Submission to Legislative Assembly Standing Committee on Health, Community and Social Services

Inquiry into access to primary health care services

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Background

Health Care Consumers' Association (HCCA) of the ACT was formed over 30 years ago to provide a voice for consumers on local health issues and now provides opportunities for health care consumers in the ACT to participate in all levels of health service planning, policy development and decision making.

The Health Care Consumers' Association welcomes the opportunity to make a submission to the Standing Committee of the issue of access to primary health care. We have sought views from our members and drawn on that input in preparing our submission.

HCCA is currently running an online survey, entitled **GP Snapshot 2009**. The survey is designed to capture a snapshot consumer experiences and expectations of general practice I the ACT. It includes issues such as waiting time, whether consumers have regular GPs, the quality of the interaction and demographic material The survey closes on 3 July 2009 and to date there have been more than 500 completed surveys. We have been very pleased with the number of responses and think this demonstrates a strong interest in the community around this issue. HCCA will be analysing this material in July and will be in a position to share results with the Standing Committee towards the end of July.

Overview

The HCCA believes that the approach to primary health care services and the role and supply of General Practitioners should be addressed in a broad health care context. The current development of a National Primary Health Care Strategy should also provide a useful reference for the Inquiry.

The HCCA supports the broad approach proposed in the 10 key elements of the Federal Government Discussion Paper *Towards a National Primary Health Care Strategy.* In particular the HCCA sees the following elements for primary health care as important in the private and public setting:

- Accessible, clinically and culturally appropriate, timely and affordable;
- Patient-centred and supportive of health literacy, self-management and individual preference;
- Well integrated, coordinated and providing continuity of care, particularly for those with multiple, ongoing and complex conditions;
- Better management of health information, underpinned by efficient and effective use of e-Health;
- Flexibility to best respond to local community needs and circumstances through sustainable and efficient operational models.

There are, however, two major considerations that HCCA believes are missing from the draft national strategy that should form an integral part of primary health care and would encourage the Standing Committee to consider these further:

- consumer participation and,
- an increased focus on safety and quality of care.

As an overarching philosophy primary health care should recognise that input from health care consumers provides invaluable guidance and values for the way the health care system should operate. The consumer voice adds value to the development and operation of health care and should be recognised as a necessary and consistent element for the operation of the primary health care. This input is crucial to identifying access issues and barriers as well as providing insight into measuring performance in respect of safety and quality.

Primary health care is usually the first point of contact with Australia's health care system and is the area that most people interact with most of the time. Access and services need to be improved to ensure it is accessible to our most disadvantaged and vulnerable members of our communities.

In addition to general practitioners, primary health care services involve a range of health care providers including nurses (such as general practice nurses, community nurses and nurse practitioners), midwives, allied health professionals, allied health assistants, pharmacists and dental professionals and assistants. In Australia, primary health care is delivered through a combination of publicly and privately provided services (funded through Commonwealth, state and territory, and private arrangements), including through private health insurance funding. The Australian Nursing Federation recently released a report showcasing a variety of ways in which the nursing profession can be used to enhance primary care in our communities.

HCCA considers a benchmark health care system and especially the primary health care sector should be accessible, clinically and culturally appropriate, timely and affordable. This submission should be seen against that framework. There are a number of ACT access issues that HCCA has identified as being important, these include:

- access to primary care is poor for low income, aged and those with chronic conditions because of the low rate of bulk-billing by GPs, lack of salaried general practitioners and low general practitioner numbers;
- the lack of realistic alternative pathways into the health care system, other than through general practitioners,
- public dental care – although the ACT has implemented a public dental care program there is a lengthy waiting period and the funding arrangements are not comparable with medical care.

Terms of Reference

In addressing primary health care issues HCCA argues that the Inquiry would benefit from adopting a definition of primary health care that clearly extends beyond the current GP focus. HCCA believes that the apparent emphasis on the general practitioner supply in the Inquiry's Terms of Reference is not helpful in achieving useful outcomes or developing alternative strategies.

