



General Practice Gold Coast

This isn't Rocket Science Response to the Discussion Paper "Towards a National Health Care Strategy"

Thank you for the opportunity to provide input into the draft discussion paper. General Practice Gold Coast (GPGC) supports the development of a National Primary Health Care Strategy to refocus health policy on building a stronger and more effective health care system. Despite the need for reform to achieve better health outcomes we should not ignore that Australia has one of the best primary health care sectors in the world. Efforts to reform the system should recognise and build on the strengths of the current system. The solutions really are self evident – there's no "Rocket Science" involved.

Comments on the key elements of the discussion paper are contained below:

Improving Access

What we know

Areas with more primary-care physicians have better health, even after demographic differences (such as age distribution and income levels) are taken into account. Areas with higher ratios of primary-care physicians to population had much lower total health-care costs than other areas, possibly because of the better preventive care and lower hospitalization rates that accompany good primary care. Care for illnesses common in the population—for example, community-acquired pneumonia—was more expensive if provided by specialists rather than generalists, with no difference in outcomes.¹

Nurses working under the direction of a GP and providing medical services on the doctor's behalf are clinically effective, cost effective and efficient.²

What works?

More GPs

Health Workforce Queensland suggest that 1200 GP training places nationally are required annually from 2010 to cope with retiring GPs, population growth, and the increase in complex and chronic conditions. Projected graduations from medical schools around the country would support this increase in numbers. There is a well documented and publicised GP shortage. Let's get on with it.

Increase the utilisation of practice nurses within general practices

Practice nurses have made a significant contribution to increasing the capacity of primary health care. Nurses on the Gold Coast have doubled over the past five years and contributed to a demonstrated increase in efficiency. The table below evidences the relative efficiency gains by Gold Coast general practitioners over the past three years.

Increasing access to primary health care can be achieved by:

- Increasing GP registrar training places
- Implementing one MBS rebateable service for “Consultation with a practice nurses working under the direction of a GP”
- Supporting Quality Improvement initiatives such as the Australian Primary Care Collaboratives (APCC) that enable all members of a practice team to operate most efficiently to the extent of their skills and knowledge.

Here’s the evidence

GOLD COAST & AUSTRALIA WORKFORCE DATA³ - GPs, MBS ITEM NOS & POPULATION 2005-08

	GOLD COAST				AUSTRALIA			
	2005/06	2006/07	2007/08	% Change	2005/06	2006/07	2007/08	% Change
Population GCCC	450,861	466,651	483,212	7.2%	20,334,300	20,600,000	20,915,700	2.9%
MBS Services GCDGP	2,434,731	2,573,934	2,757,699	13.3%	106,728,346	108,501,629	116,705,734	9.3%
Services per head Population	5.4	5.5	5.7	5.7%	5.2	5.3	5.6	6.3%
Nos GPs providing Medicare GP Attendances	429	444	455	6.1%	20,320	20,499	21,304	4.8%
Services per GP	5,675	5,797	6,061	6.8%	5,252	5,293	5,478	4.3%
MBS Income	87,280,666	95,787,413	105,184,698	20.5%	3,179,224,021	3,234,118,577	3,462,716,912	8.9%
MBS Income per GP	203,451	215,737	231,175	13.6%	156,458	157,770	162,538	3.9%

Note In this table, Medicare data is for area covered by GCDGP whereas population data is for GCCC, a slightly different geographical area. GP data is based on actual numbers of GPs

This data reveals the following trends

- The number of Gold Coast Medicare funded services provided per capita is greater than for Australia.
- The number of Medicare funded services on the Gold Coast is increasing more rapidly than for Australia, as is the number of services per GP and the amount of Medicare income each GP generates.
- In 2007/08, on average, each Gold Coast GP generated 10.6% more services than the average Australian GP. This indicates that Gold Coast GPs are relatively efficient compared to their Australian colleagues, on average. The increasing number of nurses in practices has contributed towards this.

What doesn’t work?

- Developing even greater numbers of MBS rebateable services for GPs and nurses

Improving prevention

What we know

Primary health care has traditionally been focused on illness and injury; however GPs are well placed to help the community see lifestyle risk factors as significant health issues to be taken seriously.

Of adults attending a general practice consultation, around half will be overweight or obese, one in five will smoke, one in four will engage in risky drinking, and two-thirds will do less than recommended physical activity.⁴

Reorientating to a wellness and preventative focus will require systems changes and change management support.

What works?

