Debate: Do GP Divisions Have a Future? An Alternative Review

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SPHERe Debating Paper No 02/03

Dedication

This paper is dedicated to my GP. He would be mightily embarrassed if I identified him, so I won't. He is well nigh my 'perfect agent' (see section 1)!

Acknowledgments

A few colleagues in and around General Practice have kindly commented on an earlier draft of this paper. These comments have improved it enormously. My thanks to them not only for these but for the moral support which has encouraged me to put these ideas out more widely in the hope of creating more debate about Divisions and thereby contributing to a better health service in Australia.

Comments

Comments on this debating paper are most welcome, to
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Abstract

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In the wake of the recent review of Divisions of General Practice, this paper seeks to promote debate about the future of Divisions. That review was heavily constrained by its terms of reference which were clearly designed not to rock any boats. The outcome is predictably disappointing. This is only to a small extent the fault of the Review Panel.

Primary health care (PHC) and within that General Practice are crucial to the success of any health care system. Patients look to GPs to act as our agents to take care of us, not only in terms of our health directly but our welfare more generally. Few of us see health care as a commodity which can or should be bought and sold like Mars Bars or potato crisps. We need an agent to help us in our ill and ill-informed states; we want to be cared about as well as cared for. That caring agent is the GP.

Yet while other countries – such as Canada and Denmark - seriously debate their health care systems, we in Australia fiddle on the margins. The government looks more and more to market forces to deliver health care. That is no answer unless we want to plumb the depths by emulating the health care system of the US.

There are opportunities to do better, to build a new health care system for Australians according to Australian principles and to do so on the basis of a much more “Ausified” General Practice sector. This paper attempts to add to that process.

We need some radical thinking about General Practice and we need to rethink Divisions. This paper seeks to promote debate about a positive future for General Practice but more especially for the future of Divisions of General Practice. The question that the Review Panel should have been asked to address was: can the money currently spent on Divisions be spent on Primary Health Care in a better way? The current overall level of funding of Divisions is either too low or too high. If the funding were to remain more or less at its current level, as is implied by the Review, then the best thing would be to close the Divisions program and use the money more efficiently in other ways in PHC.

The paper then suggests however that Divisions would be more efficient if they were much more highly funded. An alternative philosophy to the funding formula is proposed. Fundholding, the acceptance of the diversity of Divisions, the use of community values in Divisions are seen as ways of enhancing the role of GPs and in turn of Divisions in a very positive way.

Of special relevance to the author is the fact that the original terms of reference were added to by the Minister to include ‘how Divisions can and should be addressing the particular needs of Aboriginal and Torres Strait Islander people in their catchment populations’. This issue is considered at some length.

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1. Introduction

The review conducted recently of GP Divisions (Commonwealth of Australia 2003) is disappointing. In many ways it represents an opportunity lost. This is by and large not the fault of the Review Panel. The terms of reference were needlessly narrowly restrictive. One can only presume that that was deliberate. Yet in other countries opportunities are being taken to take a serious look at various facets of health services: the Romanow Report (2002) in Canada, the Kristiansen Review in Denmark (2002), etc. When the author of this paper presented to the Panel, it was largely a waste of their time and mine as most of the targets that I aimed to hit or at least have debated were outwith the field of vision of the Panel (although I suspect not those of the members as individual members).

It is the author's belief that primary health care (PHC) and within that General Practice are crucial to the success of any overall health care system. It is to the GP that we as patients look, to act as our agent to take care of us, not only in terms of our health directly but our welfare more generally. Few of us see health care as a commodity which can be bought and sold or which should be bought and sold like Mars Bars or potato crisps. We need an agent to help us in our ill and ill-informed states. We need information to help us to make the right decisions; we want to be cared about as well as cared for. That caring, informed agent is the GP.

I have gone on record before to argue that the current overall level of funding of Divisions is wrong. It is either too low or too high. There is nothing in the recent review that makes me want to change my mind on that. If the funding were to remain more or less at its current level, and that is what is implied by the Panel's report, then I think the best thing would be to close the Divisions program. Almost certainly the money could be used more efficiently in other ways in Primary Health Care (PHC). This is largely because at their current level of funding many Divisions (but not all) spend too high a proportion of their funds on keeping their doors open and then have rather small amounts left over to spend on programs that might aid the populations they seek to serve. Secondly at their current level of funding too often the management of Divisions is not very good. Before my august friends in Divisions attack me for my lack of understanding of the enormous efforts they put in to managing divisions, I would make the point that I know this and it is to some extent because of this that I am arguing for better management that is professional and to have organisations that are able to support and pay professional managers (whether they be GPs or not). My basic thesis at this level is that Divisions have never been given the resources to allow them to be as successful as they can be and as they need to be.