Term of Reference 2 – Clinic closures

The increasing corporatisation of general practice and its impact on elements such as general practitioner supply, geographic distribution and access, and integration with other primary and community care services are issues for consideration. The need to centralise practices and integrate with diagnostic services may be in accord with an efficient business model but do not necessarily improve general practice from the point of view of the consumer or improve health outcomes for consumers of the those services.

The extension of "corporate" GP practices with a strong profit emphasis is a cause of dissatisfaction for many health consumers in the ACT, reasons given are reduced geographic access, especially if relying on public transport, no doctor of choice and a 'production line' consultation process – a particular concern for consumers with chronic and complex conditions. The preliminary results from GP Snapshot 2009 indicate a difference between the quality of interactions between consumers and GPs in these medical centres with those consumers who have a regular GP. Consumers also reported a level of disruption to thief health care with the closure of general practices and move to larger corporate medical centres.

The impact of closures of practices on consumers is amplified as many existing GP practices have closed their books to new patients. The closure of practice "books" is also critical for new residents to Canberra who find it difficult to access a general practitioner. Not having ones own GP is seen by consumers as a significant health care issue affecting quality of care and health outcomes. This issue emerges clearly in preliminary results from GP Snapshot 2009.

Terms of Reference 1 & 3 – General practitioner supply and using other health professionals

Determining an ideal supply of GPs or any health practitioner is not a straightforward numerical issue. To be of value the measure needs to be set against a range of population, demographic, access, socio-economic measures and indicators, as well as health need, geography and the availability of other health care services to health care consumers in the locality. The supply of GPs in a particular region of area is usually benchmarked against the ratio of GPs to population (or GPs per '000 population) against an average national ratio. This is a simplistic measure.

In addition when assessing the community need for primary health care services, any measure of GP supply should be seen in the context of the availability of other health care practitioners including practice nurses, nurse practitioners and dental assistants.

The current widespread lack of general practitioners may well be viewed as a consequence of increased specialisation and technological sophistication of much of medical practice and the changing remuneration differentials. It may be that the role and numbers of general practitioners need to change to better reflect the current medical and community expectations of the medical and health care system. It could be that much of the traditional general practice role has changed and the numbers are no longer as relevant as they were.

The Productivity Commission report on Practice Administrative and Compliance Costs (2003) identifies a number of factors that may contribute to the viability of small suburban general practices. Much of the red tape takes doctors away from frontline care delivery. We consider that there is scope to reduce the costs to GPs of complying with state government and Commonwealth programs. For example, consumers need to have medical certificates to attest to their ongoing disability. We would like to see changes introduced so that consumers can receive a certificate attesting to their lifelong disability. This would expedite access for consumers to a range of programs at the same time alleviating GPs of this particular administrative burden.

The current rural/regional classification systems such as Rural, Remote and Metropolitan Access (RRAMA) do not provide for equitable allocation of resources and funding of health services in rural and remote areas of Australia. The classification systems are detrimental to the operation of efficient regional and cross border health care by the ACT Government. There have been a number of alternative regional classifications developed in recent years that would provide a more rational approach. However, the implementation of these alternative approaches will inevitably inflict financial pain on existing beneficiaries and would require some transitional arrangements. ACT is regarded as an urban setting and not entitled to some GP practice grants as are other regional centres.

As a result of what is seen as a chronic GP ‘shortage’ not only in ACT but also nationally and in many overseas countries, the organisation and strategies adopted in the provision of primary health care are moving away from having the general practitioner as the single pivotal point of primary health care. This movement is facilitated nationally by the growth in the numbers and the expanded roles for allied health care professionals and assistants. Many of whom could appropriately undertake roles such as case management or coordination.

Many people access their GP for what can be considered to be minor ailments that could be treated by other health professionals and community pharmacies. We would be interested to see more work done to explore the extended role of

community pharmacists in providing primary health care. Anecdotally consumers have reported to HCCA that they use community pharmacists when they cannot access GPs. This is also reflected in preliminary results fro GP Snapshot 2009.

