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STATE HEALTH AND DIVISIONS OF GENERAL PRACTICE: A STATE PERSPECTIVE

The following is the edited text of a speech given by John Wyn Owen CB, Director-General, NSW Health Department, at the National Forum of Divisions of General Practice in Melbourne on August 11, 1995.

INTRODUCTION

I would like to discuss the cooperation that has been developing between General Practice and NSW Health. I would like to leave you with three key messages:

1. Area structures, such as those in NSW, which focus on providing health care to defined populations, provide the foundation for the integration of local community and hospital service planning and delivery.
2. The level of debate about the role of primary health care and general practice and its integration with the health system needs to be raised. In NSW we are providing the opportunities and structures to achieve this.
3. NSW Health is supporting the development of integrated service models, and research into and evaluation of the effectiveness of these models, to improve health care.

THE FUTURE

The Council of Australian Governments

You will all know the Commonwealth and States are working together to achieve structural change in the health sector to accord with the perspective of patients, regardless of the level of government which actually delivers services or has the ultimate responsibility. In the words of Dr Stephen Duckett, Secretary of the Commonwealth Department of Human Services and Health, *"State and Commonwealth public servants can put aside, for the time being at least, their old territorial ways in the interest of designing new approaches to inter-governmental relations".*

In January 1995 the Council of Australian Governments issued, for public consultation, a paper entitled *Health and Community Services: Meeting People's Needs Better.* This paper describes three broad streams of care for restructuring the organisation, planning, funding and delivery of services:

- *General care.* This stream covers simple care needs or support needs, where the individual maintains choice of provider.
- *Acute care.* This provides for more intensive health care needs delivered on an episodic basis, mostly through acute hospitals.

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- *Coordinated care.* This covers situations where consumers have complex and multiple health and community care needs.

Central to the proposed reforms is the organisation of services around the needs of individuals or patients – with provision of care ***not*** influenced by the vagaries of funding mechanisms, clinical specialty rivalries or departmental boundaries. The reforms seek to remove some of the anxiety about cost shifting or duplication of services.

NSW health goals

The main goals of NSW Health – improving health, increasing people's equity of access to health services and improving the quality of care and service – align well with the proposed national restructure and relate closely to the main goal of general practice: to provide a high-quality health service to community members.

The Department sees the future with general practitioners playing a key role in providing and coordinating clinical, preventive and continuing care services extending from the hospital through the community to the home. Interactive communication systems will link general practice surgeries, specialist diagnostic and treatment services, community health care facilities, and hospital emergency departments across the State, and provide clinicians with access to databases of patient information and standard diagnostic and treatment protocols.

These developments will be a boon for rural GPs and will often save country people from having to visit specialists in a major centre. Shared care between GPs and hospitals or specialists will be much easier. GPs will develop more skills in the detection and treatment of mental illness. They will be supported by community-based mental health teams with expertise in crisis intervention, access to short-stay acute psychiatric inpatient facilities in general hospitals and access to supported residential accommodation. GPs will play a greater role in coordinating other services such as drug and alcohol counselling. They will be key players in "hospital in the home" initiatives involving sophisticated services in people's homes, such as dialysis, chemotherapy, pre-operative assessment and post-operative care, and investigations for undiagnosed illness. GPs will provide more clinical preventive services in their surgeries and from community bases such as multi-purpose service centres.

THE CHALLENGES

Is this what the future should look like? How can we better provide opportunities to develop a shared sense of direction for our health system where primary health care is a central component? How do we better develop structures, standards, policies, monitoring and evaluation systems and funding mechanisms for the primary health care of the future? How do we make things happen in a more strategic manner to move towards these future scenarios?

1 Area structures, such as those in NSW, which focus on providing health care to defined populations, provide the foundation for the integration of local community and hospital service planning and delivery.

The NSW scene

Area structures which focus on providing health care to defined populations provide the best foundation for the integration of local community and hospital service planning and delivery.

In NSW we have some 6,000 practising GPs with 36 Divisions of General Practice. Most of the Divisions are incorporated bodies. One Division (that in Central Sydney) is part of the Area Health Service structure. This arrangement has interesting consequences. A senior medical academic in Central Sydney recently commented that, for the first time, he had heard professors of medicine and surgery insist that the professor of general practice be involved on a major Area Health Service planning committee.

