KATE CARNELL CHIEF EXECUTIVE OFFICER

AUSTRALIAN DIVISIONS OF GENERAL PRACTICE

National Press Club Speech
8 March 2006

PRIMARY HEALTH CARE – THE HEALTH FIX

Introduction

I don't know about you, but I am sick of hearing from people who want to tell us about all the problems in Australia's health system without putting forward affordable and workable solutions.

The Divisions of General Practice, which I represent, is a network of 126 'can do' organisations – they link, they collaborate and they cover the entire length and breadth of the country.

Most importantly, they have the capacity to provide local health solutions to national problems.

And today I want to talk about *genuine solutions* to the problems facing our health system using the under utilised asset of Divisions of General Practice.

95% of GPs are members of their local Divisions who, along with practice nurses, practice managers and a range of other allied health professionals, make up our primary health care teams. Divisions employ over 1500 people across the country and turnover over $250 million.

Many would have us believe that the solution is as simple as “more doctors and more money”.

The reality is that there is no magic bullet to solve the nation’s health woes but there really *are* solutions.

To make a *real* difference where it matters – to community access, to health care and to the future viability of our health system - the approaches I am suggesting today will be seen as radical by some. We think they are extremely viable and, in many regions, are already happening.

Those of us who have spent our professional lives working in the health system, setting or trying to influence health policy, or reporting health issues, know that health is always a major priority. For families, for communities.

And health is never far from the top of the political agenda. In the current round of state elections, health is regarded as the most important issue by the majority of voters.

We all know the rhetoric and the issues well. Let’s face it, that’s the easy bit!

The more difficult task is to settle on *pragmatic*, *workable* and *affordable* solutions to current policy conundrums – a task that has been so often confounded by the split responsibilities for health between federal and state/territory governments.

We can no longer fiddle at the fringes with health system reform. Only *fundamental*, *unprecedented* change will arrest the impact of:

- the growing burden of chronic disease
- the ageing population
- the cost of technology and
- increased community expectations

on the costs of our health system and our national well being and productivity.

It's time to take the plunge.

With baby boomers about to hit retirement age and significant workforce shortages in a wide range of different areas, it is imperative that we keep our community healthy and in the workforce for longer – we have no choice other than to *direct increases in the health dollar away from the hospital system and into primary health care.*

Sounds easy, doesn't it?

But waiting lists and lack of hospital beds grab the headlines and stimulate crisis driven health policy and budget allocations.

We simply **have to** change this mindset.

We need primary care-led reform.

So what do we mean by that?

We mean new funding models that work as levers that will change the way health professionals coordinate and deliver care –through change in clinical practice, change in the way health professionals interact and are configured, and change in the way systems operate.

We mean new models of care that use and value the *full range* of professionals who make up the health workforce – doctors, nurses, psychologists, pharmacists, podiatrists, optometrists, diabetic educators, dieticians, exercise physiologists – the list goes on.

And we need services that support health promotion and patient self management.

And because the health issues for the Kimberley are *very* different to those in North Shore Sydney, we also need locally determined health care solutions that are wellness and prevention oriented. In a country as diverse as ours, one-size-fits-all programs simply do not come up with the goods.

Ironically, keeping people healthy has never really been the focus of Medicare or our broader health system. Medicare funds GPs to treat sick patients but, until recently, there have been no payments or incentives for doctors to keep their patients well. We were very pleased to see the announcement of a mid life “wellness” check in the current COAG initiatives.

However, we need to go much further. As a community, we need to value investments in health promotion, prevention and early intervention rather than see it as the ‘after thought’ of health.

Can we really afford to turn a blind eye to the fact that by 2020 80% of the cost of disease in Australia will be attributable to chronic diseases?

Can we really turn a blind eye to what this will mean for national productivity and the future workforce?

How can we possibly ignore the Productivity Commission’s study of Australia’s Health workforce and AMWAC’s projection that there will be a need for up to1300 new GPs every year by 2013? The intake for general practice training is currently just under 600.