Terms of Reference 1, 4 & 5 – Strategies to deal with the lack of general practitioners

The general practitioner 'shortage' provides opportunities to consider and develop alternative forms and organisation of primary health care services. The issue here is to improve health outcomes of health care consumers not necessarily increase the number of general practitioners.

While general practitioners have traditionally held a 'gatekeeper' role in relation to other medical services, with the chronic shortage of general practitioners the effect of this role has increasingly become more of a barrier to access of services than a financial filter. As education requirements and skill training have been enhanced for many health and allied health professionals and an expanding range of allied health assistants – their use has been restricted by governments slow to employ them or endorse or authorise their use, including being slow to allow public funding eg health insurance benefits to flow to them.

The development of innovative approaches to health care, especially in primary care through the extension of roles and the changing boundaries should be more aggressively addressed in the ACT. In particular, while nurse practitioners are being developed and employed in other jurisdiction in areas of need, in the ACT there remain unnecessary barriers to their employment and utilisation.

Some of the barriers come under Federal and some under jurisdictional legislation, therefore changing them will not be straightforward. However, the ACT Government can move faster than it has in some areas and the present atmosphere of reform does provide opportunities for further change.

Many of these recently developed categories in the health workforce can play an important role in improving access to primary health care. To achieve this, requires both government understanding of and support for the broader health workforce and public and consumer understanding of the changing roles of health workers. As a first step it is important that inquiries such as this understand that it may be possible to resolve current 'road-blocks' resulting from workforce shortages through broadening the approaches to the provision of primary health care, improving access to allied health care practitioners and assistant and reducing unnecessary restrictions and controls.

In some ways ACT is equated with Canberra as an urban setting but ACT and Canberra also serves a rural population and undertakes a major regional health role with cross border ramifications. It is clear that from a health professional point of

view Canberra is seen as a regional centre – this also has major implications in attracting and keeping medical practitioners.

The substantial increase in the projected number of medical graduates (1,571 graduates, a 131% increase between 2000 and 2015) could assist rural and regional medical workforce shortages if sufficient financial incentives are provided for GP and specialist training outside the traditional urban teaching hospital framework. Further development of the existing infrastructure of Rural Clinical Schools and University Departments of Rural Health would be one such useful mechanism. Through such training requirements as non-urban training placements and the provision of financial support for professional establishment for medical practitioners in rural and regional areas a number of these new graduates are likely to relocate outside major urban centres.

HCCA would like to see the integration of healthdirect into primary care. Consumers have reported varying levels of satisfaction with this service to HCCA. HCCA will be holding a forum later in 2009 around consumer experiences and expectations of healthdirect. We encourage the Committee to consider healthdirect in terms of providing triage, health information and a comprehensive health services directory for the ACT community. Currently healthdirect does not have formal structures for consumer engagement around the development, delivery, monitoring or evaluation of this service. We think this is an oversight that must be addressed.

Term of Reference 6 – linked Government and non-government health care

HCCA believes a critical element of effective primary health care is that it is well integrated, coordinated and provides continuity of care, particularly for those with multiple, ongoing and complex conditions.

The complexity of the health care maze is a major barrier to ready access to many consumers. This is particularly so for those with chronic conditions, co-morbidities and other complex conditions. The complexity is magnified when moving from one health care sector to another or across systems. The creation of strong coordinated and comprehensive health care over a lifetime is seen as important for consumers. Consumers need an interconnected and coordinated system not a maze that they can not navigate. In the interim, health professionals should be tasked to undertake a coordination or navigation role for consumers.

As health care develops into increasingly discrete service modules with complicated interconnections, the need for patient advocates or navigators is growing as a priority. The advocates, ideally employed by a health agency or authority, could advise patients or consumers on entry points and systems appropriate to their needs and assist in making then necessary linkages.

It is essential that linkages occur within each health care system, both government and non-government, as well as between the two systems. HCCA supports the NHHRC proposals for improved primary health care which are seen as capturing the

needs of most consumers. The comprehensive primary health care centre, with integrated multidisciplinary staffing, is supported as a way of overcoming the independent service "silo" effect. HCCA sees it as important to distinguish this integrated from the "corporate" group practice model which is regarded by many consumers as being profit driven not health outcome focused or patient centred. Funding is an obvious and important strategy to achieve the coordination but it needs to be reinforced by other strategies. One critical strategy is the implementation of effective consumer feedback loops.

