GPpartners
Advancing Primary Care

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# Preventative Health Taskforce Submission

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**Process:** Three GPs were funded by GPpartners to attend the professional consultation meeting held in Brisbane on Monday 24/11/08 and four GPs submitted responses that have been collated below. Those GPs were: Dr Soke Fong Ong, Dr John Bennett, Dr Geoff Catton and Dr Rick Sapsford.

## Taskforce Goals

The Taskforce's stated goal for (i) obesity is to halt and reverse the rise in obesity, (ii) tobacco is to reduce the prevalence of daily smoking to 9% or less, & (iii) alcohol is to decrease the prevalence of harmful drinking by 30% by 2020

## Obesity - Questions

- **What is a realistic target for 2020?**
  *Given the eleven year time frame, achieving the stated goal will require significant change in the mindset of all Australians and therefore inducements will need to be significant enough to change the behaviour of a significant proportion of the population.*

  *Aside from the stated goals, short to medium term milestones should be developed to measure progress along the way. Additionally, there should be a focus on high risk groups, and therefore these groups should have their own sub-set of milestones.*

- **How can key players e.g. governments, health services, communities, individuals be engaged from the outset?**
  *In terms of developing programs, each sector mentioned above should have internal professional consultations to ensure that a relevant and effective approach is developed to suit different facets of the Australian community.*

  *In terms of participation in the programs, education and motivation must be addressed contemporaneously. For the provider and the participant, education and motivation must be from both a community perspective: "Why we must do it."; and an individual perspective: "Why I should do it?". It is naïve to assume that patients and providers will be motivated by health improvements alone, and given the timeframe of the goal, providing incentives to the providers and the participants will ensure the fastest take up possible.*

  *For providers, incentives could take the form of an additional item number (Diabetes style Practice Incentive Program payments would not be recommended as they are too difficult to implement in practice).The 10997 item number is well defined, simple to claim and a similar item would be a good model for provider claiming. (This item can only be claimed for patients with a GP Management Plan, Team Care Arrangement or Multidisciplinary Care Plan and therefore is not*


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*currently available for the management of patients with obesity as their sole condition.) We would highly recommend that other members of the practice team, such as a practice nurse or a medical assistant (http://www.gppartners.com.au/index.php?action=view&view=7424), be able to take measurements (height, weight, waist circumference, blood pressure etc) and provide information in relation to the ongoing management of a patient's obesity or physical activity. Additionally other non-clinical members of the practice team could undertake accredited training, such as Medical Assisting, to qualify to provide the above services. Any item number should require measurements to be captured in a patient's practice based electronic health record in a way that can be easily extracted, collated, aggregated and analysed at an individual and practice level.*

*For patients the incentive could be in two parts:*

- *A small incentive for providing measurements on an annual basis (thus creating a baseline and a longitudinal data series),. This would apply to the entire population who provide data.*
- *A larger payment for an improvement in the measures of an obese patient, or for a non-obese patient who maintains their measures within a "healthy" range. This could be scale-able dependant on the level of improvement.*

*Patient incentives may include:*

- *Larger private health rebate;*
- *Reduced taxation (lower Medicare levy);*
- *Higher Medicare rebate;*
- *Increased government Superannuation Co-contribution;*
- *Lower Superannuation taxation;*
- *Discounted access to health related goods and services;*
- *A cash bonus upon submission of personal tax return (similar to the current Family Tax Benefit A Supplement administered by the Family Assistance Office http://www.familyassist.gov.au/Internet/FAO/fao1.nsf/content/payments-ftba-how_much_ftba-ftba_supplement.htm )*

*To aid uptake, any program should be easily integrated into existing systems. In the case of general practice:*

- *patients can easily access information and services from a familiar health care provider, who maintains their longitudinal health record;*
- *resources such as templates should be available in electronic format within existing clinical software;*
- *any obesity prevention information or services should be provided within the general practice or accessed through the GP's existing referral network;*
- *workforce should be both qualification and cost appropriate – this does not necessarily need to be a doctor but could be any "accredited" person, including practice staff, medical assistants, allied health providers or nurses;*
- *any payment for prevention services should utilise the existing claiming system.*

