GENERAL PRACTICE VICTORIA

Submission
22nd December 2008
National Preventative Health Taskforce

General Practice Victoria (GPV) works at the state level to support Victorian divisions of general practice. Divisions build capacity in general practice, working at the local level towards a skilled, viable and effective general practice sector to improve the health and well-being of Victorian communities. Divisions provide the organisational interface between government and other stakeholders and GPs because they provide broad representation of general practice, have an effective role in GP education for systemic and practice change, and they have a role in the coordination and provisions of vital services. The National Preventative Health Taskforce (the 'Taskforce') needs to be aware of the roles, contribution and capacity of general practice via divisions that general practices in preventative health care.

This submission is based on GPV's past and current work with divisions in preventative health care, and the comments of a range of Victorian divisions to whom was circulated a consultation paper that suggested key messages for the Taskforce to consider.

Summary of GPV Key Messages to the Taskforce
GPV welcomes the Taskforce's recommendation to support primary health care practices to enhance their role in prevention. Key messages to the Taskforce include**:**

An adequate incentive based funding system

- GPV advocates that the current fee-for-service (FFS) system remains intact, that no new PIPs (due to its retrospective nature) or additional fee-for-service items are created for preventative care. GPV supports a blended payment system (FFS and a practice level payment for prevention).
- GPV supports the establishment of an upfront prospective practice level funding system that funds the primary care team to deliver preventative health care with information management support, education and training, and research and evaluation strategies
- GPV advocates that practice level payments be linked to patient registration [as per the General Practice Immunisation Incentive Scheme]
- GPV supports that the practice level payments be linked to performance indicators at the division level, and not the practice, to ensure a population health perspective.
- GPV also advocates, that given existing population health inequities, the Taskforce could consider that any new incentive at the practice level needs to be used flexibly, so as to address the needs of hard to reach groups as well as the general population group.

Registering patients in practices

- GPV supports the trialling of a voluntary patient enrolment or registering system, preferably at the practice level
- GPV strongly advocates that any system to define the practice population needs to be complemented with systems to support the GPs role in: identifying patients at risk within general practice; delivering, coordinating or referring patients to evidence based services and managing their patients, via established written or telephone feedback from professionals**.**
- GPV advocates that further support is required of methodologies (e.g.,Australian Primary Care Collaboratives) to be used by practices, and to increase the use of tools (e.g., PEN Clinical Audit Tool) to assist in risk factor identification, intervention and management

Educating and Motivating the workforce

- GPV supports the use of brief interventions within general practice, if adequate referral systems exist, and if supported by a systematic change management support strategy to facilitate GPs in using the referral systems

- GPV supports the development and dissemination of evidence-based guidelines and multidisciplinary training, if these are supported via an implementation and ongoing evaluation strategies
- GPV advocates that enhanced practice level infrastructure is needed, investment in undergraduate, postgraduate, and vocational education and training on preventative health care, and multidisciplinary education through a vertically integrated career development pathways and supported by rigorous evaluation strategies.)

Taskforce's approach to a national preventive health strategy

- GPV supports a multi-levelled approach to prevention, where the role and contribution of general practice is supported within a national integrated systematic strategy across providers, government, non-government and the community
- GPV advocates for a dedicated systematic change management support approach within general practice, with clear roles for: State-based organisations; divisions of general practice; general practice clinics; and patients
- GPV supports a National Prevention Agency as it will enable greater opportunities for general practice via the divisions network to provide strategic leadership, and knowledge transfer about the role and contribution of general practice in preventative care
- GPV advocates for sustained resources and effort at the practice level to implement existing evidence-based prevention guidelines to optimise appropriate roles in prevention
- GPV advocates that 'workforce' is a key dimension in any performance based framework for the national preventative health care strategy

Background

This submission is in response to the National Preventative Health Taskforce (the 'Taskforce') discussion paper: *Australia: the Healthiest Country by 2020* which is designed to inform the Government's blueprint for refocusing the health system on prevention. General Practice Victoria (GPV) works at the state level to support Victorian divisions of general practice. Divisions build capacity in general practice, working at the local level towards a skilled, viable and effective general practice sector to improve the health and well-being of Victorian communities. Divisions provide the organisational interface between government and other stakeholders and GPs because they provide broad representation of general practice, have an effective role in GP education for systemic and practice change, and they have a role in the coordination and provision of vital services. The National Preventative Health Taskforce (the 'Taskforce') needs to be aware of the roles, contribution and capacity of general practice via divisions of general practices in preventative health care