The role of health information using the e-health technology is seen as a critical catalyst and facilitator in establishing linkages, achieving integration, interconnectedness and quality of care for consumers.

Term of Reference 7 – Other issues

HCCA regards the development of improved consumer participation and involvement in resource allocation and health care coordination as a high priority. This requires increased investment in improving health literacy in the community. Health care consumers will need to be an integral player in developing an understanding of the health care systems and an improved understanding of health data and broader health information including resource issues.

ACT Health is making progress in improving consumer participation in a number of areas such as health service planning and consumer engagement in relation to patient safety and quality of care. There remains a need for deeper consumer involvement particularly in issues such as geographic health resource allocation and between health care sectors. Deliberative techniques such as citizen juries and open space forums could facilitate this.

Further investment is needed by the ACT Government to enhance health data and its analysis, to improve the reporting on health status across the nation and within jurisdictions to enable the identification of disadvantaged groups and communities and to assess their health care needs.

Patient-centred and supportive of health literacy, self-management and individual preference

The development of patient centred primary health care requires a suite of strategies aimed at existing health professionals and health professionals currently in training and studying. There needs to be simultaneous programs to improve health consumers' health literacy, their understanding of the health system, health care, health care decision making and health information.

These programs need to be supplemented by health care organisations developing positive corporate attitudes to consulting with health consumers and receiving feedback from health care consumers.

HCCA supports the considerable efforts being made by ACT Health to develop systematic approaches to encourage consumer input both through consumer organisations such as the HCCA and individually through feedback from health care consumers.

Priorities

- Education/training of health professionals – through educational and training institutions and professional bodies
- Education/training of health care consumers inc health literacy – through schools (refer to NHHRC Interim Report) and through consumer organisations
- Development of appropriate mechanisms and building in systems for consumer/patient input and feedback through government health agencies, community based health service providers and private practitioner networks and associations

Strategies

There is no one strategy that will meet the needs of all communities, the strategies need to be custom fitted, drawing on a broad range of advice. In relation to specific strategies needed to support consumer engagement and consumer input there are a number that, on the basis of its experience, HCCA supports:

- The development of a strong group of consumer representatives that can participate and represent health consumers on committees at national;, jurisdictional, agency and service levels, this will require further training effort by consumer organisations such as HCCA
- The development of an increased role for health consumers should be built on improving health literacy in the broad population.
- Health consumer organisations will require additional financial and resource support to undertake that increased role
- Empowerment and resources for community groups – in the ACT the West Belconnen Health Cooperative is moving ahead to build and staff a community health centre.

Better management of health information, underpinned by efficient and effective use of e-Health

E-health is not a magic bullet but it does provide a catalyst to address major aspects of health care; e-health needs to be seen as a means of achieving both better and more accessible health information not an end in itself. To be effective e-health relies on consistent and uniform national health definitions and terminology – this is

a critical requirement. E-health helps to further accelerate and enhance the improvement of good quality health information.

In discussing e-health it is better to disaggregate the individual elements that comprise e-health and identify the relevant components. These components include for a start, individual the electronic health record, digital images, e-discharge summaries, e-prescribing and medication records, timely data access, integrated records between various health professionals and health sectors such as acute and primary care. ACT Health has undertaken an active role in the national e-health developments and would provide an appropriate location for e-health pilot projects.

The sharing of information on the individual electronic health record (IEHR) between health professionals is an essential contributor to the benefits that will flow from an IEHR. The sharing of that information with the consumer is as critical to deriving the enormous benefits as sharing between health professionals. Access to the shared record and the data it contains is a strong matter of principle for health care consumers.

Consumers report ongoing issues at the interface of primary and acute care. Consumers have reported to HCCA that their records from their GPs are not trusted by medical staff at hospitals and therefore not used; often resulting in clinical set backs for consumers. This is a particular concern for consumers with complex or chronic conditions. Consumers need medical staff to trust each other and to trust the expertise we have around our own conditions. We are hopeful that the personal health record can facilitate this.