What this paper does *inter alia i*s to suggest that Divisions would be more efficient if they were much more highly funded.

This review is less comprehensive than the official one. It is however more far reaching on several fronts. It looks particularly at funding issues, both the funding formula and the level of funding. It also touches on the question of fundholding.

Of special importance to the author is the fact that the original terms of reference were added to by the Minister to include 'how divisions can and should be addressing the particular needs of Aboriginal and Torres Strait Islander people in

their catchment populations'. This issue was thus an "add on". It is here considered at some length.

In the next section I debate what I see as a major flaw in the thinking underlying the review of the funding formula (ADGP 2002) which preceded the Review of Divisions and which was in turn endorsed by the Review Panel. This relates first to the obsession with the notion of need and second to the lack of recognition that funding formulae are about allocating resources and consequently *have* to deal with costs. In section 3, a new way of looking at a funding formula is presented. Section 4 examines some issues specific to Aboriginal health before in section 5 the question of the overall funding level of Divisions is addressed. The relevance and importance of community values are debated in section 6 and an enhanced role for GP**s,** as a group, through Divisions, to be agents for the community. This is followed by consideration of the very wide variation that exists across Divisions and the importance for the future of recognising this. Fundholding is the topic of section 8 before the paper ends with what is a non-conclusion which involves a call for debate.

2. The Funding Formula: Needs and Costs

One issue that the Review did little to address was the funding formula. This was presumably because a review of that formula had been conducted in the not too distant past (DHAC 2002). It remains the case that there is uncertainty, perhaps even confusion, as to just what the formula is supposed to be doing. It is claimed that it is about health need but not about costs. This is strange. When funds are being allocated to the various Divisions, how can that process avoid the question of the costs of addressing needs? Only if the costs of meeting needs were the same across all Divisions (which is clearly not the case) could it be justified to ignore costs. Funds are being allocated to do something; doing something involves using resources i.e. results in costs. This separation of needs and costs in this context is false.

In the funding formula review it is stated that: ‘The Divisions Standing Committee agreed that Divisions should be funded in a way that reflects the health of their communities, rather than their costs.’ It continues: ‘It was also thought that such an approach is more consistent with the aim of the Divisions of General Practice Program which is to ‘improve health outcomes… ''. Later it is stated: ‘the revised formula should not reflect the costs incurred by Divisions but rather the health of the populations within Divisions’. It is then added: ‘For this reason looking at the value of any such costs would not be pursued in determining the appropriate level of the loading.' This last is stated in the context of Aboriginal and Torres Strait Islander peoples and the rejection of a cost loading to take account of the extra costs of improving the health of these people. Thus the costs involved in providing culturally secure services are rejected as being irrelevant (of which more later).

There are two issues here, both related to logic. There is the allocation of funds to provide some range of services to address, in some way or other, direct or indirect health problems with the aim of improving health outcomes. The obsession with need as the basis for funding leads here to a gross confusion and distortion of what is intended. Allocating resources according to need is not the same as allocating resources in such a way as to maximise health improvements. The approach adopted interprets resource allocation as being about prioritising big problems. In the next section I will spell out a process that prioritises big solutions. That new process is about best buys, about doing good and doing better.

Some health problem (needs) are better addressed by non health service interventions such as housing or education. Even where health service interventions are the most efficient way forward, within these some health problems are more amenable to such interventions than others. If we are to use health service resources wisely i.e. efficiently, we must try to ensure that where

the greatest benefits are to be obtained per dollar spent, we give priority to these interventions.

On the second issue raised above, the question of excluding costs, this is also a problem of flawed logic. Need or health problems cannot be addressed without resources. Interventions and programs use resources i.e. they have costs associated with them. Needs cannot be tackled without using resources. The attempt to separate need from resources used (costs) is based on an ever so strange and severely flawed logic.

3. A Better Funding Formula?

There remains some seeming confusion about what Divisions are about. For example who are they to serve? Is it GPs? the community in general? or those groups in the community who are most vulnerable?

