HCCA Submission to GP Task Force

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Background

Health Care Consumers' Association (HCCA) of the ACT was formed in 1978 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.

This document is based on our research and analysis of consumer experiences and expectations of general practice in the ACT.

We have been very pleased to support Ms Janne Graham and Ms Anne Wentworth as consumer members of the GP Task Force.

We would like thank the hundreds of people who took the time to complete the GP Snapshot online survey and share their experiences and expectations of general practice in the ACT. There is a strong level of interest in the community about access to quality health services.

We would also like to thank the many people in our membership and wider networks who shared their experiences and perspectives with us.

The Health Care Consumers' Association welcomes the opportunity to present this submission to the GP Task Force.

Introduction

Our community needs primary health care that is accessible, clinically and culturally appropriate, timely and affordable.

Primary health care is the critical cornerstone of our health care system. 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 they are accessible to the most disadvantaged and vulnerable members of our communities.

Consumers have an important perspective on primary health care and add value to the development and operation of health care. Our experience and perspective is crucial to identifying access issues and barriers as well as providing insight into measuring performance in respect of safety and quality. We believe that consumer participation is a necessary and consistent element for the effective operation of the primary health care.

The Consumers Health Forum of Australia completed research into consumer expectations of general practice in the late 1990s. This research identified access issues for consumers, including structural issues such as rates of bulk billing and affordable access, physical access, out-of hours services, gender choice and good appointment systems for emergency and routine needs. The research also found that consumers prefer a holistic approach, including knowledge of and referral to other health and community resources.

Most of the results of this research still stand; however HCCA, at the suggestion of the GP Task Force, decided to test the findings with the Canberra Community today. In the decade since CHF completed this research there have been changes to general practice as a result of GP shortages, clinic closures, increase in chronic disease and the increasing focus on quality and safety of care. Many things a GP once did can now be done by others. For example, pharmacists can write sick leave certificates; allied health care professionals, such as nurse practitioners, can now issue prescriptions and psychologists can access Medical Benefits Payments.

HCCA ran an online survey, *GP Snapshot 2009*. The survey was designed to capture a snapshot of consumer experiences and expectations of general practice in the ACT. It explored issues such as whether consumers have regular GPs, waiting times, the quality of the interaction and demographic material. The survey ran from 15 June - 3 July 2009 and was publicized through HCCA members and networks, and media coverage in *The Canberra Times*, ABC Canberra and 2CC. There were 635 responses. We think that the number of responses demonstrates a strong interest in the community around this issue. Our preliminary analysis is included throughout the document. A summary of findings is attached (p 42ff).

In addition to the survey HCCA interviewed advocates for people with disabilities, culturally and linguistically diverse backgrounds, carers and also drew on the experiences of our membership of informed consumers. A summary of the issues that emerged from these interviews is attached (pp 32 – 35).

We also interviewed three consumers about their experience of primary health care and documented their stories. The names of the consumers have been changed and identifying information has been removed to protect their privacy. These are attached (pp 27 – 31)

HCCA ran a forum on 23 June 2009 at which a number of consumers, advocates and GP Task Force members were present to discuss barrier to access to primary health care. A summary of this forum is attached (pp36 - 41).

HCCA believes that personal stories can identify systemic issues and we have used consumer experiences and expectations to prepare this paper.

Access to primary health care services in the ACT

Our community needs primary health care that is accessible, clinically and culturally appropriate, timely and affordable.

In our consultations we found that consumers' experiences of primary health care were varied. Some consumers are very well placed with a regular GP who they can see when the need arises. Other consumers reported that the inadequate supply of GPs presents them with significant difficulties in accessing satisfactory care, including for urgent appointments, referrals, scripts or renewals of prescriptions.

This was confirmed by the *GP Snapshot 2009* and the HCCA Consultation Forum on Barriers to Accessing Primary Health Care. One respondent commented that appointments to see their GP "*need to be made a week or so in advance"*, which is not helpful when they need urgent attention (Respondent 236).

Consumers new to Canberra report difficulty in being accepted on to a practice's books. One respondent commented: "*I have been in Canberra for nearly 2 years and have been unable to find a female GP who I can see when I am ill"* (Respondent 316).

Closure of GP Clinics

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.

An interview with Carers ACT also identified how the closure of general practices create enormous barriers to accessing health care:

> *It isn't just that they have to find a new general practice, they have to check out suitability, physical access, affordability, try and get on the books, transfer records (cost element here), assess parking and public transport options, as well as brief a new doctor. The task is big and time consuming. There is no facilitation and carers can really struggle to replace a GP.*

The closure of practice "books" is also critical for new residents to Canberra who find it difficult to access a general practitioner. Not having one's own GP is seen by consumers as a significant health care issue affecting quality of care and health outcomes. One respondent to the survey commented

> *I have not been able to get a GP in Canberra since moving here 2 years ago because good GPs are not taking in new patients. If I need to see a doctor I travel to Sydney as my GP is familiar with my medical history and I get the proper treatment"* (Respondent 242).

Residential Aged Care Facilities

Residential Aged Care Facilities (RACFs) in the ACT are not well served by GPs. Currently there is very limited access to GPs by residents in such aged care facilities. Results from the *GP Snapshot 2009* show a small proportion (8.2%) of respondents reported that their GP visited RACFs. The majority of respondents (85.9%) did not know if their GP visited RACFs.