*In addition to the above, the following should be considered:*

- *equitable access to healthy food e.g., rural remote communities to have access to a continuous supply of affordable fresh fruit and vegetables.*
- *continued education on the value of fresh fruit and vegetables as part of daily diet. This may also include learning how to grow vegetables, how to cook vegetables individually or as part of a meal, and how to choose ripe vegetables from the shop.*
- *continued education on the value of healthy eating and exercise.*
- *engaging families in any school based education so that the learning continues at home.*
- *supporting families to achieve work-life balance as most individuals are time poor. This would facilitate families toward a healthier lifestyle.*
- *increasing access to sporting facilities, such as opening school sporting grounds, swimming pools, tennis, basketball and netball courts etc on weekends.*
- *increasing the number of, and access to "bikeways" and improving options for people to carry bicycles on public transport.*
- *limiting the number of fast food outlets in a given region.*

- **What is the best combination of 'learning by doing' & at the same time, building the evidence base?**
  *The Australian Primary Care Collaboratives (APCC) program as run by the Improvement Foundation Australia (http://www.improve.org.au/APCC/apcc.html ) offers a good balance between learning by doing and building the evidence base.*

  *This program considers diabetes, coronary heart disease and access to health services as issues for continuous quality improvement. Each participating practice is equipped with tools, training, data extraction software, and a local support network to take baseline measures of key patient health indicators and achieve improvements over time. Extracted data is reported, collated and fedback to the practice on a monthly basis. Health indicators are graphically presented in comparison with other de-identified local practices and state and national cohort averages. This program is currently funded by the Department of Health and Ageing and with appropriate funding the program could be expanded to include measures relating to obesity, smoking and alcohol.*

  *The practice based approach allows the APCC program to be contextualised at a local level, encouraging learning by doing, and ensuring that the actions are appropriate for the practice population and the capacity of the practice.*

  *It is important to note that before "improvement" in the health indicators can be measured, much work is done to ensure the quality of the data in terms of being clean, accurate and complete. Any funding for data quality improvement would need to be "front ended" to provide resources and time at both the change agent and practice level.*

  *It is also important to note the value of Divisions of General Practices as trusted change agents in the "improvement" process. Many Divisions have existing staff who: have received significant training regarding data quality of medical records; are trusted sources of information for general practices in their region; and have significant expertise in change management at a general practice level. Divisions would be well placed to support an expanded APCC program or similar improvement initiatives by the Preventative Health Taskforce.*

  *General practice, with its existing infrastructure of electronic clinical records, connectivity to Medicare and frequent patient contact, offers the best opportunity for capturing longitudinal data in relation to building the evidence base around preventative health. However, the completeness and quality of existing data in the majority of general practices cannot be assumed, and will likely require significant effort before any improvement in health indicators can be attributed to actual improvement in patient health.*

- **What can individuals & families do to be physically active, eat well & maintain healthy body weights?**
  *For the future, education of children from a young age regarding the value of good nutrition and exercise is paramount. This should be done in tandem with a reduction in advertising for non-healthy food choices. Current success improving the nutritional quality of food sold in school tuckshops could be extended, and pressure could be brought to bear on supermarkets to remove confectionary displays from checkouts.*

  *Creating a sense of individual responsibility for personal and community health outcomes is the key to encourage individuals and families to be physically active, eat well & maintain healthy body weights. This could be achieved through an annual health report card for each person, and/or individual "read only" access to an electronic health summary. The latter is an extension to existing functionality of the Health Record eXchange – a shared electronic health record currently operating in the Brisbane North region by GPpartners, and would require security authentication, and unique log-in and password for each patient.*

*The report card could include:*

- *relevant individual health indicators*
- *relevant individual social indicators:*
  - *Smoking status*
  - *Alcohol consumption*
  - *Exercise participation*
- *comparisons with local, state and national averages for same age / sex*
- *life expectancy*
- *possible health risks*

- **In what ways can high-risk groups be supported?**
  *Unique milestones should be developed for high risk groups, with additional support provided to assist and incentivise these groups to achieve their targets. Price increases on fresh produce have greater adverse impact on such groups.*

  *As a method to support high-risk groups, GPpartners would support a brokerage model of preventative service delivery. Through the Access To Allied Psychological Services program (ATAPS) GPpartners has successfully brokered access to mental health services for high-risk groups including under 25s, low socio-economic groups and those with alcohol or drug co-morbidities. (http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-boimhc-ataps). Our success in this program has been three fold:*
  1. *GPs and psychologists have developed referral relationships that can continue outside the program.*
  2. *Service costs have been contained – psychologists agree to accept a fixed fee for their services and patients are more likely to complete the treatment series as costs are known.*
  3. *Referral processes allow de-identified pre and post intervention information to be collected and reported on, thus building the body of evidence.*