E-health is a critical contributor to coordinated health care. One important aspect of the electronic health record is that it will enable health professionals to access up-to-date and complete health information concerning the consumer, including health history, recent clinical and care interventions and contacts across all care modalities, diagnostics tests, diagnoses and medications. The record needs to incorporate acute care episodes as well as community based and primary health care. Benefits can also be anticipated through generally improved health record keeping by practitioners and clinicians. This should enhance integrated and coordinated health care across all care sectors.

A valuable benefit that should flow from e-health and an IEHR is the strengthening of the information base available to consumers that can inform the consumer and carers and empower them in discussions with health carers.

The effectiveness of e-health will be greatly influenced by consumers' ability to understand and make decisions on the information available. This will be dependant to a large extent on

- improved health literacy and education of health consumers;
- improved information flows, including explanations, between consumers and practitioners; and

- the readiness, willingness and ability of health care agencies and health care professionals to listen to and consult with health consumers.

For e-health to realise its potential there is the need for considerable investment in continuing to improve the health information that is to be used in the e-health components. The information needs to be uniform, nationally consistent, valid and up-to-date. E-health is only feasible through much of the preceding work on uniform national health definitions and terminology through the National Health Information Agreement and the National Health Data Dictionary. E-health should be seen as a catalyst to further accelerate and enhance this improvement of good quality health information.

The need for consistency is important for health care practitioners when treating patients from across state/territory boundaries for example medication prescribed by a practitioner in NSW must mean the same medication to a pharmacist in ACT or Victoria. Similarly this is the case in relation to clinical interventions and treatments.

The magnitude of the change should not, however, be underestimated. It is much more than a change of system, the move to electronic recording and transmission of health information and readily access to good quality information for diagnosis, decision making, treatment and ability to undertake real-time monitoring will cause not only changed work habits but will also require changes in attitudes as well as major changes in patient treatment and care management.

HCCA would argue strongly that an extensive range of pilot projects be undertaken to trial the technology for the various components of e-health and importantly evaluate the impact on health outcomes and on the people, both the health care professionals and the consumers. These pilot projects should incorporate the existing service providers, hospitals, specialists, community health centres, GPs, community nurses, pharmacists, other health professionals and consumers.

Recently the Canberra After hours Locum Service (CALMS) introduced an electronic summary to the GPs who support the service, in respect of the consumers treated by the service. Consumers have reported to HCCA that this has greatly improved the flow of information between the locum service and the consumer's GP. We understand that there is considerable work underway in the ACT and we look forward to the roll out so there is greater connectivity between providers and the health information.

Flexibility to respond to local community needs and circumstances through sustainable and efficient operational models

HCCA regards flexibility as an essential characteristic for primary health care. As the health care needs vary between localities so do the needs of consumers. Primary health care needs to be able to vary its response to meet those needs.

Rigidity in management is usually associated with government bureaucracy; however, this is not necessary the case and other agencies, including professional bodies, are also capable of lacking flexibility. The development of flexibility in the provision of health care requires the health care providers have a joint overall objective of improving individual and community health, a good understanding of roles, a willingness to work as a team and an ability to work with the health consumers.

A critical element to health care operating effectively and with flexibility is to develop and respond to consumer input and feedback. The health care needs of consumers, especially those with chronic or complex conditions will vary considerably, often calling on a number of health care and support services. This is of particular relevance in relation to community and primary health care.

There are a number of approaches that can be used to address flexible management of primary health care, there is no “one solution fits all” answer. Which approach or indeed combination of approaches is appropriate will be influenced by factors such as the size and demography of the community being cared for, geography, population density, access to acute care and health labour force composition.

The approach to organisation of the health services in an area will depend upon how the overall health services in the area and jurisdictions are organised. There needs to be compatibility between the planning and organisation of the local area and that of the jurisdiction. Funding and allocation of resources are two of the critical elements for which there needs to be consistency.

