

There is more focus on disease prevention and chronic disease. For example, managing lifestyle conditions requires involving and linking with other service providers such as allied health:

We have like a primary health care team, we have general practitioners, we have allied health, we have specialists under the same roof. We work together as a team, so I think that’s the way it’s going, and so that you look at a patient and treat the patient holistically rather than bits and pieces. I still think the GP is probably – whether you call them team leader or team coordinator, and you put all the bits together from the various people, and is the patient’s main coordinator, navigator, treater, so you can navigate the patient through the system which they need to be, and they can transition, rather than be just discharged from hospital – say transitioning from primary to tertiary care and then back. So GPs still should be – if you don’t want to call them leaders, but at least coordinators of primary health.” GP.

The role of the family GP who did everything has decreased, and referral to specialists and follow up is now a larger part of practice. However, as the above quote shows, GPs still maintain a perception of their role is as the central co-ordinator of care. This implies a gate keeping role and knowledge of who to refer to. There is less incentive to provide after hours and emergency visits and this was believed to put more strain on emergency departments. This change was also linked to a decline in job satisfaction:

“The previous image of a GP who does everything, who delivers babies, who does small operations, who does the whole family care is falling away which is a shame because ultimately I think that’s the kind of GP that I would like to evolve into down the track. That’s certainly

something that I would like to continue to focus my training efforts towards. I think that takes away from the attractiveness of becoming a GP” GP.

Another role mentioned by one GP was in patient advocacy with, for example, Centrelink, Workcover, and insurance claims:

“I advocate for all the Centrelink, Workcover, insurance companies, that’s what I see my major role as now. I’m happy with that, I don’t begrudge that, I’m not really interested in doing a lot more now; I’ve sort of been doing it too long already.” GP

The impact of care plans received a mixed response. GPs saw care planning as a growing role for practice nurses. Some GPs noted that they used to spend time talking to and counselling people with mental health issues, now these patients are managed through mental health plans using EPC packages. The administration process was seen as particularly burdensome:

“From my point of view the care plan process was paying you more to do what you were already doing but having to generate paperwork and tick all the little boxes to be able to send someone to the physio and having all of that communication you’re required to have, then created a time consuming extra to what you were already doing...The frustration is that it takes you away from what you are here for which is patient care. It creates an administration process.” Focus group

3. Links with PHC Services

Links with the five local PHC services were found to be varied for both general practice participants and the Divisional representatives.

GP participants typically reported having limited links and awareness of their local PHC service during interviews. PHC links had often come about because the PHC service was a well recognised PHC provider or one that offered a specialised (e.g. sexual health) service to GPs:

“I do indeed [refer to SHine], particularly as a male GP. For things like, they have an insertion of Mirena service that they offer and I often use them for that. Sometimes as well the females might come and see me and want particular things done that they’re not happy to have a male doctor do. I’m happy to do them but if they don’t want me to do it, that’s fine, I refer them on.” GP.

Other avenues through which links had formed were through previous personal contact with the local PHC service, positive feedback from patients who had used these services or from a third party link, such as the following:

“Look, I think that probably an area that I wouldn’t organise direct referral but I’m 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.

Links and awareness of the local PHC service among practice nurses also varied. Information about the availability of other health services in their local area was often sought through their GP Division. In areas of lower socio-economic status, practice nurses were generally found to be more active in sourcing government funded PHC services for their practice patients:

“Definitely. I use [local PHC service] consistently, you know, how many referrals a week, I’d have to say lots.” Practice Nurse.

The support offered by the local PHC service was often well regarded and utilised by practice nurses in lower socio-economic areas, especially for patients with established or borderline chronic disease conditions:

“I think they [local PHC services] are the cornerstone, because you’ve got to have somewhere to get the back-up services if you’re offering five allied health visits, they’ve got to be somewhere that people in low income streams can go to and get at least an idea of where their health needs are.” Practice Nurse.

The GP Division participants were aware of most of the services available through government funded PHC services. Links with local PHC services varied from shared professional development such as practice support relationships, shared programs, steering committee roles, to promoting local PHC services through the Divisional newsletter. Practice support to nurses in general practice often provided a vehicle for promotion of local PHC services:

“I guess – well, we’ve been to visit the nurses at both the [PHC service] and [local PHC service], although technically, they’re not – they’re a bit separate to other practices in that they are government-funded whereas the others are usually private. We still certainly keep a link there so that the nurses know what education’s up and coming...” Division.

Awareness and links between GP Divisions and PHC services were also facilitated by co-location. Some strategic connections had formed, however minimal ‘on the ground’ contact was reported by most participants:

“From on the ground though, I’m not sure of other colleagues within the Division but, minimal involvement really with government funded local community health but that might’ve been more prevalent previously I would say than what I’ve seen of late.” GP.

The links reported between general practice and government funded health services were found to vary according to practice location and capacity. GP Divisions appear better placed to establish links with state government managed and funded PHC services. The nature of general practice often meant that unless information about local PHC services was provided directly to the GP and practice nurses, or made easily accessible, links between the healthcare providers were minimal as establishing referral pathways required extra time and effort on behalf of the GPs and practice nurses.

4. Benefits of Links with PHC Services

On the occasions GPs, practice nurses, and Divisions had established links with the local Primary Health Care service, they were generally very positive about the outcomes of these links. The following benefits were identified for practitioners and for patients.

Benefits for practitioners

Links were reported to aid the sharing of work and meeting demand for services. Participants acknowledged that without PHC services, the demand and workload would be unmanageable:

“So rather than the education having to be done by the doctor or the nurse at the general practice, it would be done by the community health service” Division.

PHC services provided services that GPs couldn't, such as support or walking groups, or the ability to see a female doctor at SHine SA (for male GPs). Practitioners appreciated knowing that the PHC service would be *“keeping an eye on the patient”* (GP).