What do we do about the shortfall?

The answer is investment in primary care.

So why is primary health care important?

Let me quote from professor Barbara Starfield, a leading US researcher:

“More than two decades of accumulated evidence reveals that having a primary care- based health system matters. People and countries with adequate access to primary care realize a number of health and economic benefits, including ….reduced all-cause

mortality… lower care-related costs …[and] reduced health disparities…"[i]

To explain why the Divisions Network is *absolutely steadfast* in the view that primary care-led solutions are the answer, I want to discuss:

- the factors that are driving the need to overhaul the system

- some examples of primary health care innovations *already* happening across the Divisions of General Practice network which we know are delivering results and have enormous potential to be taken up on a national scale

- what we need to change about current approaches to health system funding and coordination of care and – most importantly - *how* Governments can implement these changes (without losing elections).

Firstly, let's look at the factors that are driving the need for change. The two big ones are, of course, increases in chronic disease and the health workforce shortages.

If we don't address these, they will have grave implications for the future – both for the long-term health of Australians and importantly our future wealth of the nation.

Chronic disease

A healthy population is always important. But the pressure to maintain the nation's health is now critical - our productivity is facing the very real threat of an ageing population base.

With its current structure, our health system will not be able to meet the challenges it faces.

Around 80% of ill health, disability and premature death in Australia[ii] is already due to chronic diseases such as heart disease and stroke, lung and colorectal cancers and mental illnesses such as depression.

And the burden is set to rise at a **rapid** rate.

Of course Australia's current obesity epidemic is a critical public health issue in its own right. If not addressed as a matter of urgency, it will significantly add to the burden of chronic disease.

As you know, obesity levels in Australia are growing – we now rank fourth in the world and are increasing at the fastest rate. But there are more alarming statistics. Did you know that more than 20% of people who are overweight or obese are not even aware that they are?[iii] Population health education is simply not reaching the right audience.

The impact of chronic disease on Indigenous Australians is *even worse*. Not only do they develop most chronic conditions, they

have an earlier onset. It is of grave concern that Indigenous Australians have higher rates of obesity and mental health disorders, are 2.7 times more likely to develop cardiovascular disease and 8.3 times more likely to develop diseases such as diabetes[iv].

You know the sad thing is, at least one third of these health problems **are preventable[v].**

The future burden of these chronic diseases will be largely determined by **current** exposure to risk factors – and we all know what they are: smoking, lack of physical activity, unhealthy diets and inappropriate alcohol use. We actually have to act **NOW,** not next week or next year, but now. If left unchecked, the ramifications on Australia's health and on its productivity will be profound. We need serious investment in a sustained health promotion and prevention agenda.

And even small changes make a difference. It is estimated that $8 million per year could be saved for every 1% increase in the proportion of the adult population that is sufficiently active[vi]. As well, every 1% change would lead to 122 fewer premature deaths and 1,764 years of life gained[v].

The Divisions network believes strongly that obesity should be deemed a chronic disease by government so that GPs and practice nurses can access existing Medicare based programs to develop and implement care plans in collaboration with appropriate

allied health professionals such as a dietician and an exercise physiologist.

But we need to go much further than this.

For example, if practices were to receive a discretionary budget to purchase packages of care, patients with complex and chronic diseases would have improved access to the range of services they need and would be supported in their journey through the health system.

We also strongly urge government to create a new item number for practice nurses that would allow them provide health promotion services and support to help patients with the implementation of the GP's care plan. This is another way we can support preventive interventions in general practice.

Workforce

So do we have the medical workforce to handle this escalation in chronic disease? The answer is simply "NO"!

Even our current medical workforce is under *serious* strain – we are already short of GPs and it's predicted by 2013 we will need 1300 new GPs **every** year to meet demand.