The Central Sydney Division collaborates with the Area management in the planning and development of hospital and community-based services, with clinicians, and with units responsible for community health, public health, health promotion and mental health. The Division has a vibrant research agenda and is involved in projects ranging from immunisation and diabetes to randomised clinical trials of drug therapies. Staff also participate in undergraduate medical training at the University of Sydney. Management, clinical specialty groups, community health groups and general practitioners are pleased with the collaboration between units and the focus on the outcomes of health services for individuals and the population of Central Sydney.

2 The level of debate about the role of primary health care and general practice and its integration with the health system needs to be raised. In NSW we are providing the opportunities and structures to achieve this.

Statewide and local initiatives

Structures and processes in NSW aim to support Statewide and local collaboration and to stimulate debate and research on better ways to integrate care around the individual and community.

Divisions of General Practice and academic departments of general practice are linked through a network of units located in the community and in teaching and smaller hospitals.

The Department has established a Centre for Clinical Policy and Practice within the Public Health Division. Its purpose is to develop standards and evidence-based practice models for improving clinical practice and to work with clinicians to monitor the quality of services. We have also established a Centre for Disease Prevention and Health Promotion – to develop best practice for prevention and health promotion; a Centre for Mental Health – to expand and improve our mental health services; and a Centre for Research and Development – to develop a strategic approach to research support, balancing support for basic and

applied research, and strengthening clinical and public health practice.

General practitioners serve on all our key clinical advisory groups. These include the NSW Medical Board (which is responsible for medical registration), the Medical Services Committee (legislation review), Medicine and Management (industrial issues), the Standing Committee of College Chairmen (professional development, standards and specialist training), the Rural Doctors Resource Network (rural health issues), and the Postgraduate Medical Council (training of junior doctors). We are establishing a liaison committee between GPs and NSW Health to encourage general practice input into Departmental planning and policy development. This is in part a response to the 1994 NSW General Practice Task Force Report.

The Department supports the Rural Doctors Resource Network to encourage medical practitioners to work in the country, and stay in the country. In addition to supporting the development of rural Divisions of General Practice, the network promotes training and improved clinical communications.

GPs have been involved in the planning and development of four rural multi-purpose service centres and 13 that are on the drawing board. GPs have also been on advisory groups that have helped us develop our community health, aged and youth care policies.

General practice groups are working with us on a number of service development projects. These include projects aiming to:

- improve discharge planning for patients;
- develop shared care models of management for depression in the elderly;
- develop evidence-based guidelines for the management of fractured neck of femur;
- utilise registers for the management of diabetic patients;
- utilise immunisation registers; and
- provide health services for the homeless and unemployed.

Aboriginal health

Aboriginal health remains our greatest challenge. But we have some successes – for example, two successful projects initiated by a Division of General Practice in collaboration with Bourke and Brewarrina Aboriginal Medical Services. These projects have sought to provide broad-based health screening for Aboriginal people in Western NSW, with a particular focus on diabetes. Working with the local Aboriginal Medical Services, the local Division of General Practice was able to promote the importance of diabetes screening and transfer skills to Aboriginal health workers.

3 NSW Health is supporting the development of integrated service models, and research into and evaluation of the effectiveness of these models, to improve health care.

Diabetes prototype

Perhaps one of the best examples of collaboration between the Department and Divisions of General Practice can be seen in our Diabetes Outcomes Project. Diabetes was chosen as a prototype for the implementation of initiatives to produce health improvement.

Diabetes is a highly appropriate model because it typifies the problems associated with many chronic health conditions in the community.

- It is common and costly. Diabetes in its various forms affects 3-4 per cent of the Australian population, up to 10 per cent of older people and possibly 20 per cent or more of some Aboriginal communities.
- We estimate that up to 50 new cases of blindness are attributable to diabetes in NSW each year, and some 775 parts of lower limb are amputated because of diabetes.
- There are real opportunities for health improvement with diabetes because there is strong evidence that the complications of diabetes can be prevented or reduced. With better organised services, we estimate that 32 cases of blindness and at least 340 amputations could be prevented in NSW each year.
- Like many other chronic conditions, diabetes care involves numerous types of services in the full range of health care settings. People with diabetes encounter a very wide range of health professionals. Diabetes services operate within a variety of funding and administrative systems – private, Commonwealth-funded via Medicare, and State Health-funded via Areas and Districts.

