

THE EMERGENCE OF GP SUPERCLINICS

Will SuperClinics deliver the changes needed in prevention and primary care?

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Introduction

Australia's healthcare system ranks well internationally, as reflected in our continuing high average life expectancy and low rate of infant mortality. But these advances are now under threat as our health system is stretched by an ageing population, the growing burden of chronic illness, and the increasingly outmoded organisation of our health services. Inequalities in health between our most and least advantaged citizens persist and are the sentinels that remind us that there is no room for complacency or reform inertia in our healthcare system.

There is almost universal agreement that the healthcare system must focus on prevention and better management of chronic illness, to relieve the current pressures on busy GPs and public hospitals and to ensure a healthy and productive workforce and better quality of life for everyone.

During the election, the Rudd Government pushed for health care reforms, including the need to bolster frontline health care services and primary care. It was in this environment that the commitment was made to invest \$220 million to establish GP SuperClinics. Now work is underway to realize this election commitment.

If you haven't already smelled the peanuts, let me highlight that there's an elephant in the room and it's this: in a conference given over primarily to prevention and primary health care, why are we talking about GP SuperClinics and primary care?

The ALP New Directions paper on GP SuperClinics talks a lot about prevention, but it's pretty clear that the prevention activities will mostly be focused at secondary and tertiary prevention activities, but – it is confused and confusing.

But I will tackle the issue as being about the delivery of prevention activities (the whole range of prevention activities) within the GP SuperClinic setting.

Which brings us to the key point of my talk today – will GP SuperClinics deliver the changes needed in prevention and primary care?

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Current barriers to preventive health reforms

There's a whole list of obvious reasons why prevention doesn't work as well as it should:

- It's poorly funded, less than 2% of the health budget.
- Proactive prevention measures that might take decades to have an effect lose out to quick fixes like elective surgery waiting lists.
- Asking people to change their behaviours – get more exercise, eat healthily, have a regular mammogram, check their blood sugar levels, or take their high blood pressure pills – is difficult and time consuming.
- It's not just about health and doctors, but a whole-of-government approach.

But I would like to explore some less obvious reasons:

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Semantic confusion

There is considerable confusion surrounding prevention both as a concept and as an activity. This was the focus of a paper I published with Stephen Leeder and George Rubin in the MJA earlier this year.

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In that paper we argued several things:

1. That the term 'preventative health' should be banned, especially if you really intend to include tertiary prevention within the scope of prevention activities.
2. While we are all familiar with the definition of prevention, viz "action to reduce or eliminate the onset, causes, complications or recurrence of disease", and the ideas of primary, secondary and tertiary prevention, we are all very loose with the way we use these terms, and others such as public health, primary health and primary health care.

For example, while 'public health' is defined in the same way as primary prevention, public health funding encompasses both primary and secondary prevention activities.

'Primary health care' is not 'primary care', which is taken to mean the first point of entry into the health system, generally for someone who is sick and seeking treatment.

'Primary health care' refers to a community-based approach to address the social, political, environmental and economic determinants of health. This 'primary health care' formulation is broader than primary health prevention and plays a critically important role in dismantling barriers to health and health care and addressing health disparities.

In Australia 'primary care' is almost always delivered by general practitioners. But 'primary health care' is often the responsibility of people with no medical training who may function in jobs outside the health portfolio.

The principal instruments of primary prevention lie outside the doctor's office, and require political, social and economic action. The primary prevention of childhood obesity is a classic example of a problem that will not be solved within the medical arena.

This might sound pedantic and pedagogical, but it has very real implications in terms of who does what and who pays for what to be done.

Work force issues

Beyond the obvious – that there is a health workforce shortage and what workforce we have is poorly distributed – there is a more complicated issue.

The public health workforce, upon whom the organisation and implementation of primary preventive strategies might be expected to fall, is hard to define and there is no official document that specifies a strategic plan for the development of Australia's public health workforce.

It follows that if primary prevention is to take its place in the preventive scheme, then a lot more attention will need to be directed to the size, location and competencies of the public health workforce.

In this public health vacuum, there is a growing push for expansion of the role of GPs in population health and prevention.

Most clinical encounters should include prevention support, and there is some evidence that brief interventions during consultations can assist individuals to make changes to high-risk behaviour such as smoking, poor nutrition, excess alcohol and too little physical activity.