This submission is based on GPV's past and current work with divisions in preventative health care, and the comments of a range of Victorian divisions to whom was circulated a consultation paper that suggested key messages for the Taskforce to consider. This submission specifically comments on two main areas, the Taskforce's:

1. Recommended strategies to support primary health practices to enhance their role in prevention
    - 1.1. An adequate incentive based funding at the practice level
    - 1.2. Enrolling or registering patients in practice
    - 1.3. Educating and motivating the workforce

2. Approach to approach to a national preventive health strategy

1. Taskforce's recommended strategies to support primary health practices to enhance their role in prevention

The Taskforce states that primary health care is a fundamental part of preventative health as seen in immunisation and screening for cancers and brief interventions for smoking and alcohol use. It suggests three main support strategies including:

1. An adequate incentive based payment at the practice level
2. Enrolling or registering patients in general practice
3. Educating and motivating the workforce.

1.1. An adequate incentive based funding at the practice level

The Taskforce suggests the need for an adequate financial incentive, such as a Practice Incentive Payment or at individual practitioner level (e.g. MBS item No) to support delivery in primary care practices of brief interventions and follow up. The structure of the MBS item could be a small add on to standard consultations in primary care practices when the interventions are delivered and as a stand-alone item at follow-up. It further suggests that such an item structure could narrow the opportunities for inappropriate use and practice as well as help improve the evidence base. The Taskforce paper also states that "Given that brief interventions and the use and promotion of lifescripts can be adequately done by practice nurses, the incentives would be better placed at the practice level". The Taskforce also emphasises the need for a system of accountability and reporting to complement the incentive payments scheme

Evidence suggests that current financial incentives for general practice (e.g., FFS, PIPs, SIPs) are not adequate or appropriate for preventative health care, and that alternate incentives are required. Two recent papers commissioned this year by the NHHRC on possible funding options for preventative care have suggested:

- a *practice level funding* system that supports the primary care team to deliver preventative health care with information management support, education and training, and research and evaluation strategies; and monitored according to *practice level targets* such as the provision of a 'basket of

clinical services'; critical health workforce mass; information management e-health system; and research and teaching opportunities[1];
- clinical prevention activities should be funded under existing programs (such as the MBS, PBS, and NIP) perhaps with an extended the range of providers. A Preventative Priorities Advisory Committee (PrePAC) should be set up to provide guidance and funding for health promotion activities via a dedicated Preventative Benefits Schedule (PreBS) budget. [2]

The GPV Board has indicated that it is not supportive of creating more PIPs (due to its retrospective nature) and additional MBS items for preventative health care. Discussion with division leaders at GPV's State Forum in July, 2008 suggested that there may be support for other funding models (e.g., a blended payment system with a per capita payment for enrolled patients for prevention and chronic disease management). However, until such models are worked up in detail, it is difficult to gauge the likely level of support. Thorough consultation would be necessary for there to be wide spread GP acceptance. For instance, practice-level payment appears appropriate, as it avoid the FFS problems, patients are practice-level patients. However, problems experienced through practice-level payment such as the PIP/SIPs include: no incentive for employed GPs to do the related items; the perception that there is an insufficient business case to warrant the time, effort, and business development needed to take up all the incentives; falling accreditation rates (accreditation is needed to get PIP payments); and resistance to perceived 'red tape.' The GPV State Forum also highlighted that a key role of divisions was to develop approaches for high-need, hard-to-reach groups. Anecdotal evidence exists that MBS items or a practice payment may do little to get to the 'hard-to-reach' population groups who are also less likely to have a general practitioner.

Key GPV Messages
- GPV advocates that the current fee-for-service (FFS) system remains intact, that no new PIPs (due to its retrospective nature) or additional fee-for-service items are created for preventative care.
- GPV supports a blended payment system (FFS and a practice level payment for prevention).
- GPV supports the establishment of an upfront prospective practice level funding system that funds the primary care team to deliver preventative health care with information management support, education and training, and research and evaluation strategies.
- GPV advocates that practice level payments be linked to patient registration [as per the General Practice Immunisation Incentive Scheme**].
- GPV supports that the practice level payments be linked to performance indicators at the division level, and not the practice, to ensure a population health perspective.
- GPV also advocates that, given existing population health inequities, the Taskforce could consider that any new incentive at the practice level needs to be used flexibly, so as to address the needs of hard to reach groups as well as the general population group.