  *We believe these successes could also be achieved for services around obesity and physical activity.*

- **Are the priorities for action appropriate? If you do not think they are appropriate, or have other suggestions, what would you propose we do as a nation to halt the toll of early deaths and disease caused by overweight and obesity?**
  *We would encourage the taskforce to ensure that the effectiveness of any major activities is evidence based. This must be weighed against the difficulty and cost of implementation. Where there is a lack of evidence, it would be wise to prioritise building the evidence base etc, however given the goal and timeframe, we must act now.*

**Tobacco - Questions**

- **Should our government progressively increase the tax on tobacco products to the levels in places such as Ireland, Scandinavia & the UK & reaching $20 for a pack of 30 cigarettes?**
  *Yes, price increase restricts availability and is a powerful disincentive. However, without careful implementation, this is likely to have a negative impact on other preventative health goals, especially for high risk groups. Those who continue to smoke will have less money to spend on fresh fruit and vegetables and physical activities. Additionally, those who use smoking as a coping mechanism may turn to more affordable substances such as alcohol.*

- **Should our government invest $40-50 million a year in public education- <1% of revenue from tobacco tax?**
  *Yes. Public education must continue to reinforce the negative effects of smoking and the benefit of not smoking on the community and the individual.*

- **Other suggestions**
  *As well as mandating plain paper packaging for all cigarettes and cigarette packaging, the government could insert smoking cessation information into cigarette packets, thus targeting those at risk directly. Another suggestion is to include vouchers for smoking cessation classes, psychologist fees, or discounts to purchase nicotine patches with every pack.*

**Alcohol - Questions**

- **Do you support a focus on the suggested priorities?**
  *Yes.*

  *Additionally, we would support a focus on the impact of alcohol on maternal and child health including research on conditions such as foetal alcohol syndrome, and the development of shared care pathways for alcohol related conditions.*

- **If you do not support these actions, what would you propose we do as a nation to halt the disease & death toll caused through alcohol-related harm?**
  *We support the suggested priorities, however the taskforce should also review the effectiveness of the 0.05 blood alcohol limit for drivers, and the message that this sends to the entire population – "some alcohol is OK". In many instances, such as driving a vehicle or operating heavy machinery, some alcohol is not OK. It is our understanding that Japan has recently introduced a zero blood alcohol limit for all drivers and we would encourage the taskforce to review the outcome of this with a view to implementation in Australia.*

- **What are the most important issues that can engage support from individuals, communities, industry & governments & drive cultural change?**
  *To look at the socio-cultural reasons for drinking (this also applies to overeating, lack of physical activity, and smoking) and target the underlying causes. An example of this would be to change the cultural norm of alcohol use as a means to enjoy oneself. The association of excessive alcohol consumption with sporting activities and celebrations in general is a link that must be disassembled before significant progress can be made.*

  *Alcohol is also used as a coping mechanism and we must educate people regarding alcohol as a depressant drug. This should be in tandem with education about coping with life issues and where to access services to address mental health issues. Additionally, the importance of the family unit should be emphasised and supported as a means to positively influence current behaviour and that of future generations.*

  *Premises with a licence to serve alcohol should be encouraged (or required by law if necessary) to offer a range of non-alcoholic options, beyond the standard range of soft drinks and juices. Hoteliers could also be required to provide intoxicated patrons with free/subsidised transport to return home*

  *Public education around the negative consequences of excess alcohol consumption should continue, as should education about responsible alcohol consumption.*

- **What prevention strategies work best for high-risk groups, particularly among young & in indigenous communities?**
  *Alcohol is so readily available in most communities that the only real option to effect change in the short term is to increase price.*

  *In the medium term, targeted education and provision of alternative activities, such as sport, may also be effective. Both education and alternative activities are best developed and implemented from within the target groups themselves.*

  *In the long term, the best prevention is to change the culture and develop a majority cohort within these high-risk groups that does not consume alcohol, or does so responsibility. This cohort will then model their behaviour to subsequent generations.*

*Finally, our patients' healthy longevity depends on our following more parameters than just smoking, alcohol and obesity, therefore we would strongly recommend that post 2020 the government look at new areas of preventative health, whilst at the same time continuing the good work and building on the considerable achievements that will occur in the next 11 years.*