The advice the PHC services could provide regarding the progress of their patients was also valued by some GPs:

“So we will always give them a ring often. Often in the day, throughout the day.” GP.

GP and practice nurse participants with Aboriginal patients noted the importance of having cultural brokerage such as that provided by the Aboriginal Health Service:

“... can we do inter-agency communication so that if I recognise that a mother looks like she's depressed, and her doctor's looking at a mental health care plan, where do I go amongst the Aboriginal services, that she gets the care she needs? I can refer her to a psychologist, but that's not necessarily culturally correct for her.” Practice nurse.

The need for external cultural brokerage and support for some Aboriginal clients is an example of a service that is not present in the private sector, and further adds to the importance of current efforts to achieve acknowledgement of Aboriginal Health workers as health professionals.

Benefits for patients

Those GP, practice nurse, and division participants who had links with their local PHC service were enthusiastic about patients obtaining good health outcomes from attending PHC services, as evinced in the following quotes:

“On quite a number of occasions we've sent people there for extra help and they've benefited, increased their mobility and as they've moved around a bit more blood sugar levels have

decreased, increased their enjoyment of life, treated some mild depression a bit because they're getting out and doing things, they feel better in themselves" GP.

"I had an elderly woman whose husband died about two years ago. A woman in her late seventies. She needed grief counselling and I referred her to [local PHC service] she wasn't able to afford counselling through any other mechanism and she had a positive experience and that was quite a positive process. She was able to speak to a counsellor about her grief" Focus group

A number of GP and practice nurse participants believed that their patients had received good health education (with particular reference to diabetes) from the PHC services:

"I would say every single time I refer someone for their diabetes, they're a benefactor because they get fast education, which is very important. If somebody's just been diagnosed, we don't want them waiting three months before they actually know what they should be eating and doing and how they should be doing their blood sugar levels and so forth." Practice nurse.

A few GP, practice nurse, and Division participants indicated they considered issues of access and equity, and noted that PHC services were free, and (in some instances) had short waiting lists compared to private allied health. Some participants tended to particularly emphasise the accessibility of PHC services once patients had exhausted the private consultations allowed through care plans.

"Well I think it's definitely worthwhile because obviously not all patients, depending on where they're located can afford private providers. I think a lot of GPs for the more chronic patients are doing team care arrangements so therefore are referring them onto private providers, but five visits across all disciplines depending on how many they want to refer them to isn't much, so really connecting them with government funded public providers I think would be certainly something that should be encouraged more" Division.

A number of GP participants noted that due to the time constraints of fee for service practice the PHC services were able to provide more comprehensive support and follow up than general practice typically had the capacity to provide:

"It's always good to have extra supports to help the patients. One of the consequences of general practice is that your time is short in terms of being able to counsel and discuss the management of the patients. So having extra resources who have the time is important because that means that they can go over things more in depth with patients that what I have time to do" GP.

In addition, when patients used PHC services, it provided an opportunity to link in with all the other co-located supports and services.

These reported benefits indicate that the difficulties associated with integrating general practice with government-managed PHC services were not due to issues of patient health outcomes or quality of care, but rather issues of promotion, communication, and ways of working.

5. Enablers of Links with PHC services

Analysis of the interview data identified three key enablers : a) the Divisions of General Practice, b) establishing relationship, communication, and trust, and c) practice nurses.

Divisions of General Practice

The Division participants talked about the strategies they had used to foster communication and relationship between GPs and PHC services. Divisions reported playing a role in promoting PHC services to general practice, and also in acting as a broker or liaising with government-managed PHC services.

Divisions were better placed to build relationships with the local PHC services, which allowed subsequent promotion of the services to general practice. Divisions reported investigating government-managed PHC services in their area, either informally or more formally through audits of available services, and then providing this information to general practice. Methods of promotion included referral pathways, resources, publications, websites, and at education and training events.

Divisions also reported acting as brokers who could negotiate demand management, and provide access to GPs:

"I guess they're not formalised agreements, but agreements about I guess the sort of demand management in a sense that if we see things that we think are more appropriate for community health, or they see things that they think are more appropriate for us, or you know think that we might be able to get a service quicker, we do have some agreements with some of them to be able to do basically communicate back on our end with a GP and organise for the referral to be sent on" Division.

One Divisional representative noted their clinical leadership group was able to look at systems barriers and processes in order to facilitate integration and communication between general practice and other systems.

The following quote exemplifies both these activities:

"I think probably the best example is with, probably [local PHC service] so I think they had noticed a bit of a referral drop to their programmes, and so they spoke to us about that and that's when we really looked at how we could work together, because I guess at times we're probably experiencing most of the demand, but it's also then we have information about how in other areas the demand is being managed, or where it's coming from. So I think we've been able to talk about the cross referral, get some agreement about cross referral, and also then look at a particular target population and then how we can work together to best service that. So around perinatal for example, which is both of our objectives in target populations is then we can say 'Okay well you know, we'll promote this within general practice, you promote this within community and then we can bring that together', so then it's accessed by both people directly and through general practice" Division.

It seems that Divisions will be the basis for the proposed Medicare Locals, which are central to the Federal Government's reform of primary health care. One measure of the success of the Medicare Locals will be the extent to which they are able to maintain and extend these capacities and linkages.

Relationship, communication, trust

A common critical finding was that "*things only work well if you know the people*" (Division). All participants emphasised the need for established trust and relationships. GPs referred to a person, rather than a service, so it was important for the participants to know and trust the person in the PHC service they were referring to:

"It also helps if I've met the person like there was someone there at [local PHC service] who was doing the diabetes and I knew her, I'd met her through work, and I knew she was good so that made me more likely to refer to that service." GP.