But there are many practical barriers to delivering these services in the primary care setting, including GPs' lack of time and specific skills, practice nurses with other responsibilities, Medicare payments that reward episodic care, patients' illness and stress at the times they present, and the fact that access to referral services is often problematic for patients due to cost, transport difficulties and waiting lists

A push for GP surgeries to be the focus for primary and secondary prevention activities will mean that many people most likely to benefit from these activities will be deterred

from accessing them by cost or perceptions that this is medical treatment they don't need. This in turn will inevitably mean that the potential ability of these services to address health inequalities will not be realised and that these inequalities will widen.

Whose budget?

Without rehashing all the current arguments about cost and blame shifting, unless we can be clear about who does what in prevention and who pays for it, we can end up in some confusing situations.

For example, public health programs are run by the States and Territories and jointly funded by them with the Commonwealth Government in capped funding arrangements. Are some or all of these activities to be taken over by GPs and paid on the basis of an uncapped, fee-for-service by the Commonwealth-funded Medicare?

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What GP SuperClinics will offer

There are many – from the AMA to Jeremy Sammut – who are suspicious and cynical about GP SuperClinics. I'm not, but let me assure you that doesn't mean I think they are the answer to prevention and primary health care problems or even that they will work.

The primary focus to date has been on location.

- The 31 geographical locations have been decided on. There are issues around how this was done.
- The co-location issues are seen as being at the heart of the SuperClinics. The idea is that having a range of health services co-located together will make it easier for people to access needed GP care, diagnostic testing, allied health services and pharmaceuticals.
- And finally there are the issues of relocation and the need to get doctors, nurses, physiotherapists, psychologists and other health professionals into the GP SuperClinics.

GP SuperClinics will operate on the traditional Medicare fee-for-service, and they will be encouraged to bulk bill and to provide 24 hour access to services. The aim is to drive a multidisciplinary team approach to the provision of care, especially for patients with chronic illness.

To date we really have little information about precisely how GP SuperClinics will work, so I thought it would be most useful to highlight what we know works in terms of the provision of preventive health services in primary care.

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What do we know works

Having a medical home

The US based Commonwealth Fund has produced research that shows when people have a 'medical home' - defined as a health care setting that provides patients with timely, well-organized care, and enhanced access to providers - disparities in access and quality are reduced or even eliminated. Access to needed care, receipt of routine preventive screenings, and management of chronic conditions improve substantially.

In Australia we have shied away from the idea of requiring patients to sign up to a specific GP or even a GP practice, but there are definite benefits and we should therefore explore how this might be encouraged, if not mandated, certainly for chronically ill patients.

Chronic disease prevention and management

The main ingredients for success in the organisational delivery of chronic care include:

- Central registry of patients by particular disease types;
- Clinical guidelines and doctor education;
- Collaboration, better communication and delegation of tasks to other team members (particularly nurses and pharmacists);
- Patient self-management education and support; and
- Regular assessments and follow-up.

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Helping patients to coordinate their care

Work done by the SCIPPS group at the Menzies Centre shows clearly how difficult it is for chronically ill patients to know about and get access to all the care they need. The smallest things can be immense hurdles – finding a parking spot within walking distance of the doctor's office, worrying about what happens when they forget to take their pink pill, and the complicated guidelines about when they can have their needed oxygen subsidized.

Work done at Melbourne's Sunshine Hospital has shown that care facilitators can help older people with multiple health problems to identify and access the healthcare they need and facilitate their communications with their healthcare providers. This model of coordinated care reduces patients' use of acute hospital services, with a 21% reduction in ED presentations, a 28% reduction in hospital admissions and a 19% reduction in bed days.

Taking services to the community / the patient

The people most in need of preventive services, especially screening, check-ups and early intervention, are those least likely to walk through the door of the doctor's office. And under our current system, nothing happens without that first step.

One approach that works is to 'de-medicalise' the services and deliver them where people gather and peer pressure will help with participation. This means sports clubs and sporting events, workplaces, RSL clubs pharmacies and even pubs.

E- Health Records

Much is made about the potential for team work, coordinated care and multidisciplinary care, but this is easier said than done. Just putting people in the same space is no guarantee that they will talk to each other or that in doing so the accurate information about a patient they are treating is transferred.

The issues around e-health are a seminar in themselves. Suffice it to say that we will see no real progress on the delivery of quality coordinated care until e-health records become a reality.

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What we know doesn't work / doesn't work as well as it should

Incentive payments and GP management plans

To date, efforts to strengthen the role of general practice in the provision of primary care in Australia have been predominantly through GP funding incentives such as Practice Incentives Payments and Service Incentive Payments, and through new Medicare items. These incentives aim to encourage health assessments, multidisciplinary care plans, access to allied health services and psychologists, and use of practice nurses.