What good and whose good is sought from the allocation of health care resources to different Divisions? One possibility is that it is to maximise health. That appears often to be the aim that is stated for Divisions. (If we were to consult the community a different answer might be forthcoming but that issue is left for section 6 below.) This is in essence an efficiency goal. It might be however that what is sought is to maximise something wider than health. For example in certain instances there might also be a concern for informing, creating reassurance, treating with dignity, treating with respect, facilitating access to other social services. All of these may contribute to health but they may also be objectives in their own right and not simply instrumental in the pursuit of health.

It may also be that the nature of the good embraces some concerns with equity or fairness. Indeed it is normally the case that so-called "resource allocation formulae" are concerned to some extent, often a large extent, with equity. This

may be couched in various terms, for example equality of health, equal access for equal need or equal use for equal need. These are but three possibilities. It can be useful to distinguish between horizontal equity (the equal treatment of equals) and vertical equity (which is the unequal but equitable treatment of unequals). While there is considerable debate in the literature as to which particular definition of equity is the most appropriate, that debate is not pursued in this paper, at least not directly. It is crucial however that there is some explicit consideration as to what the equity goal of Divisions is to be or at least of the funding formula.

This paper argues that the way in which the nature of the good is conceived within the proposed approach to funding Divisions ought to reflect what is sought from the General Practice Divisions program. The first component of the new approach proposed is the *capacity to benefit* (or capacity to do good) as an alternative to the notion of need. This represents a major shift in philosophy. It is not looking at the issue of the size of the problem as is the case with the concept of need in the current formula. Instead it is concerned with the question of improvement, i.e. doing better, in essence working with whatever concept of good is agreed. It seems highly likely that a sizeable component of this 'capacity to benefit' will be perceived in terms of capacity to improve health. There is no reason to believe however that the nature of this benefit will be confined to health alone. Certainly in surveys in the general population in Australia, there is evidence that benefits from health care resources are not restricted to any conventional concept of health (Mooney 2000).

How to measure capacity to benefit in Divisions would need to be worked out. In the context of work done by the author and others for the Indigenous Funding Inquiry for the Commonwealth Grants Commission (CGC 2001) it was argued by key leaders in Aboriginal health in WA that capacity to benefit was greatest in environmental health. It was further argued that the second greatest marginal return was likely to be in social health and thirdly and last the return would be

lowest in trying to change the behaviour of individuals which was having adverse effects on health. It is not argued that the same factors will be relevant for GP Divisions. These would need to be established.

The second component would involve a factor which would be used to weight capacity to benefit. This would reflect vertical equity (or positive discrimination). It is based on the idea, for which there is some empirical evidence (Mooney 2000), that, according to the preferences of Australian society in general, the value attached to nominally equal benefits will be different depending on who the recipients are. For example health benefits to people who are in poor health compared to those in relatively good health would have these benefits weighted more highly. There is in other words a recognition that in terms of equity it is not necessarily the case that all benefits from health care resources be weighted equally irrespective of the characteristics of the people who receive them. In the context of a formula for allocating funds across Divisions, it is proposed that this weighting would reflect some element (to be determined) of relative disadvantage. This might be in terms of, for example, income, health, socio-economic status or education. There are a number of possibilities. What should constitute 'disadvantage' in this context should be again determined according to the preferences of society.

This may look somewhat similar to the socio economic weighting in the current formula but it is different. It is a factor which reflects the willingness of society to discriminate positively in favour of those who are disadvantaged. Put another way, the further down the ladder any group is in terms of disadvantage, the more society is prepared to pay to get them to move up a rung. For example in various surveys, as between Aboriginal and non-Aboriginal benefits of health care, weights of between 1.2 and 2.5 have been suggested (Mooney 2000). This concept is clearly value laden. It is a function of how compassionate the society is or wants to be with respect to the disadvantaged. The more compassionate it is, the more concerned it will be for the disadvantaged and the higher the

weighting will be.