And we still have a problem getting doctors (and other allied health workers) to places where they are needed most – rural and remote areas – as well as outer metropolitan and regional areas. The

number of doctors declines drastically with increasing geographical remoteness whilst hours worked by GPs in these areas increases – about 39% of GPs in rural and remote regions work 50 – 64 hours per week, compared to 28.6 percent in capital cities. The burn out rate is huge!

But more doctors is **not** the whole answer. There has been a steady increase in medical student numbers over recent years and predictions are that over the next five years, medical graduates will rise from the current annual level of 1300 to approximately 2100 places a year – 800 new places. There are still issues though – and this is why we need to start to think beyond just more doctors.

Let's have a look at the problems.

Firstly, at the moment just under 600 doctors start general practice training every year – as I mentioned earlier, this needs to increase to 1300 by 2013 to meet demand. – that's an extra 700 places annually.

So of the extra 800 medical graduates, around 700 would have to choose general practice training to **start** addressing the GP shortfall. Given current trends of graduates choosing other medical specialties, this simply won't happen!

And secondly even if we got these numbers (and we won't) could we train them? The answer again is "NO". A recent study

estimates that the current system can only manage about 800 new entries to general practice training a year – **not** the 1300 required.

We welcome the new medical school places, but the fact is that, for a time, the increased graduates coming out will actually put the system under **even more strain**. In fact training doctors ALREADY places a strain on the current system.

Why?

Because graduates need medically supervised placements, initially in hospitals and then in their chosen discipline. Both areas will have trouble coping.

And the burden on general practice will be even greater. In general practice the increased demands of supervision are not just on a GP's time. Supervision also requires adequate infrastructure – GPs must have sufficient room in their practice to house a student or registrar.

All up, general practice training requires enough general practices, and enough GPs with sufficient time and space to oversee their students and registrars. Yet we are already operating in a climate of a reducing number of practices and diminishing workforce capacity. This is a **vexing problem**!

And we must not forget the profile of new medical graduates entering general practice training.

They are older, (average age 34 years) more than half are female and frequently (and this is true for both males and females) - choosing to work much less than the 60+ hours a week that their predecessors worked.

And there are no guarantees these new doctors will choose to work where they are most needed. In fact the increased family commitments of the older graduate will make that **less** likely. It is hard to convince a 34 year old female doctor that she should leave her family and go bush for the three year training program!

What all this means is that Australia will continue to have a shortage of GPs into the foreseeable future.

So what will solve these pressures?

So we need new smarter models of care to address this increased burden of chronic disease and these workforce issues, supported by system reform.

We need to look further than the hospital sector for solutions.

We need to move **beyond** the notion that the solution is just about more doctors or more dollars.

What is required is a re-modeling of the system – an overhaul – to place more emphasis on primary health care, prevention and proactive health promotion activities which focus on **health** rather than illness; where practitioners are rewarded for keeping people

well and out of hospital and where individual responsibility for health is understood and supported.

Multidisciplinary teams (comprising GPs, practice nurses, pharmacists and other allied health professionals such as dieticians, physiotherapists, psychologists and Aboriginal Health Workers) have a key role in the new system. They assist with workforce issues and provide models of care that are better matched to preventing and managing chronic disease.

There is good evidence that successful chronic disease care and prevention involves a team of health professionals. General practitioners have a key role in such care as conductors of the orchestra, if you like. But other team members are also crucial.

Nurses are *especially* important. They have a unique role in the general practice team and **do** improve patient outcomes.[vii] [viii]

Labour force figures show that there were just over 23,000 nurses *not* currently working in nursing[ix] - what an untapped resource!

The opportunity to work in general practice nursing is enticing a growing number of these nurses back into the profession – and that is good news for health care in this country.

ADGP has recently surveyed practice nurses. We can tell you that there are approximately 5000 nurses employed in just over 50% of general practices across Australia. This represents a 20-25% increase in the number of practice nurses employed over the last

two years. This a result of Divisions who work closely with practices to improve access to practice nurses – again good news for health!