A 2006 study by the Australian Primary Health Care Research Institute at the ANU and the Research Centre for Primary Health Care and Equity at the UNSW concluded that, while there have been many initiatives aimed at promoting access to more comprehensive primary care and multidisciplinary health care teams, these have generally been local initiatives that have not been generalised or sustained. Also there have been few innovations in workforce roles in primary care, with the exception of practice nurses.

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Last year the Medical Journal of Australia devoted an issue to primary care reform. There are several points to highlight:

- The introduction of new MBS item numbers is a very crude and unpredictable approach to the goal of a strong, robust and integrated primary care system. There is a paucity of evidence that new MBS items have improved patient care (Beilby, 2007).
- Only about 2% of patient consultations involve health assessments, care plans and chronic disease management items. Less than 14% of patients with chronic disease are placed on care plans and less than 1% are followed to see if patients adhere to these plans (Beilby, 2007).
- About half of general practice care for chronic illness does not meet optimal standards. Factors contributing to the gap between optimal and current practice include the method of financing, the availability of other disciplines to participate in team care, limited engagement with self-management education, and lack of information and decision support systems (Harris & Zwar, 2007).
- A strengthened practice nurse workforce has the potential to drive change and improve the delivery of many aspects of primary care, but current initiatives to support the expansion of practice nursing are not based on strong evidence about effectiveness, outcomes or efficiencies (Keleher et al, 2007).

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Increasing out-of-pocket costs for patients

The increasing inability of Australians to afford needed health-care services should give policymakers most cause for concern. Thirteen per cent of people surveyed in 2006 said they did not visit a doctor when sick, 17 per cent did not get a recommended medical test, treatment or follow-up, and 13 per cent did not fill a prescription or skipped doses because of cost. Overall, 26 per cent of people went without needed care or treatment.

In 2005-06 17.4 % of health care costs came from individuals. That's around \$700 person.

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What should we require for GP SuperClinics?

Workforce issues

If we don't have the workforce we can't do anything innovative and we can't even do more of the same.

It's about making the best use of workforce skills, and ensuring that systems are set up and funded to enable training, reskilling and mentoring.

People need access to health care services 24/7 not just 9-5 on week days.

New payments systems and better use of incentive payments

Fee-for-service was last century's payment system. I would argue that we need a different one, arguably several different ones, in the 21st century.

We could begin by looking at a new payment system to cover the integrated care needs of the chronically ill. It doesn't need to be capitated, but it does need to ensure that people get the care they need (as opposed to the care they want) without having to juggle out-of-pocket costs, multiple billings, multiple safety net thresholds etc.

We should put pay for performance on the table for discussion, as a way of moving beyond counting the number of services delivered to rewarding the outcomes of those services.

We should require that health problems that show up as part of a health assessment are addressed, and that treatment plans are more than a letter saying 'this patient has a problem'.

And maybe we should consider paying incentives to patients rather than doctors as a way of ensuring that treatment plans are delivered in full, required follow-ups are initiated and preventive services and screening checks are done.

With the right information and a financial incentive an elderly diabetic patient can be emboldened to query why there has been no referral to the chiropodist or for an eyesight check.

Patient records

Shared e-Health records facilitate team care and help promote quality and safety.

Central disease registers help with patient monitoring and follow-up and with assessment of treatment protocols.

Recall notices and follow-up are key to ensuring patients receive the care they need.

Evaluation

If we are going to invest all this time and effort, then we need to know what we are getting. Is it working? If not, why not? If it is working, can we grow this program and translate it elsewhere?

Putting the needs of the community and the patient first

This should be obvious, but too often it is not. The establishment of GP SuperClinics and their role in the delivery of preventive health services and primary care should be about delivering measurable benefits to the Community and the people who will use those services.

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Conclusion

The benefits of the Australian Government's proposed prevention agenda will only be realised if there is greater clarity as to what constitutes preventive health activities, who is responsible for carrying out these activities, how they are integrated and funded within the health care system and how prevention outcomes will be measured and evaluated.

A revitalized public health strategy offers the most sustainable way to address current health inequalities and prevent chronic non-communicable diseases.

There is a role for GP SuperClinics in the prevention agenda. However this increased role for GPs and practice nurses in primary and secondary prevention, and the use of Medicare funds to reimburse for these services, which are currently funded through Special Purpose Payments from the Commonwealth and by the states and territories, raise issues of workforce flexibility, GP and practice nurse training, dual delivery pathways for health promotion and screening services, and effective targeting of these services and the Medicare funds used to support them.

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