There were two main factors that helped GPs and practice nurses feel that they trusted and had a relationship with a practitioner from a PHC service. The first was getting good feedback from the client about the service:

"And getting that confidence, is that about having a trust of that practitioner and that comes from the feedback you get from your patient too." Focus group

"It makes my job easier I guess and I think if you know that patients are happy because we review them every six months, so we're asking how that service has gone. So getting that feedback we know that their happy and you feel good that you can refer someone knowing that they're going to get good service." Practice nurse.

The second aspect was receiving good communication and feedback from the service, such as when the patient enrolled, or if the patient did not attend, and outcomes of their interaction with the patient:

"We would get letters to say that the patient had been made an appointment, so we'd straight away get feedback, even if they hadn't seen the patients that they'd been booked in with a fax through to say, this patient has been booked in to diabetes on this day. Then if they don't turn up, they will send us one saying this patient did not attend. If they turn up, they will then provide us with what they'd done. So they went through education and went through diabetes, the pricking and actually detail what they have done, when they're due to come back. That sort of feedback is very good." Practice nurse.

Practice Nurses

Practice nurses emerged as "*instrumental*" (Division) in linking general practice with government-managed PHC services. Division participants indicated practice nurses tended to be better placed to build the links with PHC services, and to communicate with patients, and also that practice nurses often handled much of the chronic condition management work:

“What I’ve noticed with other programs that we’ve introduced to the GPs is; it’s all well and good there and then, they go ‘Fantastic, love it, I’ll do that’, then they go back to the practice, then they’ve got a fully booked day, someone might present, tenth patient in the day that would be an appropriate person to refer, but that information is gone. So that’s where I think we need to bring the nurses on board and ensure that they actually know what is on offer within their immediate local areas so that they can be the reminder for the GP. They tend to spend more time with the patient, get a little bit more detail out of the patients so I think they are going to be the connectors with the general practice to the community health centres” Division.

“I think they [GPs] might be just looking at the patient when they come in just for the colds and do that and the chronic disease management stuff won’t get done unless they’ve got a nurse there. That’s how I look at it. If you’ve got a nurse there, then all of those things will get done.” Division.

These views indicate practice nurses may be a key resource to utilise in establishing better links between general practice and government-managed PHC services.

6. Barriers to Linking with PHC Services

Analysis of the interview data revealed three main barriers to establishing links between fee for service general practice and government funded PHC services. These emerged as 1) communication barriers, 2) access and availability of services and 3) GP perceptions about referral pathways.

Communication barriers

A number of communication barriers emerged from the interviews. GPs and practice nurses reported that they lacked knowledge about services provided, and were often not made aware of changes to programs or services. Lack of uniformity in the paperwork required for making referrals and lack of feedback when patients are referred was also reported as a difficulty. Confusion around changes in terminology used to describe PHC services also emerged as a barrier during analysis. Other issues were also raised such as inconsistency in the types of PHC programs available where these varied from site to site, and lack of information given to the GP or practice nurse from the PHC service about the support they could provide.

A number of GPs and practice nurses reported that they lacked knowledge about their local PHC service and the programs being provided:

“I’d like some information about [local PHC service] if you could send me something so I know more about it. I’m totally ignorant on even where it is or what it does.” GP.

“We haven’t had as much involvement with Aboriginal services as I would like. It was only when I went to the course for practice nurses through the Australian General Practice Nursing organisation that I even knew of the Aboriginal services available to us from Southern Area.” Practice Nurse.

An exception to this finding among the five case study sites was SHine SA. All participants in the study were aware of the services SHine SA provided. This awareness was often related to the specialised training provided by SHine SA directly to GPs and practice nurses (e.g. pap smear, intra-uterine device insertion), and also the specialised nature of SHine SA itself as the sole PHC provider of sexual health support services to the community:

"We only have two full time female GPs here so obviously seeing them can be quite difficult. I use SHine a lot. I've had one or two cases where I've had to refer for sexual assault type cases so I know that SHine can see them on an as-needed basis." GP.

Although most referrals between general practices and local PHC services were reported to be informal, GPs raised a lack of communication around the referral process as a problem. For example a number of GPs were unsure on how to access programs for their patients:

"I see there's a lot of groups here, we don't even know that these happen or how to send my patients off for prevention and lifestyle...does the patient self refer, do I refer, do I need to write the referral letter. It's all very vague, very delightfully vague. Just having a program, yes, but how does the patient get into the program? Who is the contact number, who is the contact person, who do they speak to? Do they speak to the person or do I just tell them that there is a program, just find out. It's difficult for a lot of patients to find out things, so if you have a structure to the whole thing then it's easier." GP.

The occasions when there had been a lack of feedback, or a poor quality of feedback to the GP when patients had visited the local PHC service was also reported as a concern:

"Yeah I think they need to look at all their services and decide on a system of how they'll accept referrals and how they'll just feedback, it doesn't need to be detailed feedback, but it is quite nice to get something sort of regular. Just in a more systematic way I guess." GP.

"So it's not a very quick feedback that we get and very less personal feedback for that matter because my psychologist who is private, she feels that something's not right she picks up the phone and has a quick word with me which is more appreciated than waiting for the word written feedback." GP.

Another communication barrier that emerged was confusion for participants about recent name changes in the sector. During the interviews, it was important to ensure that participants understood which service the interviewer was referring to. The specified service was not always understood by participants to be the same service under a different name until this was explained. Once clarified, it was found that participants often continued to refer to the local PHC service as the 'community health service' or community health centre':

"We did clarify we're talking about the community health services down here on [name] Road?"
Division

"I mean for a long time, and I don't know whether community health or primary health, I use them interchangeably." Division

In one area the term 'primary health care' was further confused with a private general practice corporation that used the same title:

"You know, the terminology is confusing, in that case: I've never heard of [local PHC service], primary health care is what we refer to as the corporate practice in [location] near Port Adelaide."
GP

Access and Availability

Issues of access and availability of services was another area identified by all participants in the study as a barrier to establishing links with their local PHC service. Participants' concerns were related to physical access barriers and service availability.

