

From Divisions to Medicare Locals to PHNs in Tasmania

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Background

The last two decades have witnessed large scale primary health care reform in Australia. Given ongoing health disparities between urban and non-urban areas¹, the nature and scope of this reform is particularly significant for rural health.² Tasmania has the largest percentage of its population living outside metropolitan centres, compared to other Australian states and territories. This paper concerns the transition from the three Divisions of General Practice and the State Based Organisation (SBO) to the Tasmanian Medicare Local (TML). Recognising that both the creation of Divisions³, and the subsequent development of the TML some two decades later represent major structural reform in the primary health sector, we suggest that our retrospective look at Tasmania's 'journey' in primary health care reform is instructive as the country embarks on the latest chapter of reform—the establishment of Primary Health Networks (PHNs).⁴

The broader context of the health sector in Tasmania has changed dramatically during the same period, with at least four major restructures of the Tasmanian State Health agency, and new national imperatives in health services delivery. Like other Medicare Locals (MLs) across the country, the major initial component of the TML was its foundation in the three regional Divisions of General Practice, and the SBO, known initially as Tasmanian General Practice Divisions (TGPD), and then as General Practice Tasmania (GPT). However, there are several features that make the Tasmanian experience noteworthy.

Firstly, in Tasmania the early integration of the Rural Workforce Agency (RWA) into TGPD was unique, and ensured a high focus by the key players in the general practice world on rural health and the rural health professionals who delivered it.

Secondly, unlike other MLs, the SBO and Divisions were integrated into one expanded network prior to the formal establishment of the TML.

Thirdly, in the early stages of the establishment of the TML in 2012, it was charged with a major role in the rollout of the nationally-funded Tasmanian Health Care Package (THAP) which effectively added \$60million to its budget over four years, and placed significant pressure on its emerging governance, accountability, infrastructure and capacity for stakeholder engagement.

The initial development of Divisions in Tasmania, the integration and then subsequent separation of the RWA (now Health Recruitment Plus (HRP)) from the Divisional movement, and the establishment of the TML is a major 'story' in primary health care service delivery which has been scantily documented despite some national level evaluations and reports being produced.⁵ To address this gap, a small team from the University of Tasmania, together with the TML, established a collaborative project in early 2014 to chart the journey of Divisions to TML, exploring the perspectives of major stakeholders.

Shortly after the project commenced the Horvath Review⁶ was tabled and the Government responded by announcing major changes to the primary health landscape, including the replacing of MLs with PCNs. This gave added impetus to the importance of our project in ensuring the significant contributions of the Divisional movement and the TML, both positive and negative, were not lost in yet another transition. The project team was particularly keen to identify any potential negative impacts on

¹ Humphreys J, Gregory G, Celebrating another decade of progress in rural health: what is the current state of play? Australian Journal of Rural Health 2012, 20(3) 156-163

² Wakeman J, Gregory G, Sustainable primary health care services in rural and remote areas: innovation and evidence, Australian Journal of Rural Health 2011, 19(3), 118-124

³ Smith J, Sibthorpe B, Divisions of General Practice in Australia: how do they measure up in the international context? Australia and New Zealand Health Policy 2007, 4(1), 15

⁴ Horvath J, Review of Medicare Locals: Report to the Minister for Health and Minister for Sport, March 2014.

⁵ For example, Brown L, Katterl R, Bywood P, Oliver-Baxter J, Cheffins T, Medicare Locals: A Model for Primary Health Care Integration? Report 4, PHCRIS, August 2013.

⁶ Horvath J, op cit

rural services, given the clear separation of rural GPs and practice recruitment from the TML infrastructure.

The specific objectives of this project were to a) explore stakeholder views on the transitions from the Divisions to the TML, so that b) the contributions of these earlier iterations were not lost and c) the specific impacts on rural service could be considered, in the transition to the PHNs.

Methods

The two researchers were supported by a Reference Group of the TML chief executive officer and a senior Board member, and input from key staff as required. The group identified key stakeholders to be interviewed for the project, comprising a selection of Board members of both the Divisions, RWA, TGPD and TML, current and former senior staff, key partners from the State Department of Health and Human Services (DHHS), the Tasmanian Health Organisations (THOs), other professional bodies and partner NGOs. After appropriate approvals from the Human Research Ethics Committee, 27 key stakeholders agreed to be interviewed, of whom eleven were GPs, most of whom were in, or had recently been in, rural general practice, and all of who had been a Board member of one of the antecedent organisations at some stage. Seven interviewees were current or former senior staff of the TML or Divisions/TGPD/RWA, four were current 'partners' from various aspects of the State health system, and there was one each from the current TML Board (non-medical member), professional organisation, NGO and Aboriginal Health Service. The interviews were transcribed verbatim and analysed thematically using NVivo.