***http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/DF7218195E74C315CA25719D00183387/$File/gpii_review_2004_summary.pdf*

1.2. Enrolling or Enrolling or registering patients in general practice

The Taskforce states that, to define the population that the practice is working with and for, it is essential for preventative health care to have enrolled or registered patients in practice. Current evidence clearly shows that for general practice to provide preventative health care, it requires a known population, via either a voluntary or compulsory patient enrolment system, preferably at

[1] Young, D., Gunn, J., Naccarella, L. (Sept, 2008),Funding Policy Options for Preventative Health Care within Australian Primary Health Care The University of Melbourne. http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/discussion-papers

[2] Harris, A., Mortimer, D (Sept, 2008). A Preventative Priorities Advisory Committee and Prevention Benefits Schedule for Australia, Monash University.

the practice level, to ensure identification of at risk patients. GPV's ongoing discussions with Victorian divisions of general practice, reveal that divisions appreciate the need for general practices to know their practice population, and a number of division leaders have expressed interest in trialling approaches that involve voluntary patient registration with their usual practice. (GPV State Forum, July 2008). GPV work with divisions has also highlighted that the use of patient registers is optimised if complemented by practice level methodologies (e.g., Australian Primary Care Collaboratives continuous quality improvement Plan-Do-Study-Act cycle) and tools (eg SNAP tool - smoking, nutrition, alcohol and physical activity in general practice[3]; PEN Clinical Audit Tool; Lifestyle Prescriptions, or Lifescripts[4]) and training (eg Nursing in General Practice Program) which are resource-intensive, but crucial if general practice is to be meaningfully involved in preventative care with a defined practice population.

***Key Messages*:**

- GPV supports the trialling of a voluntary patient enrolment or registering system, preferably at the practice level
- GPV strongly advocates that any system to define the practice population needs to be complemented with systems to support the GP's role in: identifying patients at risk within general practice; delivering, coordinating or referring patients to evidence based services and managing their patients, via established written or telephone feedback from professionals**.**
- GPV advocates that further support is required of methodologies (eg Australian Primary Care Collaboratives) to be used by practices, and to increase the use of tools (eg PEN Clinical Audit Tool) to assist in risk factor identification, intervention and management as part of the prevention strategy. Although divisions have undertaken work to build systems within general practices in these areas, more practice support is needed for 100% uptake.

1.3. Educating and Motivating the Workforce

The Taskforce states that a skilled and motivated workforce especially in the public health and primary health care sectors will be essential to support delivery of health promotion and preventative health care measures across the community. The Taskforce recommends expanding the supply of relevant allied health workforce to improve people's access to professional advice and care, and to increase health workforce capacity.

Australia is currently facing a health workforce shortage, particularly in the primary health care setting, which is being exacerbated by an ageing population, increases in chronic and complex disease, and enhanced technology. Furthermore, within general practice, there is a lack of infrastructure to train and accommodate new graduates (registrars) or workers (practice nurses). GPV's State Forum in July 2008 also revealed the need to invest in undergraduate, postgraduate, and vocational education and training on preventative health care, to enhance general practitioner skills in identifying patients at risk; delivering, coordinating or referring patients, and managing their patients.

***Key Messages*:**

- GPV supports the Taskforce's acknowledgment that an expanded health workforce is needed. However, enhanced practice level infrastructure is needed as well as investment in undergraduate, postgraduate, and vocational education and training on preventative health care, to enhance general practitioner skills in identifying patients at risk; delivering, coordinating or referring patients, and managing their patients. Furthermore, multidisciplinary education is needed through a vertically integrated career development pathways and supported by rigorous evaluation strategies

[3] Smoking, nutrition, alcohol, physical activity (SNAP) framework for general practice. Canberra: Australian Government Department of Health and Ageing, 2001.
[4] http://www.health.gov.au/lifescripts

The Taskforce recommends developing and disseminating evidence based clinical guidelines and other multidisciplinary training packages for health and community workers to enable health workers to be supported in the delivery of preventative health strategies at the community level, and to enhance the health workforce.