Physical barriers included difficulty in accessing the location of the PHC service and patient preferences for access to private allied health providers co-located within the same building as the general practice:

"So I think geography is perhaps one of the main reasons that [local PHC service] isn't more at the forefront of my mind at the time of making those referrals." GP.

"Obviously if we have services here then we'll do that, and the services we don't or can't provide here that I think are beneficial for my patients, I'm happy for them to go somewhere, within a reasonable distance. A lot of patients like the services here because they come and see their GPs here, it's central for them, it's close, there's a car park, it's nice and handy for them." GP.

Barriers related to the availability of services were also identified by some GPs and practice nurses when considering establishing links with the local PHC service. These included difficulties such as gaining access to allied health providers, limited times available for patients to access a required PHC service, long waiting periods for patients and the high turnover of PHC service staff.

For example, GPs and practice nurses reported that overly complicated entry criteria for certain programs was a barrier to referring:

"I think probably the biggest problem with all of this primary health care stuff is there's so many packages, and so many things out there, that trying to get a handle on and keep them in your head...and trying to work out all the criteria for everybody and the limitations and costing."
Practice Nurse.

Long waiting times for patients and staff turnover were also considered a difficulty by GPs and Division representatives as the examples below illustrate:

"...and that's one thing that I, I know about GPs over the time that I've worked here is a lot of it is about access, they will adjust who they refer to based on both the communication they receive, the feedback from the patient and how quickly they can access services." Division.

"No, normally with the public system and things like that there's a bit of a wait and, I understand, a lot of time they have different staff coming through so, I mean, sometimes you're lucky and the staff remain but I think they do rotate a little bit." GP.

Some GP and practice nurse participants commented on 'bureaucracy' and understaffing issues they had encountered when referring to government funded and managed PHC services. This was also perceived as a barrier to forming links due to difficulties they had experienced. For example, long waiting times for patients and gaining direct access to health staff within a local PHC service:

"...I used to do a lot of work down at [PHC service] and actually trying to get things done, or to see people the bureaucracy is absolutely phenomenal, like they've got two receptionists down there looking after 30 people, and I mean they just can't do it, so the messages get lost and it is frustrating that way, but I think that's probably the biggest thing, that." Practice nurse.

Concern about the ongoing availability of programs and health providers at local PHC services was also reported as a barrier. There was little inclination to set up referral pathways to services and programs that were considered reliant on short term funding and therefore faced an uncertain future. This concern was raised not only by GPs but also GP Division representatives:

"And the next question is, are they on funding and will they be there next year?" GP / practice nurse group.

"So I think there is a bit of that mind set like 'my contract only goes (not mine, but in a health centre), this program only goes until July, so we won't work really hard to generate more referrals after that point of time, because it might not happen'." Division.

GP perceptions about their role and referral pathways

Difficulties experienced concerning communication and access with local PHC services were further compounded by the GPs' perceptions of their role as the main primary care provider to their patients. Most GPs reported a conservative approach to providing referrals for their patients. Many referral pathways had evolved through building relationships and trust with other health providers.

GPs discussed the notion of medico-legal responsibility as a barrier to referring to allied health providers with whom they had not developed a referral relationship:

“The question that always comes up is always the medico-legal question. So who is going to take medico-legal responsibility? And so the thing that one doctor raised is the patient goes to see a physio ... they have asthma or they might have a mild renal impairment, they might have a peptic ulcer, there’s a lot of things the patient has, there are complications. So does the physio then pick up the medico-legal issues raised under the other diseases or not? I think a lot of the conservatism of the general practice population is mainly by medico-legal 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 / Practice nurse group.

Continuity of care for patients emerged as a key factor in determining patient referral for all GP participants. GPs felt a responsibility to provide continuity of care to their patients and were concerned that they should remain informed about their patient’s progress from other health care providers. This could also act as a barrier to referring outside of a GP’s established referral pathways with ‘trusted’ providers:

“I’ve got many patients who feel that I am their GP or that this surgery is their general practice. 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

GPs also felt that the quality of care their patients received from the providers they referred them to was a reflection of their own ability to provide good care to their patient. Because of this, taking care to ensure patient satisfaction could also serve as a barrier to referring to unfamiliar allied health providers:

“Because it reflects on you. If I send someone to see a practitioner who isn’t professional and doesn’t do the right thing, it reflects on me. I don’t know this person. If I send my patient to someone who hasn’t treated them well, they’re not coming back. They may or may not have a go at me, but I feel bad because the outcome of treatment has not occurred. I send patients to people I know will treat them well, with respect and I know have been there for quite some time, and they won’t be there today and gone tomorrow.” GP.

A lack of understanding by GPs about other services in the health sector was reported by a Division representative as having been a barrier to forming links with local PHC service:

“Yeah because it is, and that’s exactly right it’s the trust because it’s, they need to know who they are, and I think over time, probably less so now, but particularly when a lot of these initiatives first came out, general practice didn’t, well some of general practice didn’t have a good understanding of what other health did, particularly mental health, allied health. I think with co-location and with us trying to really push having clinicians in with GPs they’ve started to understand and build

that trust and understanding of what actually occurred, before it was a bit mystical. So they didn't have the trust, whereas they'll say to me 'I know what a specialist, I know what a cardiologist training is, I know what they're going to do, and they make sure they give me the letter back. I understand all the processes and I have trust in it.'" Division.

Many GPs reported having had little time to educate themselves and follow up on PHC services that were available to them locally. A perceived lack of face to face contact with many of the local PHC providers in order to promote referral links was considered to be a further barrier by GPs towards developing a referral relationship:

"You know and yeah it would help to rather than just have something in the mail. If someone just comes in and tells us once in a few months that these are the new programs we are offering." GP.