The information provided to the interviewees, as agreed by the research team and Reference Group, clarified that the aim of the project was **not to evaluate** either the Divisions or the TML, but to gather, **through narratives**, valuable lessons learned on the journey during the past two decades, and to attempt to ensure that major contributions were not underestimated. Equally, participants were enthusiastic to ensure that errors and wrong directions of the past were not repeated. The value of retaining as much as possible of the corporate memory from the organisational 'building and rebuilding' process was seen as an imperative.

The interviews were conducted by the first or second authors (usually both) at a time and location convenient to the interviewees. All interviews were digitally recorded with permission and lasted for between 20 and 80 minutes, with an average of about 45 minutes. A 10 item semi-structured interview guide was used, which included aspects of specific interest to the research team (including perceived strengths and weaknesses of the Divisional movement and the TML) but allowed interviewees some flexibility. The interviews were transcribed verbatim and analysed thematically by both authors, with the assistance of NVivo.

The interviewees were asked to explore with the researchers their personal perspectives, from their own involvements in the various organisations, of the respective strengths and weaknesses of the Divisional framework and the TML, what had been lost and what had been gained, and what needed to be retained for the future. The narratives would be different if different stakeholders been interviewed. Nonetheless, the story presented here is arguably an authentic representation of the range of views presented by those who were interviewed.

Findings

Findings of the project came from the strongly held beliefs, values and experiences of the interviewees. Some of the participants had been involved in the early days of Divisions and continue to play a role in the TML; others were major players in both Divisions and RWA but have declined, for a range of reasons, a significant role in the TML. Others are newly part of the TML as staff, members and Board. The findings below reflect these diverse perspectives but, together, provide a vivid picture on the strengths of the TML and its antecedent organisations, and what is imperative to be built into any future PCN. Some of the key themes which emerged were:

Primary care service integration

There was general acknowledgement from interviewees that the advent of the TML had led to enhanced service integration in the primary care space, and between primary and secondary/tertiary

care. An often-cited positive example was that of Health Pathways, a project funded under THAP where the TML had played the lead role in working with clinicians across all levels in various geographic locations to smooth the patient journey between parts of the health system.

Connecting health has got to be my number one focus. It's to get everyone involved with health in Tasmania to communicate and work together on one single line (TML Board member)

Other identified projects such as Social Determinants of Health and Risk Factors were providing, for the State Health system *a whole brand new interface of the type we've never had before...there's been some tremendous things DHHS director)*

From the perspective of one partner organisation, however, there was still a gap in engagement with allied health

TML has done better than the Divisions but there is a huge gap from an engagement point of view (Professional organisation leader)

Engagement of general practitioners and general practice

For the majority of GPs in the study, the loss of Divisions had left a gap for them in relation to collegiality, professional development and a sense of control. While there was clear recognition that the TML needed to extend to a broader primary care focus, engaging more widely with other primary care systems and providers, some GPs felt general practice had lost some support

So I think TML moving into primary care network is a very good thing. But it left a void of a forum, a body for GPs to expand what they do, enhance what they do, work collaboratively together (rural GP)

What did we lose or gain in the shift to TML? We lost a voice (urban GP)

The TML, at senior executive and Board level, recognised these concerns

...general practices have felt, and GPs in particular have really felt disenfranchised once the TML came in...although, as we continue to point out, there is almost no service we provided under the Divisions that we don't provide under TML. The only difference is we have a broader membership of more primary care healthcare providers (TML Board member)

We simply didn't have the time to be out there communicating on a one to one basis like we used to with general practice (TML Board member)

Leadership locally and nationally

An unexpected outcome of the project was the identification of key GP leaders in Tasmania who had played significant roles in both local and national primary care reform. Leading GPs from each region of the state were identified as taking on key leadership roles from the evolution of Divisions and RWAs, to contributing nationally and on a statewide basis to structural reform in primary care. From establishing the first GP IT portal to integrating rural and urban divisions to leading the push for a broader primary care focus, Tasmanian GPs were at the national forefront. In the move to the TML there was a widely expressed view that, under both the TML and the PCN, these relationships would remain critical to the health system as a whole and would need to be nurtured, with GPs still to play some leadership roles.

In addition, the leadership demonstrated by the current CEO of the TML was universally regarded as a significant asset for the organisation by all interviewees.

Rural issues

Given the singularity of the Tasmanian experience in relation to the close integration of the rural doctors' support infrastructure (RWA) with the previous Divisions and SBO, the project felt it was valuable to specifically explore the sentiments of rural GPs and the new workforce organisation, Health Recruitment Plus (HRP) about the 'parting of the ways' during the period when the TML was established.

And the thing was that probably two thirds of the people who were involved in decision-making in terms of TGPLD had significant involvement with the rural doctors (Urban GP, former TGPLD Board member)

Apart from the general feelings about the loss of collegiality from the old Divisions, rural GPs surveyed felt they, and their practices, were well supported by HRP, and were not concerned by its 'stand alone' status in the current arrangements.