Thirdly there is what colleagues and the author in allocating resources across different Aboriginal communities have called ”MESH infrastructure” where MESH is Management Economic Social and Human infrastructure (CGC 2001). This concept arose in recognition of the fact that not all Aboriginal communities are equally well placed to take advantage of the resources allocated to them to develop programs, for example in diabetic health or in eye disease. In Aboriginal health some communities function better with respect to their ability to invest in programs than do others. MESH involves good management, it requires the availability of resources, it requires a socially well functioning community and ideally good human resources particularly in terms of leadership skills. Where each of these is present then the likelihood that programs on specific health problems will be able to be implemented efficiently is greater. Where some or all of these elements are missing, then resources may well be wasted or at most be used to lesser effect.

There would seem to be a close parallel here with Divisions and their infrastructure to build capacity to benefit. It is similar to but not the same as the $50,000 infrastructure allowance in the current formula. Having worked on a project to look at funding of Divisions in Queensland, it is clear that the current allocation for infrastructure (again endorsed by both the funding and the Divisions Review bodies) is woefully inadequate both in size (there a figure of $200,000 was proposed) and in concept. The MESH approach is one that might well work better and be more equitable for Divisions.

Lastly it is crucial, despite the protestations of the funding review, that any funding formula takes account of differential costs in different locations. Anything else would be unfair. While space does not allow a detailed discussion, which costs and how to include them are major issues. These certainly should take

account of the costs of distance/remoteness and the costs of incentives needed to recruit and retain staff in areas which are unattractive to staff.

4. Aboriginal Issues

The fact that costs are excluded from the formula, as discussed in section 2, is a problem of flawed logic. It becomes a moral problem in considering Aboriginal and Torres Strait Islander health. It does cost more to treat equally sick Aboriginal people, even if only because of the need to take account of cultural security costs (Houston 2001; Wilkes et al 2001). If Aboriginal people are to have the same access to primary health care as non Aboriginal people, then the cultural barriers to access must be no higher. That will require a major investment in cultural security. For example in a study of Debarl Yerrigan Aboriginal Medical Service in Perth (Wilkes et al 2001) it was estimated that ensuring cultural security would raise the costs of PHC by 75%. In arguing against including such costs, the authors of the formula clearly have decided to deny Aboriginal people equal access to General Practice. This is immoral, as is the Review of Divisions that then endorses this position by agreeing with this aspect of the funding formula.

NACCHO (2003) have recently suggested a figure of over $60 million a year for 'national support for GPs working in Aboriginal health'. While it is difficult to make such estimates with any precision, the costs of the cultural security components of this (the lack of which currently constitutes the biggest barrier for Aboriginal people in using General Practice) look to this author to be greatly understated in the NACCHO calculations.

There is some other very strange morality in the review of the funding formula. For example it is stated: ‘Large increases in the Aboriginal and Torres Strait Islander loading may result in very large increases in Outcomes Based Funding Allocations for a small group of Divisions with relatively high Aboriginal and

Torres Strait Islander populations, and consequent reductions for other Divisions.' The logic here is impeccable, one might say in fact that it is not logic per se but a truism.

What it has to do with morality is another matter. The facts are clear: to give more to Aboriginal people would mean less for non Aboriginal people. That is then being used as an argument against such a proposal. What sort of argument is that by way of justification? By way of justice? By way of equity? Issues of morality have been denied, thrown overboard.

There is also a fascinating discussion in the review of the funding formula about justifying extra money for Aboriginal people i.e. that perhaps Divisions should be made 'accountable for how the Aboriginal and Torres Strait Islander loading is used'. I could find no similar discussion with respect to any other loading. For example there is no discussion of making Divisions accountable for how they spend their extra monies for lower socio economic groups. Yet this issue apparently is very clear to the authors of this report when they look at the loading for Aboriginal people. It is black and white. It is racist.

There are comments made in the Divisions' Review about cultural security and what is called “cultural sensitivity”. While these are to be welcomed, there is no recognition of the cost of cultural security and no allowance in the formula for implementing these. There is no appreciation that cultural security is a rights based concept. Cultural security has been defined by Houston (2001) as

'a commitment that the construct and provision of services offered by the health system will not compromise the legitimate cultural rights, views, values and expectations of Aboriginal people. It is a recognition, appreciation and response to the impact of cultural diversity on the utilisation and provision of effective clinical care, public health and health systems administration.

Cultural Security is about ensuring that the delivery of health services is of such a quality that no one person is afforded a less favourable outcome simply because they hold a different cultural outlook.'