7. Learning from Links with Other than PHC Services

During the interviews, GPs, practice nurses, and Divisions mentioned links with services other than the government managed PHC services. Key services linked with included hospitals, private allied health providers, and Division mental health services, as well as local councils (*"we definitely do use the services through the [local] council, having rails put in homes after we do assessments"* Practice nurse).

Concerning the focus area of diabetes, interviewees mentioned the diabetes services available at the Lyell McEwin and Queen Elizabeth hospitals. Referring to hospital services may reflect referral pathways that GPs are used to, are aware of in the area, and get good feedback from.

GPs and practice nurses typically referred to a private allied health provider rather than a Primary Health Care service for issues such as podiatry, physiotherapy, psychology, dietetics, dentistry, and chiropractics. One key mechanism promoting referrals to private allied health providers was care plans, such as dentistry care plans or mental health treatment plans.

A particular strong facilitator of linking with a private allied health provider was co-location. Some GPs and practice nurses mentioned referring to a physiotherapist or psychologist that used the same building. This reflected both convenience for the patient and an established relationship that promoted trust between the GP/practice nurse and other health provider.

However, the co-location within general practices of private allied health providers may provide a barrier to establishing links between GPs and local PHC services located at other sites within the community that may be seeking to offer support services for patients on care plans.

Some GPs were mindful of issues of equity of access when referring to private providers. Interviewees noted that while some private providers bulk bill, others may charge a gap payment that may inhibit people with lower incomes using the service. This was particularly discussed with

reference to mental health providers. One interviewee noted of the review of Better Outcomes in Mental Health and Better Access to Mental Health Care initiatives:

“Because effectively it’s a fee for service model and people can charge whatever gap they want, they noticed that then there was disparity in terms of where the providers were located and also who could afford it.” Division.

When asked about sending clients to fee-for-service versus government funded services, one GP noted:

“To tell you the truth I think that it’s not a political point it just is the fact that I think you actually get better service from... we get better feedback and everything from privately run places, there’s less mucking around and the referral pathway is often clearer and you can send someone along and you know who they’re going to see and they tend to follow them up, and it’s probably a bit of a generalisation really.” GP.

As one of the focus areas for the NH&MRC study is depression, the Division-run mental health services, including Headspace and mental health programs with psychiatrists, were raised as key services utilised by GPs. The appeal of these services to GPs included a shared way of working, close, pre-existing working relationships (with the Division) that promoted trust, and two-way feedback that meant the GP shared the care of the client with the service:

“What happens is a GP can send a referral into us and say, ‘They’re happy managing the client, however they need support, they’d like some support from an experienced clinician’, so we’ll make an appointment with one of the psychiatrists ... and what that does is help the GP have that opportunity with the patient, with the GP, with the mental health clinician, with the psychiatrist, and it gives the GP a chance to ask the psychiatrist best use of medication, get some advice on how best to manage that client, get some referral pathways to other services they might require. But it means that the patient can still be managed by the GP, but with that additional support from shared care.” Division.

However, the promotion of division-run mental health services has engendered a certain perception of competition between the Divisions and local PHC services. The difficulty that this has made for advancing collaboration with local PHC services was recognised within some Divisions:

“...so sometimes I think there is a bit of a turf thing which is natural as well, like I think services become apparently protective of themselves, I mean everyone’s guilty of that at different times, so I think sometimes that’s a barrier to probably as integrated, collaborative as we could be, it becomes probably a little bit more competitive. I don’t think that’s visible, but I think that’s always underneath.” Division.

8. Improving Links between General Practice and Local PHC Services

General practice perspectives of the main facilitators and barriers to forging links between fee-for-service general practice and government funded PHC services are presented in the findings above. Ways of improving these links also emerged from the interview data. Overall, findings revealed that improving avenues of communication and information were key factors for improving links between general practice and local PHC services. The study participants suggested a number of ways in which they believed the links between general practice and local PHC services could be improved.

Division representatives believed that promoting further information sharing and collaboration between the Division and local PHC services would facilitate and improve links. For example, it was suggested that better service planning and flexibility in directing program funding would reduce service overlap and facilitate responsiveness to community needs:

“So I think if everyone had to in their plan, if we had to get on together as part of our planning and say ‘What are you doing? What are we doing? How can we...’, and that does also require flexibility from the Government in terms of saying if we decide that Community Health and us are sitting in the same patch and we’re doing the same thing and we say ‘Oh okay that’s duplication, but we think this is an area of need’, then someone needs the flexibility to be able to redirect their funding to meet that need. But if we could do that we’d be actually much more responsive to what the community needed, as opposed to what the services are having to provide. So I think that would probably be the only other way that I think we could do a better job at being better integrated.” Division.

All participant groups considered direct contact with local PHC service staff to be an effective means of promoting services and establishing links. For example, inviting attendance at meetings at the Division and PHC service level, improving GP and practice nurse awareness of PHC services by holding information evenings and updates, and offering assistance to local general practice staff seeking access to PHC services:

“You know I think that things only work well if you know the people. I guess that’s why we’re trying to build those links, so if staff from the community health service come along to meetings, you would feel comfortable to ring them up and say, what can you do for this patient here? What have you got to offer? You often feel a bit uncomfortable about doing that if you don’t, if you can’t put a face to a name, or know that person. I think they are probably the things that will work best, it’s getting to know each other and knowing what services we provide and knowing what services they provide.” Division.

“Face to face awareness is probably the best option or information evenings or things like that is probably the best way because without awareness, it’s sometimes underutilised because people just don’t know to use it.” GP.