A coordinated approach utilising motivational interviewing and counseling to effect behavioral change in patients. Increasing access to self management courses and lifestyle modification courses for patients. Supporting systems for health professionals to gain skills to be able to deliver self management education and conduct motivational interviewing and counseling. To adequately perform these roles the following is supported:

- A reformed MBS system that adequately remunerates general practice for the time spent providing high quality care to chronic and complex patients and preventative health care to those at risk of developing disease.
- Practice nurses undertaking appropriate services on behalf of the GP.
- Support for general practice to improve measurement, clinical monitoring and reporting of preventative and clinical outcomes through such programs as the APCC
- Financial incentives for the provision of quality preventative care.

Here's the evidence

The number needed to treat (NNT) is a measure of the number of people who need to be treated (often for a specified time period) in order to prevent one event or achieve the treatment target. For example, brief advice (3–5 minutes) by a GP that incorporates assessment of interest in quitting, provision of pharmacotherapy and arranging follow up has an NNT of 14. If the GP provided this advice to 14 smokers then one would quit for at least 12 months, as shown in the table below.⁵

Estimated NNT for a range of lifestyle interventions

Target area	GP time	intervention	NNT	outcome
Smoking	3–5 minutes (up to 1 minute)	Brief behavioural counselling using the 5As	1 in 14 (1 in 20)	Quit for at least 12
Hazardous drinking	3–5 minutes	Brief behavioural counselling using the 5As	1 in 10	25–30% reduction in alcohol consumption
Exercise	3–5 minutes	Brief behavioural counselling using the 5As	1 in 10	Engage in at least 30 minutes three times a week

* 5As: Ask, Assess, Advise, Assist, Arrange

What doesn't work?

Large scale change without adequate financial, systems and change management support.

Integrated and Coordinated Care

What we know

There is lots of evidence that a good relationship with a freely chosen primary-care doctor, preferably over several years, is associated with better care, more appropriate care, better health, and much lower health costs.⁶

The transfer of patient information and the coordination of care is particularly poor between health providers. This is particularly evident in the transfer of patients between primary care and the acute sector. When patients leave the hospital without clear understanding of their diagnoses, medication instructions, or need for primary care follow-up, chances are that they will wind up back in the emergency department (ED).⁷

A team only functions with a leader.

What works?

- General practice should be supported to coordinate care. Practice nurses coordinating care for their patients under the direction of the GP can reduce the fragmentation and increase the integration and coordination of person centred care.
- Health and community services working within formal partnerships create efficiencies and enable a more seamless patient journey through agreed roles and pathways.

- Voluntary patient registration could enhance continuity of patient care, increase the range of information available to health practitioners and reduce duplication.
- Information systems that enable the transfer of patient information between health care providers.
- Coordination of social and medical needs is most efficient when conducted by the people who know the patient's social and medical history (usually a general practice).

Here's the evidence

In Victoria more than 500 GPs have worked with Primary Care Partnerships (PCPs) on issues such as multi-disciplinary care planning and better referral through the use of the Service Coordination Tool Template and electronic referral. This work with GPs through PCPs has resulted in broader benefits such as clearer, more comprehensive and timely formal and informal communication between GPs and other service providers.

Since 2005 the number of referrals sent electronically has increased by 12000. Because this saves the receiving agency up to 50% of the time taken for registration and needs identification, this could mean that up to 6000 hours have been spent on service delivery rather than administration.⁸

What doesn't work?

- Further fragmenting care by creating additional infrastructure, administration and bureaucracies outside of general practice to coordinate care.
- Fragmenting care further by expanding Medicare services to other health professionals without a referral from a GP. Currently, the vital role of coordinating care for people receiving services from multiple health practitioners is being performed by a GP. This is made possible as the existing system supports their role as the leader of the health care team.

Improving quality

What we know

GPs make improvements against clinical indicators when they have the knowledge, skills, systems and supports to capture, view and evaluate strategies using practice clinical data.

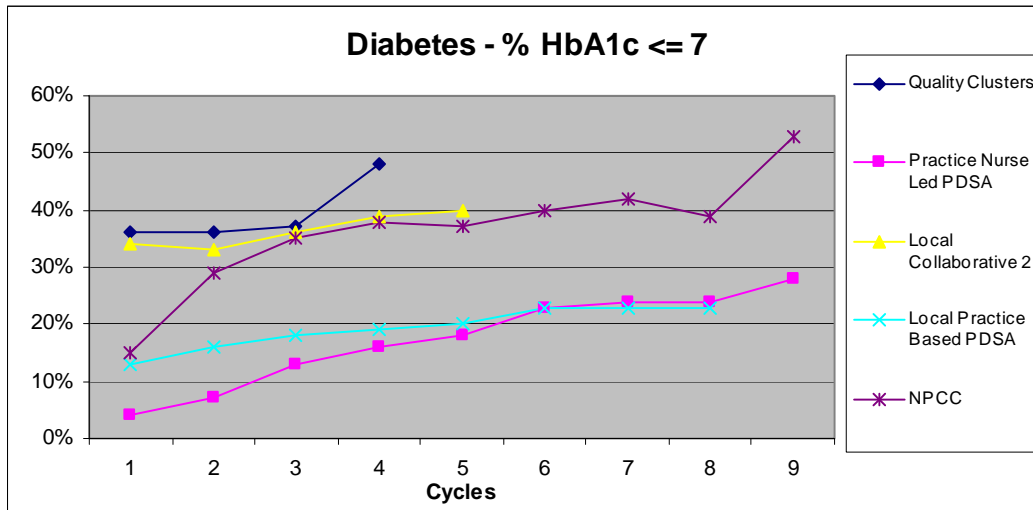
What works?