The impression is left that the Panel were out of their depth here, that they saw this as little more than an add-on (which is how the issue emerged in the terms of reference from the Minister) and that to stick up a few Aboriginal pictures would go a long way to meet the requirements of making the practice environmentally 'welcoming and comfortable' for Aboriginal people. If the Minister had been serious about this issue, then surely to appoint an Aboriginal person or doctor to the panel, or at least a GP who worked in an AMS, would have been the way forward. What is fundamental here is to recognise not just the health problems of Aboriginal people but their access problems as well.

Most concerning is that there is no debate about whether mainstreaming for Aboriginal people's PHC is appropriate. Yet this is a major policy question. There are important cultural issues here that have not been addressed. There is no mention of the fact that the Aboriginal conceptualisation of health is different from that of non Aboriginal people nor that the standard PHC model may not apply to Aboriginal people. Even if mainstreaming were deemed the way to go by Aboriginal people, given the Panel's acceptance that the funding formula should be based on need alone and not costs (see section 2 above), this means that no resources would be made available even to make the practice environment 'welcoming and comfortable'. Indeed the Review states that existing resources are to be 'shared'. There is no call for extra monies for cultural security.

5. Overall Level of Funding of Divisions

The experiences I have had with Divisions is that they are a very mixed bag, some are managed well, some badly; some with really dedicated staff trying to make a difference; others struggling. The Review Panel's much broader

experience seems similar. There are two routes to travel here. One would be to cut the funding of Divisions markedly and make them "GP clubs" to help to reduce the isolation of GPs. That is an important role for Divisions and needs to be recognised as such. There is little doubt in my mind that a Divisionless General Practice sector would mean much greater burn out of GPs. The money released might then be better spent on incentives to get more GPs into rural and remote parts of the country or on other PHC workers. If the amount of money available for Divisions is not to grow, then I suspect that this alternative use of funds would have a greater impact on the health of Australians than continuing with Divisions as they are. That however is not my chosen solution.

What would be preferable in my view is for Divisions to be funded at a much higher level. Given how large a proportion of their allocations is currently spent on 'keeping their doors open', as was show in the Queensland study, doubling their funds would result in their current output being more than doubled. That might also allow Divisions to employ highly qualified managers. This is not to criticise the often dedicated managers who currently exist and do so on relatively poor salaries. The level of funding as of now does not allow the employment of high quality managers, except in a very few Divisions. Greater funding could also mean better paid CEOs but with also greater responsibilities.

If Divisions are to be the force for PHC and public health that they could become, then something like five times their current level of funding would allow that to happen. This would result in their becoming major players in health care - at last, 25 years on from Alma Ata.

Could the money be forthcoming for such moves? That depends on many things but it is here that the 'power of the people' as discussed later in this paper might be the way to go. The money? Well, while it is a different bucket, the overspend or budget blowout of the teaching hospitals in WA alone last year would have allowed a doubling of spending across the whole country on the Divisions!

Part of the problem is the AMA and its lack of support for GPs, as exhibited all too clearly for example in its recent letter to ADGP about fund holding in Divisions (discussed below). It may be time for the Australian GPs to follow the example of their Danish counterparts and set up their own Union. They may want to find other initials however…The Danish GP Union is the Praktiserende Laegernes Organisation, known locally as the PLO!

6. Bringing in Community Values

What is the good that the monies to Divisions is supposed to do? The answer to that tends normally to be seen in terms of meeting patient need but that is such an abused and confused expression that it gets us little further forward. Sometimes it is said to be to maximise health (and that is not the same as addressing need).

What is required is to ask the population served by a Division what they want from their Division as a social institution. Some work has been done on this in Perth in the Osborne Division of General Practice where a selection of citizens in the Division were invited to discuss as a group what principles or “constitution” (Mooney and Wiseman 2000) they wanted to underlie the work of the Division. (A distinction is drawn here between "principles" and "objectives" where the former relate to the values that underlie an organisation and the objectives are what the organisation is attempting to achieve. The two do tend to fuse together but let us not worry too much about that for the moment.)

One advantage of sticking to "principles" is that they involve "big" "broad" issues that citizens can have views and values on and do not require them to get too close to the more technical end of the spectrum. In other words there is more chance of separating the technical from the social. That is necessary especially as I suspect citizens do not want to get into technical matters and GPs don’t want

them to do that either. There is a debate in the literature about what role if any citizens might have in informing or being involved in decision making in health care. That debate can by and large be circumvented by suggesting that citizens as citizens have a view about what issues they themselves want to be involved in - citizens' preferences for citizens' preferences if you like.