Accountability encompasses a number of considerations, partly in relation to the employing or funding agency, partly professional accountability and importantly accountability to both the individual consumer and the community being served.

Increasingly there are good quality health data that enable the compilation of a range of health indicators and community wellness indicators. While these are indicators and provide trends rather than measures their sensitivity to change is variable depending on the validity of the indicator and the quality of the data. The development of appropriate health outcome measures would assist not only primary health care providers but health care agencies in general to address effectiveness of care techniques and modalities.

E-health, through requiring better and being more up to date data, is a resource that can improve community monitoring of health care by improving the quality of the data in the information base. E-health can facilitate monitoring of health care not

only in terms of the quality of health care but also assist in developing a better understanding of the groups not receiving adequate health care and the health impact on those groups.

Given the existing regional allocation of health care resources a regional planning approach makes sense but as one size does not fit all it depends on the jurisdiction. For example ACT could be considered as one region.

For consumers to be effective consumer input into to planning, monitoring and evaluation needs to be valued and seen as active input not passive

- need to improve health literacy of all health consumers
- consumer organisations need financial and organisational support to undertake training
- consumer input must be valued and responded to as a legitimate input to the provision of health care

Training of the health professionals will be required for data to be use effectively in primary health care. In the primary health care setting the collection, reporting and analysis of health data should also be one of the features assessed for accreditation.

Sub-acute care

A further consideration that HCCA proposes, as a key element in an enhanced primary health care system, is that of sub-acute care – the transition between acute and community care. The NHHRC Interim Report recognises the sub-acute care "glue" that links acute with community care and acknowledges that there is a significant need for an increase in sub-acute care. We consider this to be an under resourced area of the care continuum and there is room for general practitioners to support sub-acute care. The growth and importance of sub-acute care to primary care should be explicitly recognised by the Inquiry as it has important implications for community and primary health care in relation to both aged care and rehabilitation services.

Traditionally sub-acute care has been tacked on to hospital services, as the focus has been to 'transition' consumers from acute care in the hospital sector to their homes. We would like to see sub-acute care reframed to a primary care perspective where a multidisciplinary team - including GPs and nurse practitioners – are empowered to provide more support to keep consumers out of hospital.

We look forward to governments responding to the call by the NHHRC for clear targets in the provision of sub-acute care. Consumers will be advocating for a range of community (and home based) options. One such option supported by our members is establishment of step-up step-down facilities within community health clinics. This is possible within the ACT where there is large-scale planning and building program that is based on more consumer centred models of care. There is

also support for home based programs such as the Community and Post Acute Care (CAPAC) Program which is currently being developed in the ACT.

This Inquiry while seeking to address ACT specific issues is particularly timely and relevant given the National Primary Health Care Strategy, the Interim Report of the NHHRC and its identification of connected comprehensive care for people over their lifetime as one of four major themes. Primary health care and the proposed comprehensive primary health care centres and the ACT Walk-in Centres are essential components of that theme. The publicly funded dental care proposal is also a valuable extension of services, especially for lower income groups.

5. Role of self-help groups in chronic disease self management

HCCA supports self management for consumers with chronic conditions. As such we strongly urge the inclusion of proven "peer-led" self-management education and ongoing self help group support options for chronic illness as a part of the primary health care strategy. Consumers with chronic conditions make decisions everyday about their health and self manage their illnesses. Education programs are designed to help people gain self-confidence in their ability to control their symptoms and how their health problems affect their lives. This requires a health system that supports collaborative care and self-management education.

HCCA believes ACT Health should support self help groups to develop and conduct self management education and other support options which will allow consumers to live the best possible quality of life with their chronic condition. Studies have shown that most participants of chronic disease self-management programs experience statistically significant improvements in a variety of health outcomes with fewer Emergency Department visits in the year following the completion of the training.

We note that one of the five initiatives announced by the Council of Australian Governments in February this year as part of its Better Health for All Australians package is to encourage active self management of chronic disease. With the funding available for this reform package HCCA strongly believes ACT Health should support proven "peer led" consumer education and ongoing self help group support options.