“It would be a great thing to be able to go and spend two hours there, and say can you teach me what you do, can you show me how to access your services, can you tell me what is a good way to

approach people? Because the Aboriginal world is a world unto itself, and I'd like to find a way that we could join services." Practice nurse.

Reducing waiting times for patients that are referred by GPs was considered important to improving links between local PHC services and general practice:

"Int: So if I was to ask you what could be improved with local PHC..?"

GP: Yes. Improve communication and reduce waiting times." GP.

Online access for GPs and practice nurses to information about which services are available and referral forms was also seen as means to facilitate further links between general practice and the local PHC service. For example direct online access for GPs to the area required for referral within the local PHC service:

"And if you could sort of be able to direct the referral according to the problem specifically. So if you've got someone who's elderly maybe refer them to someone more focusing on that area specifically or if it's substance abuse or if it's domestic violence or whatever." GP.

A more general database of all PHC services available that could be accessed by general practice staff was also suggested as a means of improving links:

"As I keep saying, I'd love a database please. I'd love a database through the Health Commission, where we'd just list the people that are available through the Health Commission. Once again, just a big long list. There are lots of lists around, but you've got to find them... For instance if you've got six services amongst the Aboriginal health service, not just psychiatry, podiatry, diet, but perhaps a little bit more in that they specialise in adults or children, because that's something that we're having difficulty finding." Practice nurse.

Finally, better and regular feedback to GPs about their patients and establishing referral relationships with general practice was considered a key factor toward improving links between the services:

"I suppose if they made; well maybe this is me having blinkers on, but 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.

"It's always good to get some feedback as to...when they start with the patient it's nice to know that they have finished their course of treatment otherwise you assume they're still going there. It doesn't have to be very long just what's been done..." GP / practice nurse group.

Discussion

A report from 1994 (Baum et al. 1994) investigating links between GPs, hospitals and community-based health services concluded that *'personal contacts and networks, mutual respect and credibility, and accessibility and sharing of information were found to be the most important factors in ensuring cooperation between workers. ... GPs were more satisfied referring their patients to a system in which they could make personal contact with the health worker who would be responsible for their patient's care and who could provide timely an adequate feedback on that care.'* (p45). GPs then stated that worker availability and knowledge of services available were the main factors influencing their decision to 'refer' a patient to a community-based health service. Information about services and feedback from the service were suggested as ways to improve patient access. Our current research suggests that many of the communication difficulties remain similar but that Divisions and the spread of practice nurses have improved some elements of the co-ordination between the two primary health care sectors.

Respondents were selected on the basis of their relationship with a PHC service participating in the main study. Respondents in this study, however, still appeared to have limited knowledge of what PHC services were available and how these might be of benefit to their patients.

Where there were links, respondents reported on these positively. Benefits were the ability to share workload and meet demand for services, and to access services for patients that GPs could not provide directly. Diabetes education and counselling were seen as particularly valuable. However, a number of factors influenced the capacity for GPs and PHC services to work together.

Nomenclature and organisational change

From the GP perspective, frequent changes in staffing and programs, differing eligibility requirements, and the change in name from 'community health' to 'primary health care' were all barriers to developing good links:

So I think they do get frustrated that there is a lot of change of government or change of name, or change of branding. At the end of the day it is community health whether it be called primary health services or whatever, and I think they see that as a lot of funding that's gone into changing a logo, new letterheads and cards when really it's the same services that are on offer. Division.

This nomenclature confusion extended to State GP Plus clinics, Federally funded GP superclinics, and large corporate general practices. It was found necessary in the interviews to clarify the differences between these services. Our study suggests that GPs, practice nurses and Division representatives are quite confused about the ways in which the primary health care landscape is changing with the current round of reforms.

Competition

While some GPs believed there were *'more than enough patients for everyone'* there was suggestion of competition between chronic disease programs. The following quote from a Division representative discussed two overlapping chronic disease programs:

"There are lots of programs like that that do the same sort of thing and really nobody does it as well as Do It For Life, because that's one-on-one individual counselling, yet we have trouble putting bums on seats on Reset-Your-Life program here at the Division, we can't get enough people to keep the momentum going. I just think one's federal government and one's state government, they both do the same thing, one does it not quite so well and I work in the Division and I'm the Reset-Your-Life facilitator and I can see that Do It For Life does it that much better and that much more successfully, yet we still have to put our energies in to trying to drive this program that isn't really workable. I find that frustrating." Division.

It is interesting to note that during this research the Do It For Life program was substantially cut by SA Health and emerging findings from the broader NH&MRC study indicates that the criteria for this program were too restrictive and the program was unable to be adapted to the particular circumstances of individuals.

Mental health was another area where Division runs their own programs and this meant there was little felt need to collaborate with other community-based services.

"All divisions run their own mental health programs: We don't have direct links in terms of what's out there in the community because we have all the community services here at the Division, so we run Headspace, which is the northern region's young people's services for depression and anxiety. We have Northern Wellbeing program which is for the adults, and we have suicide prevention program. So they're all run through the division." Division.

Central role of GP

Underlying discussion of links with other services was the strongly held conviction by most GPs in this study that they provide the central coordinating role for their patients. This means that many GPs prefer to use in-house practice nurses and allied health providers, which ensures them control of quality, timeliness and feedback. Referring to private specialists usually allows the same central coordinating role to be maintained. On the other hand, there is no formal referral system to PHC services. Clients often refer themselves and the GP can be *'out of the loop'*. Baum et al. (1994) make the point that clients often request confidentially when attending community-based health services and services are obliged to respect clients' wishes. However, the resulting absence of feedback to the GP can be seen as ignoring the central coordinating role which is seen as so important by GPs.

Fee for service Medicare funding

A number of policy and funding arrangements have an impact on links between general practice and other PHC services. The fee-for-service Medicare funding restricts GPs' involvement in anything but individual medical consultations. However, the introduction of EPC items has

increased opportunities for referral to, and accessibility of, private allied health providers. For some GPs this means less need to use allied health services based in PHC services, although for some patients the restrictions on EPC items mean that government managed PHC services are still more accessible.