Current evidence and GPV work with divisions highlight that guidelines and training packages in isolation are not sufficient to facilitate change at the neither individual nor organisational level. A dedicated implementation support and evaluation strategy is required. GPV work with divisions supporting general practice to implement the new Medicare Benefit Schedule items for the '***Prevention of Type 2 Diabetes Program,'*** including the use of the Risk Assessment Tool and referral to Lifestyle Modification Programs, has revealed poor uptake by GPs undertaking patient risk assessments.

Key Messages:

- GPV supports the Taskforce's recommendation for developing and disseminating evidence-based guidelines and multidisciplinary training, if these are supported by strategies for implementation and ongoing evaluation. GPV's work with divisions implementing the Commonwealth Diabetes Prevention Program to assist GPs access the new MBS items to undertake a Type 2 Diabetes Risk Assessment has been hindered by the lack of a sufficient implementation and evaluation strategy.
- GPV advocates that to engage general practice in multidisciplinary team-based preventative health care (particularly health assessments), clear trusted and evidence-based referral pathways to preventative health services are required. Furthermore, systematic change management support strategies are required to facilitate GPs in using the referral systems.

The Taskforce recommends developing and disseminating information and training packages with a focus on screening, effective brief interventions and appropriate referral pathways for health and welfare workers.

General practice is recognised as an ideal setting for preventative health care. However, evidence exists that, to provide all the recommended preventative tasks for patients would add approximately 7.4 hours to the day of already busy GPs[5]. Furthermore well documented challenges still exist leading to the provision of preventative care being sub-optimal within general practice.

Current evidence confirms the effectiveness of brief lifestyle interventions by GPs in the clinical setting. However, the reach, compliance and sustainability of GP advice and its translation into large population health outcomes have yet to be achieved[6].

Good evidence exists to support the use and expansion of referral systems to increase the reach and sustainability of brief interventions by GPs[6]. GPV's work with divisions to enhance practice capacity to maintain a population focus with the practice population, and work in a multidisciplinary team-based approach has highlighted that (particularly for health assessments), clear trusted and evidence-based referral pathways to preventative health services are required. Evidence exists that GPs are less likely to undertake health assessments if they do not perceive them to lead anywhere. However, gaps exist in current evidence with regard to referral systems, including: the specific mode, intensity, and frequency of contact; the skill requirements for people to staff referral destination; the local costs of referral systems; and optimal incentives to encourage GPs to use referral systems.

Several Commonwealth-funded successful models for effective preventative health care exist that highlight the interface between brief interventions and referral systems, including

[5] Britt H, Miller GC, Charles J, Bayram C, Pan Y, Henderson J, Valenti L, O'Halloran J, Harrison C & Fahridin S. (2008) General Practice Activity in Australia, 2006-07, General Practice Series no. 21. .http://www.aihw.gov.au/publications/gep/gpaa06-07/gpaa06-07.pdf

[6] Huang, N & Menzies, D (2005). Referral options for GPs in lifestyle interventions: a review of the evidence. Kinect Australia.

- ***ACTIVE Script program -West Vic Division of General Practice***. This model combines evidence-based information with innovation to create a referral program that successfully motivates sedentary patients to become physically active. The GP or PN identifies a patient who would benefit from an increase in physical activity and requires support in becoming more active. The patient is referred to a local physical activity professional, known as an 'enabler', who is employed by the local health service. They contact the patient via telephone to discuss lifestyle issues, exercise barriers, local exercise options and resources using health coaching techniques. The enabler provides written feedback to the referring GP.

- ***Good Life Club project* -** Melbourne East General Practice Network. This model utilises multiple interventions to support people with diabetes to improve self management of their condition and more effectively utilise existing local health services. These include: individual telephone coaching by practice nurses and allied health professionals to support healthy behaviour; club activities such as walking groups, nutrition and healthy cooking sessions, supermarket tours; regular club newsletters; and a client health website.

- ***Diabetes Coordination & Assessment Service (DCAS) –*** *Dandenong & Casey Division of General Practice*. This model is designed to: support and enhance an effective system of service coordination & delivery for patients with diabetes; and to support GPs in linking into the broader health system and their role care coordinator. Patients are referred to DCAS who performs comprehensive diabetes cardiovascular assessment develops an action care plan and refers the patient to appropriate services, including referral to self-management education and a multidisciplinary diabetes cardiovascular advisory clinic located at the local hospital. The model includes GP training and specialist telephone support for GPs.