So, to an extent, the demise of the Divisions has been well and truly softened for us, in this practice, by the leadership shown by Health Recruitment Plus. They have a practice managers group and have a two day meeting once a year and several half day meetings...and that for us has been a fantastic network (rural GP)

Prior tensions between RWA and the three Divisions on role clarity has also been eliminated by the current separation

When they (rural doctors) decided not to go with the current iteration it has probably been a good decision (urban GP)

It was just a sense that they had different priorities...they felt they needed to go out and do their own thing...it wasn't seen as a great schism or anything like that (TML Board member)

However, rural service delivery in general remains a strong concern of both the TML and rural GPs as the structures change and funding regimes alter.

There's always an underrepresentation of rural issues. But we try very hard to make that as minimal as possible (rural GP)

And there is a very strong understanding that unless we work together we are not going to resolve Tasmania's long standing sustainability issues in healthcare (TML senior executive)

In the delivery of mental health services for the high prevalence disorders, and the risk around losing the capacity to deliver those services...it's fine for the cities where there might be heaps of private providers who you can subcontract work to, but we need some really good strategies for delivery in rural areas (TML staff member)

Both DHHS partners and GPs themselves recognise that the role of rural GPs in their communities is of a high value

These doctors do more than care for in-patients (in rural hospitals). They are far more valuable in a rural community (DHHS senior staff member)

Rural general practitioners are true general practitioners (urban GP)

While the organisation realignment for rural GPs and practices has been smooth, there continue to be perceived threats to the viability and capacity of primary care services in rural areas if and when funding arrangements change.

Governance

Horvath⁷ identified general practice engagement as critical for the new PHNs, and recommended increasing the number of GPs in governance arrangements as one means to this end. All respondents apart from one in this study, however, believed that increasing GP members of Boards was not the optimum way of engagement. There was a virtually unanimous view that Boards should be skill-based and members should have a strong understanding both of governance requirements and of the broader health system and the role played by primary health care. While Divisions had begun with GP-only Boards, those Boards recognised the need for them to develop their own governance skills, and then to include on their Boards non-GPs with additional governance skills.

Instead, there were a range of suggested approaches for improving engagement with GPs (and equally, to other providers) as the new organisation is formed, including clinical panels, a paid part-

⁷ Horvath op cit p 10

time GP co-ordinator provider, and continuing the valuable interdisciplinary clinical planning coming from the Pathways project.

Tasmanian Health Care Assistance Package (THAP)

One of the most significant challenges for the TML in its journey from its Divisional and regional base came late in the first year of its establishment, when Health Minister Hon Tania Plibersek announced a major funding package for the health sector in Tasmania, which included over \$60 million over three-four years for a range of projects, which came with firm guidelines and substantial reporting requirements, over and above the 'normal' TML reporting. While it was not the role of this project to discuss any of the THAP projects in detail, it was of significant interest that interviewees held strongly divergent views on the value to the TML of taking on the THAP funding and projects. Several of the GPs, in particular, felt the *TML, as a fledgeling organisation, was ill equipped to deal with a budget of that size:*

The design and engineering had been for \$7million, I think, and it [TML] did not have the tools to ...engage on \$60 million (rural GP)

THAP was both a blessing and a curse; a blessing in the sense that it was a real opportunity for the TML potentially to shine, because it would have so much money to do things with, but a curse in the sense that it was such an enormous amount of money....a trebling of the TML budget (former TML staff member)

What THAP has done has given us the capacity to work at the broader level as in with the Social Determinants work. That would have been more difficult with the Divisions because the Divisions were very much focussed on individual patient care and fixing the system but not looking more broadly (TML Board member)

In short, the angst felt by some of the key players in relation to the THAP funding and the struggle which the TML then experienced in implementing its core business together with these new major projects, keeping its old and new stakeholders engaged, was a significant issue in early implementation of a new organisation, although the actual value of the TML THAP programs as they are evolving is not contested; in fact they are often cited as major strengths of the organisation which should not be lost in the move to a PCN

Conclusions—imperatives for the future

Our narrative has ensured the recording of some of the significant organisational building blocks for an engaged, better integrated primary health care system. These building blocks have emerged from both the Divisions and the TML, and will continue to add value if the transfer to a PCN occurs smoothly. It has also identified shortcomings and risks which need to be assessed and managed by the new organisation. Collaboration and relationship-building across the sector will continue to be imperative, especially in the re-engaging of GPs and general practice. Developing and maintaining sustainability of programs in rural communities is another significant ongoing issue. Ensuring organisational integrity and flexibility, maintaining the strong credibility established by the Divisions and strengthened by the TML, and simultaneously building new networks while maintaining former ones, remain the major challenges. To do that within the strictures of onerous and often inflexible reporting requirements and while heading irrevocably towards yet another major restructure will call on all the accumulated wisdom from the past two decades.

Policy recommendation

Primary Health Care Networks need to have funding flexibility to enable innovative approaches which target and meet local need. Similarly, reporting requirements, while ensuring accountability, should have broad criteria for success, and these, in rural and regional areas, should aim at sustainable and appropriate services. Soft hands, broad horizons!

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Presenter

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