Uncertainty about future reform

All study respondents expressed some uncertainty about future reform. The proposed Medicare Locals appear to imply changes to the Division but are largely an unknown quantity at this time. It is intended that Medicare Locals will integrate PHC services and improve access to services. It seems likely that they will do this by building on the strengths of the current Divisions but broaden them to include a greater range of provider and activities. It is acknowledged that Medicare Locals will need to take account of existing PHC infrastructure and partnership arrangements (Medicare Locals Discussion Paper on Governance and Functions, 2010). However, at least one Division representative saw this as an opportunity to 'take over' PHC:

"Let's say for example, we've already been allocated to become a primary health care organisation and so there's an opportunity for example for the Division of General Practice or [other Division] to merge with us, so we provide services for a much larger region, so that will mean we're not just servicing GPs as we currently are known to, as our member GPs and basically general practice environment, but we'll be basically servicing the whole of the community, which is what we're already doing through things like our cervix screening, sexual health program, all of those sorts of things; it will be more widely known and of course there will be bigger budget and bigger programs to roll out."... "So I think we'll just continue to grow and grow, and I think that's why as an organisation – we'll be set to become primary health care organisations in the future."
Division

Role of Divisions and practice nurses

With the advent GP Divisions, GPs are certainly less isolated from each other and have greater access to professional development, resources and support, accreditation programs and opportunities to be involved in research. Divisions have an important role in promoting and facilitating links between different parts of the currently fragmented primary health care system. For example, Division participants refer to their promotion of local PHC services by producing and disseminating resource material and hosting joint information sharing sessions.

It may be that as the practice nurse role further develops it will facilitate links with PHC and other services. Practice nurses are likely to have more time to build links with external providers. One large national study (Phillips et al., 2008) described them as "agents of connectivity between the practice and the community" (p. 12), as well as identifying five other roles. Some Divisions are offering joint professional development for practice nurses and nurses working in PHC services which may help to break down barriers and increase understanding on both sides.

Promotion of PHC services

GP and practice nurse respondents suggested better promotion of PHC services so that they were more aware of what was available and how to access services. However it may be unrealistic to expect individual general practices and individual PHC services, both of which are likely to be time poor and focused on client care, to achieve a consistent, high level of communication and integration without a co-ordinating organisation. This may be an appropriate role for Divisions or the new primary health care organisations as they become established.

Conclusion

Where our study respondents did have relationships with PHC services and made use of these in their interactions with patients they were generally satisfied with the quality of care and patient outcomes. There was particularly high satisfaction with the services offered by SHine SA. The main benefits of links were seen to be managing demand and achieving better outcomes for patients, and the main barrier was the lack of communication between GPs and state government funded PHC services and thus knowledge about the services.

Referral pathways to these PHC services compete for GPs' and practice nurses' attention with co-located private providers, Division-run services set up specifically with GP shared care in mind, and hospital services. GPs and practice nurses may be more likely to establish relationships with these other providers given the lack of awareness of PHC services and programs and the potentially more closely aligned ways of working and expectations of the alternative providers. These are issues not of quality of care or patient outcomes, but of methods of promotion and interaction between services.

Overall, our study confirmed that there are parallel systems of primary health care in Australia, one directly funded largely by the State government and the other a fee-for-service system funded by the Federal government. While there are some important and useful links between the systems and GPs are able to refer to the State government funded services, the ways in which this happens appear somewhat haphazard. The Divisions of General Practice clearly improve the co-ordination between the systems but once again this happens more by chance than through systematic planning. The Council of Australian Governments is in the process of agreeing on a series of reforms to primary health care in Australia and central to these should be a mechanism to build on the strengths of both systems and ensure that there is systematic, planned and supported co-ordination.

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Abbreviations

| | |
|--------|---|
| CPHC | Comprehensive Primary Health Care |
| EPC | Enhanced Primary Care |
| GP | General Practitioner |
| NH&MRC | National Health and Medical Research Council |
| PHC | Primary Health Care |
| SACHRU | South Australian Community Health Research Unit |

Appendices

A: Project Advisory Group membership

Dr Don Allan, Adelaide Western General Practice Network

Dr Amanda Allport-Haller, General Practice SA

Prof Jeffrey Fuller, Flinders University

Ms Di Jones, Central Northern Adelaide Health Service

Assoc/Prof Libby Kalucy, PHCRIS, Flinders University

Ms Sinead O'Brien, Statewide Service Strategy, SA Health

Prof Richard Reed, Flinders University

Dr David Scrimgeour, Aboriginal Health Council of SA Inc.

Ms Clare Shuttleworth, Southern Adelaide Health Service

Dr Helena Williams, General Practice Network Southern

B: Interview tools

GP Interview Guide

Intro: 1. Background – positioning statement (in context of health reform?), why we are asking them to participate, what we hope to gain from interview. (*explain what is meant by directly funded PHC service.)