Underpinning any health service organisation are value questions: equity, accessibility, the nature and type of benefits (only health?) to be provided, facilitation, linkages to other social services, etc. These are the sorts of issues that citizens can readily get into without having detailed technical knowledge of treatments and interventions. The key here I suspect is to concentrate on the idea of Divisions and General Practice as *social institutions*. Here "institution" is defined somewhat more broadly than might be conventionally the case. It is in a sense the value context in which General Practice operates. So to think of citizens devising a "constitution" or set of governing principles for General Practice is probably about right.

The other point to be made here is that a distinction is being drawn between consumers and citizens. When discussing General Practice and Divisions as social institutions, the preferences of citizens and not consumers are what is required. This is not to say that the latter's views are never relevant but in this specific context they are less relevant than citizens' preferences.

There clearly are differences between the two. More importantly there is evidence that there are differences between the values of consumers and the values of citizens.

Eliciting citizens' values does three things: first it directly engages the community and allows them to be a part of the decision making process about health services. Second but a related point, it alters the distribution of property rights away from the "formal" decision making system to the community. That shift is I

believe the way that health services have to go in the future, not, as I have emphasised, with respect to technical medical issues but with respect to social institutional contextual issues.

Thirdly bringing in community values will I suspect give GPs more say rather than less in the political environment in which they work. Currently that environment is very much Canberra driven. Involving the local Divisional community in the way proposed will encourage GPs to think more about their local community, help to develop the bottom up approach, etc. This GP/community agency role which would then mirror the in individual GP/individual patient agency role will enhance rather than diminish the GP's role and autonomy as compared with what currently is possible. The individual GP remains the individual patient's agent; the GPs collectively through the Division become the community's agent.

7. Variety Is the Spice of Divisions

Divisions are quite incredibly and challengingly different. Their size geographically varies from 10 to 815,464 square kilometres, their populations from 17,051 to 583,486, the number of GPs from 12 to 771 and their incomes form $166,836 to $1,441,809.

Instead of recognising and even celebrating these differences and diversity, by and large the Review attempts somewhat perversely to try to make Divisions the same. That is unfortunate. There is a need to accept that these differences exist and then allow these to be reflected in the way that different Divisions in different locations might be run. The communities they serve are clearly very different. Almost certainly the communities' voices will be very different in terms of what they want from their Division. There is a need to move away from the current top down attitude, not that I think that was welcomed by the Review Panel but rather imposed by the Department.

Some communities might (hopefully!) even opt to get rid of the name ‘Division’! Why have this military terminology for what ought to be humanitarian and caring organisations? One wonders if the B in SBO is for Brigade!

More seriously there is a need to experiment more with these organisations. Their roles will inevitably be different in the Territory than in Central Sydney. Almost certainly the people in the NT want their Division’s monies used differently from the folks in Central Sydney. Let’s ask them. Let’s truly involve the communities that Divisions serve rather than have the odd consumer rep as an add on to boards. There are two points here: first to engage communities in a meaningful way and secondly to involve them in non-technical issues with which they can readily grapple.

This, as emphasised previously, should leave the GP with a more influential role. Many doctors enter General Practice as a career because they want to be involved with the community. There is an opportunity here to get GPs engaged in furthering this "bottom up" community-voiced approach. Indeed the combination of GP expertise and the community's preferences could be a powerful driver of health care. The GP is so often the patient's agent; through these more powerful, better funded Divisions, they can become the community's agent as well.

As the Review stands, there is no sense of vision that comes through. Again this criticism is not aimed at the Panel but at the terms of reference. There is no stepping back and saying ‘right, we have these organisations that can be a force for good. What good do we want them from them and who should decide that?'

There is a lot of confusion about the Divisions’ objectives and the review does little to reduce that. I recall one Division where the GPs were split fairly evenly between those who saw the Division as promoting the GPs and those who saw it as promoting health. Perhaps this lack of clarity should be seen as a strength – allow or even foster diversity in goals/principles but according to the voices of the

people and not the GPs. What might that do for the principles of PHC as set out at Alma Ata 25 years ago!