Many of these nurses are located in rural practices where a government subsidy is available. To really increase the numbers of practice nurses, government must increase the number of item numbers available for practice nursing. Practice nurses should be able to charge an item number for a wider range of services including health promotion, chronic disease monitoring, women's health clinics and, in certain circumstances, home and nursing home visits. This is a cost effective approach and improves the patient's access to services. Extending the rural practice nurse subsidy to urban areas would also make a big difference.

Broader multidisciplinary team approaches are also required. They too play a valuable role in chronic disease management, assist in health promotion activities[x] and can especially enhance care in other areas such as mental health and palliative care.

Multidisciplinary primary care models are already in place in parts of Australia, coordinated and supported by Divisions of General Practice.

Let me just give you a flavour of the sorts of innovations that are happening out there – these are very much local solutions to national problems in action.

In Queensland, one division, North and West Queensland Primary Health Care pools funds from multiple sources, including federal and state governments, to provide primary care services to rural and remote communities. This is an area that *would* ***otherwise be without services****.* The Division works in partnership with local agencies and employs 75 health service employees to deliver primary health care services in a variety of locally appropriate ways such as outreach programs.

Riverina division have taken a similar approach. They have established primary health services in 13 small communities all with a population of less than 1000 people. Practice nurses provide clinical services and support the role of visiting GPs who provide outreach services to the areas.

In the Kimberley, the Division uses More Allied Health Service (MAHS) funds to employ allied health workers such as dieticians and podiatrists. There were none before the Division became involved – an amazing thought when we consider the incidence of diabetes in Indigenous Australians.

In regional Victoria , the North East Division, has integrated Victorian **State** and **Commonwealth** government mental health funding to employ a critical mass of staff to deliver a co-located fully integrated mental health counselling service in a community that would otherwise not have had a specialist mental health service at all.

The **Hunter Urban Division of General Practice** runs a GP Access After Hours program. 100,000 patients who would otherwise have been seen in an emergency department *adding to long waiting lists*, received GP care more appropriate to their needs and were seen within 30 minutes of their appointment. And this is delivered at a cost **less** than current Medicare arrangements.

So you can see, there are seeds for national innovation and value for money health service delivery out there being driven by Divisions of General Practice every day. Just these few examples alone show that there *are* perfectly feasible ways of addressing our health system's challenges and deliver outcomes *if we are prepared to embrace different models* and use existing assets differently - mental health outcomes can be improved, appropriate diabetes care can be delivered, health services in remote areas are possible, and hospital emergency department attendances can be reduced.

And every single one of these approaches rely on the Division holding funds and purchasing services appropriate to the local community.

What's got to change?

If we are serious – and we should be - about addressing the challenges of the current health system, approaches like the ones I

have just described need to be ***embraced***, ***expanded***, ***accelerated***.

In November last year, we launched our *Primary Health Care Position Statement.* It is our blueprint for primary health care reform - our contribution to the current health care debate.

It provides a number of 'must haves' for primary health care reform.

There is no doubt that care is more responsive to community need and more effectively and efficiently delivered through teams at the local level.

Team based care will increase consumer access and enhance the range of primary health care services available through general practice to the local community.

The guiding principles to enable the best use of our scarce workforce resources should be that:
…wherever possible, services should be delivered by the team member with the most cost effective training and qualification to provide safe, quality care .

The role of the GP will continue to be to diagnose and determine the best care plan for their patients but various aspects of the plan will be carried out by others in the team. A new funding model must reflect this approach.

While an appropriate funding model is essential to make multidisciplinary teams work, so is significantly better access to good patient information. When a range of different providers are involved in a patient's care it is essential that all members of the team are well informed of relevant information to ensure quality care. This will also avoid multiple ordering of tests, drug interactions and ensures issues such as allergies are known to all those involved. Access to accurate, relevant and timely patient information is essential good quality, safe patient care. We need an e-health solution.

To adequately embrace the integrated team based approach to general practice and to address the training issues I referred to earlier, a National General Practice Infrastructure Program must be established.