2. Confidentiality protocol

How many and #FTE GPs in practice? [see practice manager]

1. How long have you practiced as a GP?
 - a. How long have you been in this practice?
 - b. What type of patients do you mainly see (e.g. mums and babies, CALD)?
2. As a part of the study we are particularly interested in what happens with patients with chronic conditions, particularly Diabetes and Depression.
 - a. Do you have many patients with Diabetes?
 - b. Do you have any links with [local PHC service] around the management of patients with Diabetes?
 - c. Can you provide an example?
3. Do you have many patients with Depression?
 - a. Do you have any links with [local PHC service] around the management of Depression?
 - b. Can you provide an example?
4. Do you have any other links with [local] PHC service? ***define what is meant by 'referrals'** as GP's refer to individuals not organisations. ***Use 'card' to prompt for trigger context – under what conditions would you use local PHC service**

- a. *Probe: referral formal and informal, (two way), [information sharing- after referral], shared resources, personnel, workforce development, joint projects/policy making, networking (to what purpose?).*
 - b. How did these links come about?
5. Can you give an example of when working/linking with [local PHC service] has been of clear benefit to your patients? To you?
 - a. What do you think works well?
 - b. What are the benefits for you? For your patients?
 6. Are there any difficulties to developing further links with [local PHC service]?
 - a. Can you give an example of when working/linking with [local PHC service] has been difficult?
 - b. How do you think this could this be improved?
 7. As a part of the move towards health reform, the state and federal governments are establishing PHC networks, GP Plus centres, Super Clinics.
 - a. What do you see is the role of **fee-for-service general practice** within these initiatives?
 - b. *If time allows prompt for change – Do you think the GP's role is changing? (if so) How has it changed?*
 8. Is there anything else you would like to say about improving PHC services for your patients?
 - *We will be presenting and discussing the early findings from this and a related study at a research symposium on 20th – 21st October. You will receive more information and an invitation closer to the time.*
 - *We currently have a grant application to extend this study for a further 3 years. Would you be willing to be interviewed twice more if this goes ahead?*
 - *We are happy to provide a copy of the transcript from this interview for your comments. Would you like a copy of the transcript? **Thank you for your time***

Practice Nurse Guide

Intro: 1. Background – positioning statement (in context of health reform?), why we are asking interviewee to participate, what we hope to gain from interview.

(*Need to explain what is meant by directly funded PHC service.)

2. Confidentiality protocol

1. How long have you been a practice nurse?
 - a. How long in this practice?
 - b. How did you become a practice nurse?
 - i. What training or orientation [for becoming a practice nurse] have you had?
 - c. What is your role?
2. As a part of the study we are particularly interested in what happens with patients with chronic conditions, particularly Diabetes and Depression.

- a. Do you have any links with [local] PHC services around the management of Diabetes?
 - b. Can you provide an example?
3. Repeat for Depression.
 - a. Do you have any links with [local] PHC services around the management of Depression?
 - b. Can you provide an example?
 4. Do you have any other links with [local] PHC service? ***Use 'card' to prompt for trigger context – under what conditions would you use local PHC service**
 - a. *Probe: recommendations to patients - formal and informal, (two way), [information sharing- after referral], shared resources, personnel, workforce development, joint projects/policy making, networking (to what purpose?).*
 - b. How did these links come about
 5. Can you think of an example when working with/recommending patients to [local] PHC service has been of benefit to your patients?
 - a. What do you think works well?
 - b. What are the benefits for you? For your patients?
 6. Are there any difficulties to further developing links with [local] PHC service?
 - a. Can you think of an example when working with/referring to [local PHC service] has been of difficulty to your patients?
 - b. What/How do you think this could be improved?
 7. As a part of moves towards health reform, the state and federal governments are establishing PHC networks, GP Plus centres, Super Clinics.
 - a. What do you see as the role of **practice nurses** within these initiatives?
 8. Is there anything else you would like to say about improving PHC services for your patients?
- *We will be presenting and discussing the early findings from this and a related study at a research symposium on 20th – 21st October. You will receive more information and an invitation closer to the time.*
 - *We currently have a grant application to extend this study for a further 3 years. Would you be willing to be interviewed twice more if this goes ahead?*
 - *We are happy to provide a copy of the transcript from this interview for your comments. Would you like a copy of the transcript? **Thank you for your time***

GP Division Interview Guide

Intro: 1. Background – positioning statement (in context of health reform?), why we are asking interviewees to participate, what we hope to gain from interview.

(*Need to explain what is meant by directly funded PHC service and to define what is meant by 'referrals' as GP's refer to individuals not organisations.)

2. Confidentiality protocol

1. How long have you worked in [GP] Division?
 - a. What is your role in the division?
2. Can you describe the links you have with PHC services [e.g. local services in the region] directly funded by government in your area?
 - a. Probe: *links for referrals (two way), shared resources, personnel, workforce development, projects, planning, networking, joint policy making.*
3. As a part of the study we are particularly interested in what happens with patients with chronic conditions, particularly **Diabetes** and **Depression**.

Diabetes:

 - a. Do you have any links with [local] PHC services around the management of Diabetes?
 - b. Can you provide an example?
4. Repeat for Depression:
 - a. Do you have any links with [local] PHC services around the management of Depression?
 - b. Can you provide an example?
5. What do you think works well in the division's interactions with local PHC services?
 - a. Can you give me an example of when linking with PHC services has worked well?
 - b. What are the benefits of linking with PHC services for GP's and their patients?
6. What are the difficulties to developing links with [local] PHC services?
 - a. Can you give me an example of this?
 - b. How could establishing links with [local] PHC services be improved?
7. As a part of moves towards Health Reform the state and federal governments are establishing PHC networks, GP Plus centres, and super clinics.
 - a. What do you see as the role of **fee-for-service general practice** within these initiatives?
 - b. What do you see as the role of **PHC services directly funded by government** within these initiatives?
8. Are there any aspects of **health policies** or **funding systems** that limit or enable establishing links with PHC services?
9. Is there anything else you would like to say about PHC and how these links could be strengthened to the benefit of your [network's/division's] GP's and their patients?
 - *We will be presenting and discussing the early findings from this and a related study at a research symposium on 20th – 21st October. You will receive more information and an invitation closer to the time.*
 - *We currently have a grant application to extend this study for a further 3 years. Would you be willing to be interviewed twice more if this goes ahead?*
 - *We are happy to provide a copy of the transcript from this interview for your comments. Would you like a copy of the transcript? **Thank you for your time....***