- Funding evidence based quality improvement activities such as the APCC to deliver improved health outcomes and more efficient general practices. 77 of 140

Gold Coast general practices have participated in a GPGC led quality improvement activity and this has led to improved patient outcomes and increased practice efficiency.

- Providing incentive payments for practices capturing and reporting data against defined clinical indicators.

Here's the evidence:



Improvement results for HbA1c indicator using comparative data from a variety of national and locally developed quality improvement initiatives

What doesn't work?

Implementing a Pay for Performance framework to elicit improved performance without evidence this will lead to the desired results.

Responding to local community needs

What we know

Australia's health system is fragmented and operates within silos. Few enablers exist to developing effective relationships and systems to correct this. Agencies working together can improve the experience of health consumers. Partnering works.

What works?

Initiatives such as Victoria's Primary Care Partnerships and Queensland's Connecting Health Care in Communities support partnerships to identify local needs and utilise a

region's resources most effectively through collaborative action to address these. Six years of partnership work in Victoria has enabled the systems to better respond to consumers through coordinated preventative efforts, earlier identification of need, clearer referral pathways and improved demand management.⁸

Supporting partnerships through skilled and efficient facilitation and program support.
Hosting primary care partnerships within community and non government agencies.

Here's the evidence

In Victoria, they are seeing the improvements to the continuity of care for consumers through their primary care partnerships (PCPs). These achievements have been achieved through a systemic approach of agencies working together in a supported way.⁸

On the Gold Coast, the Primary Care Partnership Council (PCPC) funded under the CHIC initiative has brought together representatives from 17 agencies to improve the health of the community through collaboration. The PCPC has been able to examine local needs and identify gaps in service provision. Using tools such as the Australian Early Development Index (AEDI) the vulnerability of children under certain developmental domains has been identified. The PCPC has responded through partnerships with relevant agencies to improve the health and well being of 0-6 year olds.

What doesn't work

Expecting a spontaneous outbreak of partnering without adequate support by skilled partnering practitioners and adequate infrastructure.

Expecting those with the least experience and poorest skills in partnering, such as public health services to lead the way.

Education and Training

What we know

Training medical practitioners within general practice is time consuming, costly to the practitioners and requires additional space within a practice

What works?

- Increasing financial support for training primary care practitioners
- Providing support for models of vertical integration within practices that support the training and supervision of medical students, pre-vocational doctors and registrars, and nurses.
- Providing infrastructure support for practices to be able to expand physical space to incorporate adequate rooms for training and supervision.

In 2008 General Practice Education and Training (GPET) commissioned a study on the practice costs and benefits associated with supporting vocational training for the AGPT program. This soon to be completed study will provide the best evidence of the cost and benefits of training within general practice. Until then just ask any GP undertaking supervision of students, junior doctors or registrars.

What doesn't work?

Increasing expectations for training and supervision within a general practice without consideration of their capacity to dedicate sufficient time and utilise adequate space and resources. Caution should be exercised in providing geographic incentives as they create inequities, particularly in outer metropolitan areas.

So - Who pays?

Obviously the development of a strengthened primary health care sector with a strong emphasis on better management of chronic disease, coordination of health services, and prevention will save taxpayers and consumers money. Many of these savings will be in the mid to long term, although the impact on consumes health and well being will be realised earlier in many cases. Those receiving the benefits of enhanced or reformed services should pay the costs. In many cases this may be Commonwealth and State Governments who will see significantly reduced acute care costs from a strengthened primary health care sector. Some effort should be directed into quantifying expected cost savings and applying implementation costs to these organisations benefiting. This will also incentivise these bodies to ensure implementation of the reform process is well resourced, evidence based and adequately managed.

If the reference panel requires any further details of the General Practice Gold Coast initiatives described in this submission, we would be happy to provide it.

References:

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4. Lifestyle Risk Factor Management in your Division – A Guide for Divisions, 2005, Commonwealth of Australia
5. RACGP Green Book Putting Prevention into Practice (RACGP 2006) Appendix 3
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8. *“Primary Care Partnerships are making a difference”*, An evaluation of the Primary Care Partnership Strategy October 2006. Victorian Government.