A multi-disciplinary approach to diabetes care is well established in many centres, and over the past couple of decades the emphasis has shifted from inpatient to ambulatory care. However, relationships among the components of diabetes care in our loosely networked health care system are not always clear.

But with a more integrated care system we are confident we can do better for people with diabetes. The focus of our diabetes project has thus been on the development of an integrated diabetes care system. The work has involved wide consultation with health professionals. It has been done collaboratively with an expert panel comprising consumers and representatives of the spectrum of health professionals connected with diabetes care. We have given special emphasis to consultation with Divisions of General Practice throughout the State.

There is now clear agreement that we need to focus on three things to make a substantial difference to the outcomes for people with diabetes:

- First, we must ensure that everyone with diabetes receives education about the condition – education for self-care, education about when to seek professional care, and education about preventing or minimising complications.

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- Second, we must ensure that everyone with diabetes has good metabolic control, through appropriate care, and education for self-care and self-monitoring.
- Third, we must ensure that everyone with diabetes has regular clinical monitoring for signs of complications, and appropriate treatment of complications.

To achieve these three things we have evolved an implementation plan for integrating Area and District Health Service-based diabetes care with care given by GPs and other medical and non-medical private practitioners. This will involve identifying what is spent on diabetes at the local level and giving local groups responsibility for deciding how to use those funds for the provision of services, for communication and for monitoring the results.

The Commonwealth has indicated very strong interest in working with us on a series of implementation pilots, and we have called for expressions of interest from Area and District Health Services, jointly with Divisions of General Practice and others, in running the large-scale pilots. Pilot implementation will begin shortly.

Lessons from diabetes, and strategies for CV disease, cancer, mental health and injury

To date the diabetes prototype has taught us two important lessons. The first is that early and wide consultation is vital to build partnerships between professional, consumer and management groups. The second is that the implementation plan must focus on clearcut, measurable targets and have clearly defined objectives. With diabetes these relate to education, metabolic control and clinical screening for complications.

These lessons are now being applied to cardiovascular disease, cancer, mental health and injury in NSW. Discrete problem areas which require attention and which offer opportunities for improving health have been identified, and the strategic planning process is being applied to determine the action that will exploit these opportunities. The strategies will be published later this year.

Research and development

A 1994 report produced by the US Congress Office of Technology Assessment, entitled *Identifying Health Technologies That Work,* begins by saying:

"The justification for most medical practices used in the United States today rests on the experience and expertise of clinicians and patients rather than on objective evidence that these practices can measurably improve people's health."

The report makes a highly influential contribution to the worldwide move towards evidence-based health practice. This move is placing a renewed emphasis on research and development to provide evidence on what works and what does not work in health care – and what works best.

I would like to extend this beyond health care. Health policy must be evidence-based as well.

We have just finalised a discussion paper on R&D in the NSW health system*. It outlines policy initiatives which aim to align our investment in R&D with health priorities, promote the role of R&D in generating innovation and promote the implementation of research-based knowledge in health care and health policy. This will include developing better ways of linking outcomes to what GPs do, and the development of monitoring systems so GPs have better information on what works and what doesn't.

CONCLUSION

The relationships we are building with GPs in NSW are just a part of the partnership culture we are developing with all the major stakeholders in Health in NSW: health professionals, medical schools, other government departments and community groups.

Having said that, we recognise that the Divisions of General Practice present an opportunity to establish a health system which offers continuity of care and quality service to all patients and communities. And I think the health professionals win as well, because the Divisions help to create a working environment which is more satisfying for GPs and for all health care workers.

Cooperation is enabling very productive relationships to develop between the Divisions and individual Area and District Health Services, which I am sure will result in more efficient, more effective health services and genuine health gain.

I hope I have convinced you that our health system can be improved – through integrating the planning, development and delivery of population-based health services with Divisions of General Practice; through providing opportunities for debate on integrating primary health care and general practice with the health system; and through supporting the development of the best health care through R&D and training.

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* A survey of the discussion paper appears on pages 91-92 of this issue of the *Public Health Bulletin.*