- ***North East Integrated Primary Mental Health Service (IPMHS)*** – This model is a joint initiative of the North East Victorian Division of General Practice and the Area Mental Health Service that has established an integrated primary mental health service with 12.4 EFT which provide for co-located clinicians in GP clinics as well as specialist services. The model also brings together three separate funding sources – More Allied Health Service (MAHS) division funding, state funding through the Primary Mental health & Early Intervention Initiative and commonwealth funding through the BOiMHC initiative. This model provides evidence for the effectiveness of pooling of funding for primary care prevention and treatment of mental health disorders and problems.

Key Messages*:*
- GPV supports the Taskforce's acknowledgment of the need to support brief interventions, if adequate referral systems exist, based on current evidence and the work of GPV with divisions. Furthermore, investment is required into well-designed longer term studies to identify the feasibility and sustainability of referral systems for brief interventions by GPs. The Prevention of Type 2 Diabetes Program and the Australian Primary Care Collaborative Program are two examples of opportunities to study referral systems.
- Commonwealth-funded successful models for effective preventative health care exist that highlight the interface between brief interventions and referral systems, including: ACTIVE Script program -West Vic Division of General Practice; Good Life Club project - Melbourne East General Practice Network; Diabetes Coordination & Assessment Service (DCAS) – Dandenong & Casey Division of General Practice; and the North East Victorian Division - North East Integrated Primary Mental Health Service

2. Taskforce's approach to a national preventive health strategy

Overall the Taskforce acknowledges the need for a wide ranging approach to prevention, due to the multiple determinants of health, including legislation, regulation, public education, as well as the appropriate contribution of the health system, particularly general practice. The Taskforce has proposed several mechanisms to enable its vision to be realised including:

- the establishment of a National Prevention Agency
- eleven key principles in two domains (Community-driven & Governance) based on the National Health & Hospitals Reform Commission draft principles to shape Australia's health system[7]
- a framework for the national preventative health care strategy based on Australia's Health (2008) and performance indicators on 3 levels: health status and outcomes ; determinants of health; and Health (and other) systems performance:

Key Messages:
GPV supports the Taskforce's multi-levelled approach to prevention, in particular where the role and contribution of general practice is supported within a national integrated systematic strategy across providers, government, non-government and the community. The successful 1997 Australian Government's Immunise Australia: The Seven Point Plan[8]. of which the General Practice Immunisation Scheme was a part) provides an exemplary model for preventative health care. GPV's work supporting general practice has further revealed the need to have a dedicated systematic change management support approach within general practice, with clear roles for:
   - State-based organisations – SBOs (e.g., liaison with commonwealth/state government and other providers; leadership at a system level - GPV is a founding member of the Victorian General Practice Prevention Alliance; and collection of state data and outcomes);
   - divisions of general practice (e.g., GP engagement; liaison with providers; identifying and coordinating of local services; and regional data collection);
   - general practice clinics (e.g., case identification; coordination of patient interventions/monitor/data collection);
   - patients (patients need to be engaged in their care using motivational counselling to ensure patients participate when necessary)
- GPV supports the establishment of a National Prevention Agency provided that it enables greater opportunities for general practice, via the Divisions Network, to provide strategic leadership and knowledge transfer about the role and contribution of general practice in preventative care. Victorian divisions of general practice have been integral to building the capacity of general practice to provide preventative health care, in three key areas: infrastructure development at the individual consultation level, clinic and systems level via tools and methodologies; workforce development via education, training and professional development; and organisational development via leadership and partnerships.
- GPV advocates for sustained resources and effort at the practice level to implement existing evidence-based prevention guidelines (eg RACGP Redbook Guide to Preventive Care in General Practice) to optimise appropriate roles in prevention. The experience with the successful immunisation program showed us that there need to be sustained resources and effort at the practice level to achieve improvements, and for all practices to take up an appropriate role in prevention.
- GPV advocates that in any future performance-based framework for the national preventative health care strategy, 'Workforce' is a key dimension of the health system performance and enabling infrastructure. GPV supports indicators such as the number of places for community-based training for primary healthcare (and other) workforce, and would add indicators such as: the proportion of infrastructure support for practices dedicated to education, teaching and service delivery. An additional indicator could be the number or proportion of dedicated staff in general practice who work on implementing prevention guidelines

[7] http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/principles-lp
[8] http://hsd.odgp.com.au/projects/immunisation/download_update_2006/The_Seven_Point_Plan_Immunise_Australia.pdf