The Review continues the top down attitude to Divisions by setting out a series of functions which Divisions will do and aspire to. While I would challenge the desirability of this top-down configuration, I would also suggest that having done this, there was a need for the Review panel either to set out priorities or to indicate how this might be done. Is being responsible to its community (how, when the community voice is so muted?) as important/more important/ less important than 'a strong research, evaluation and development approach'. Even if there were agreement to these different functions (but why impose them?) should the priorities not be set by local communities?

Divisions are claimed to be 'independent, self-governing organisations'. They also, it is suggested in the review, need to be 'both accountable and transparent about [their] operations to the Commonwealth and other funders'. That is misinterpreted by the Review Panel as requiring sameness; yet how can we have independent sameness except by coincidence?

I am not advocating letting a thousand flowers bloom but a few, reflecting the soil and climate of the locality, and the preferences of the local people.

8. Fundholding

There is scope for thinking through whether Divisions should get into fund holding and thereby become really central players on the health care stage. The AMA would not like that as it would mean a shift in the distribution of property rights away from the hospital sector. I suspect patients and citizens would endorse such a shift as they tend to see the GP as their agent in the system and any shift of power to GPs would almost certainly be welcomed by patients. Many GPs would also welcome it.

While this is not a major part of the Panel Review, fundholding is nonetheless an issue that is worthy of debate. The AMA is strongly opposed to it (even although it is not clear in what form, as it comes in many forms). They also seem to fail to recognise that it is already happening in some Divisions (e.g. Hunter Urban with after hours services and the Brisbane North coordinated care trial). While a number of reasons are put forward by the AMA in their letter to the ADGP of 7 August, almost certainly the major cause of concern for the AMA is that such fundholding by GPs, Divisions or regionally would result in a major shift in the distribution of property rights in health care from the hospital sector to the GPs.

Who should judge the value of fundholding whatever form it takes is an important question. It would be wrong to suggest that the AMA do not have a legitimate voice in debate about such an issue. They are the doctors' union and if they are not 'on side' then it will be difficult to get any such policy implemented.

What is at least as important however is that the GP is to a large extent the agent who acts on behalf of the patient, not only in primary care directly but in advising and guiding the patient through the system more generally. Some health care systems promote this better than others and presumably some societies and cultures value this more highly than others. Not even to recognise this, as the AMA fail to do in their letter to the ADGP, is however worrying. GP fundholding strengthens the position of the GP in the health care system in a way that furthers the agency role that patients may well seek from their GP. Given just how remarkable they are, the comments from the AMA that fundholding would 'introduc[e] rationing', would 'discourag[e] service utilisation and 'substitut[e] 'cheaper' options for medical services' are worthy of more detailed comment.

First rationing exists and has existed in the past in all health care systems including the Australian health care system. Hospitals have to work within budgets; GPs have limited time to spend on their patients; the private sector

rations by price; the public sector by waiting; patients or potential patients ration their private health care by limiting the amounts they are willing and able to pay in premiums; they ration their time by not taking trivial complaints to the GP. Internationally the very expensive US health care system rations largely by price; the cheaper Danish health service largely by waiting. The idea that fundholding would introduce rationing is not just wrong; it must be the case that the AMA know this but are trying to frighten stakeholders or ideologically scare off the idea of fund holding. It is worrying that they are reduced to such an argument.

Second they argue that fundholding might discourage utilisation. Why however do the AMA imply that this is necessarily bad? For patient health it is not utilisation of services that is to be maximised but population health within whatever resources are available. There is much to be said for being explicit about such choices regarding what is to be done and what left undone. This explicitness is something that fundholding would help to promote.

Third the suggestion from the AMA that dearer is better is most worrying of all and on two fronts, first because of its direct implication; and second more generally because of the complete lack of understanding implied in the comment that there are limits to what any society will spend on health care. This is bordering on a dereliction of social duty on the part of the AMA. Reasonably, Australians look to the AMA to be socially responsible in their pronouncements. This is not acting responsible; it is unlikely to breed a responsible attitude in society more generally to issues of resource deployment in health care. It is quite startling to discover such an attitude still being expressed in the 21st century.

9. Ending? Beginning?

There is no real conclusion to this paper. The intent is to try to stimulate more debate about some of these issues.

I ask readers to ponder on the points raised not necessarily agree with but hopefully be stimulated by the ideas presented, to think about what are important matters for the future of General Practice in Australia and use this as a springboard to further this debate.

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