This Program would support practices to expand to house practice nurses and other members of the practice team as well as registrars and medical students on placements. The Program would also support innovative models of co-location or collaboration between general practices and allied health providers. All up a better result for consumers, an effective use of the blend of skills across various primary care providers and for coordination and delivery of quality care.

As we can see from the examples I described, there are alternative models of funding primary health care service delivery in locally relevant ways. Divisions are **already** pooling funds from multiple sources including federal and state governments to deliver

targeted, innovative, locally appropriate services such as the Better Outcomes in Mental Health Care and More Access to Allied Health programs – there should be more of this. How easy would it be to roll-out other programs in this fashion through an already established, well-tested, not for profit Australia-wide network?

Australia's current health system is rapidly changing and under pressure. And there are some genuinely worrying trends.

If we are to deliver a viable, quality health system …

If we are to have a supported, well distributed and sustainable workforce …

If we are to arrest the growing burden of chronic disease …

If we are to support a healthy community that is contributing to national wellbeing and productivity …

We must embrace new payment models for chronic disease that have incentives to keep patients out of hospital and healthy – a wellness rather than sickness based system

We must ensure that the community has affordable access to locally appropriate programs to help them address the avoidable risk factors associated with chronic disease such as overweight and general nutrition, lack of exercise, smoking and the appropriate use of alcohol.

Self management programs should be available to encourage patients to take responsibility for there own health.

Multidisciplinary general practice teams must be established to ensure best possible access to quality care for all Australians.

In conclusion, comprehensive primary health care relies on robust relationships and integration between general practice, other health services , government as well as non-government sectors.

Divisions of General Practice already have these relationships. They have the capacity to provide services responsive to community need and administer a range of programs to offer fully integrated services through primary health care teams and regional hubs.

We need to use the assets we already have. This is the most cost effective use of our health dollar.

Divisions have capacity and experience to independently hold funds on behalf of all levels of government to deliver integrated locally responsive services to communities in partnership with their member practices – a powerful means of overcoming the Commonwealth-State divide so endemic in our health system.

Strong primary health care is **essential** if our health system is to manage future challenges. Divisions are the platform we should be using to take primary health care forward.

Thank you.

[i] *Phillips Jr. R and Starfield B. 2004. Why Does a U.S. Primary Care Physician Workforce Crisis Matter? American Family Physician Vol. 70. (3) 440 - 447*

[ii] *Australian Institute of Health and Welfare, Health system expenditure on chronic diseases. AIHW, 23 June 2005.*
[iii] Pfizer Australia Health Report Issue 19. Overweight and out-of-shape: Australians in denial www.healthreport.com.au Accessed March 2006
[iv] *National Health Priority Action council (NHPAC) Summary Report of the Aboriginal and Torres Strait Islander Health Workshop. NHPAC May 2003*
[v] *Australian Chronic Disease Prevention Alliance January 2004. Chronic Illness Australia's Health Challenge: The Economic Case for Physical Activity and Nutrition in the Prevention of Chronic Disease*

[vi] *Sufficiently active means moderate exercise like walking for about 30 mins on most days*

[vii] *Sibbald B, Luarant M, Scott T. Changing task profiles in Saltman A, Rico A & Boerma W (Eds) Primary Care in the Driver's Seat? Organisational reform in European Primary Care. 2002.*

[viii] *Renders C, Valk G, Griffin S, Wagner E, Eijk J, Assendelft W. Interventions to improve the management of diabetes mellitus in primary care, outpatient and community settings. Cochrane Database Syst Rev. 2001;(1):CD001481*
[ix] *Australian Institute of Health and Welfare. Nursing and Midwifery labour force 2003. National health labour force series. Number 31. Canberra. 2005.*

[x] *Crawford G and Price S. Team working: palliative care as a model of interdisciplinary practice. MJA 2003.179 (6 Suppl) S32-S34.*