The need for improved access to primary health care for consumers in aged care facilities is critical. This is demonstrated very clearly in the experience of Peter and Louise (p. 28). Peter and Louise moved to a residential aged care facility in Canberra when Louise's care needs could no longer be met by her husband. They have now been in the same RACF for six months. In that time they have had to see a GP in the GP's suburban clinic, and while the care has been satisfactory their GP will not visit the RACF. The GP told Peter and Louise that his experience has been that when he attends the RACF to see his patients he is then asked by staff at the RACF to see other residents who are in the same situation and he is not able to take on any more patients. They have to face an unrealistic level of risk in order to access primary health care.

Consumer Strategies for dealing with the GP shortage

Consumers use different medical services for different needs. For conditions perceived to require extended care consumers prefer "traditional" general practices and are prepared for long waits to access their trusted doctor. This presents difficulties however for continuity of care, as the practices do not share records. One respondent said:

> *My family has attended this practice for many years. We have received great continuity of care. It helps to attand* [sic] *a GP who knows one's background, issues etc - helps the GP to develop better insight & thus offer better care. When I became a parent and discovered that small children tend to have acute episodes of illness, it was good to be on the books at a large practice so that we could get in to see a doctor QUICKLY. When I went through a period of unemployment, the practice bulk billed me (I'm back to paying again now...).* (Respondent 90)

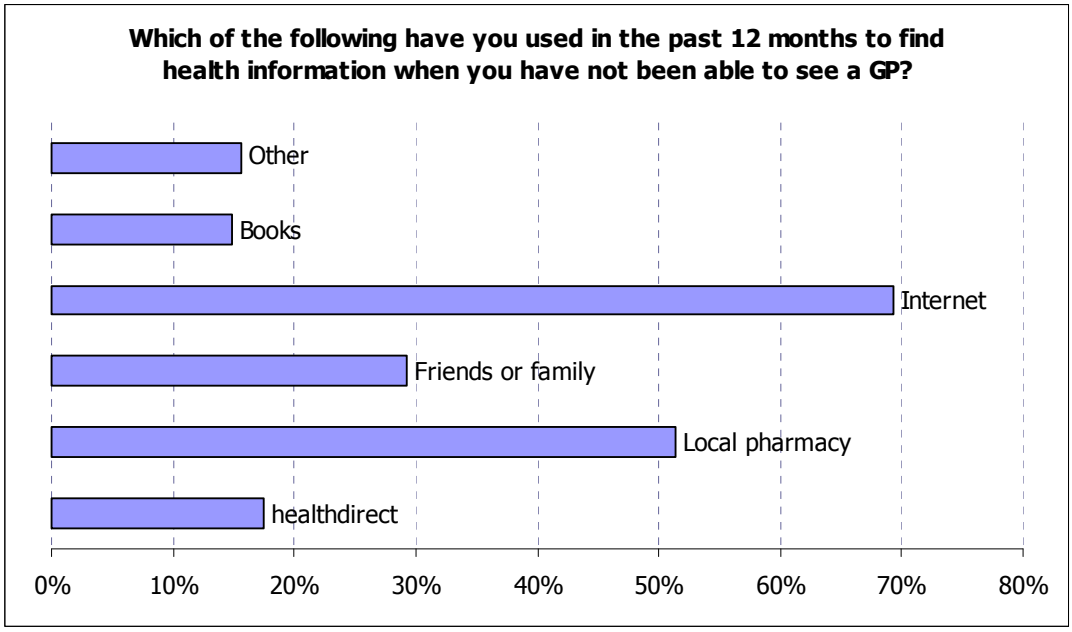
One of the strategies consumers have developed is to have a number of general practices they access. A respondent to the *GP Snapshot 2009* said that they had "*2-3 GPs because we cannot always get to see the same GP due to difficulties getting an appointment*" (Respondent 130).

In discussions at the HCCA Forum on 23 June2009 one participant shared that their family accessed three different general practices: one for ongoing treatment of chronic conditions and two bulk billing clinic for scrapes and sprains, coughs, colds and upper respiratory viruses.

Another consumer shared their experience:

One of the issues with GP usage is that many people I know often access two GPs, who may or may not be in different locations. I generally access a male GP in a single doctor practice because he is thorough and gives me time. He always asks me about consultations with other health providers to ensure he is kept up to date with any health issues between visits… I also access a female GP in a very large practice for some things where I am more comfortable seeing a female. I don't go to her for anything else as she is unwilling to spend more than the allocated time talking to me or answering questions, or catching up with my medical history since the last time she saw me (often 2 years). However, it is worth my while being on the books at this practice because if the need is urgent, and I cannot get into my regular GP, I know that I could probably get in to see one of the doctors in this larger practice. (Email correspondence CA 15 June 2009)

Consumers also access other community services and resources for health information when they cannot see their GP. Results from the GP Snapshot indicate that consumers seek information on the internet (69.4%) and also community pharmacies (51.4%).



The table shows that the majority of respondents used the internet for health information. Consumers were also asked if they had accessed a range of websites to gain health information. The majority of respondents had not accessed websites that are considered to provide reliable health information but commented that they access a range of sites including:

royal children's hospital in Sydney and Melbourne (Respondent 312)

beyond blue, black dog institute (Respondent 307)

Various disease specific sites on the internet (Respondent 213)

Speciality sites from chronic disease groups and well known medical centres/organisations e.g. Library of Medicine, Mayo Clinic, etc. (Respondent 94)

Our membership has been very interested in health literacy and would like to see resources developed for consumers to assist us to interpret and evaluation the validity, reliability and accuracy of information on the internet. The need for this is highlighted by a number of comments in the *GP Snapshot 2009*. For example, when asked about websites accessed most in the past 12 months, consumers responded: *Just Google And Hope!* (Respondent 610); *tend to Google the condition and see what comes up* (Respondent 499); *and I have googled particular health topics and been happy with the result* (Respondent 608)

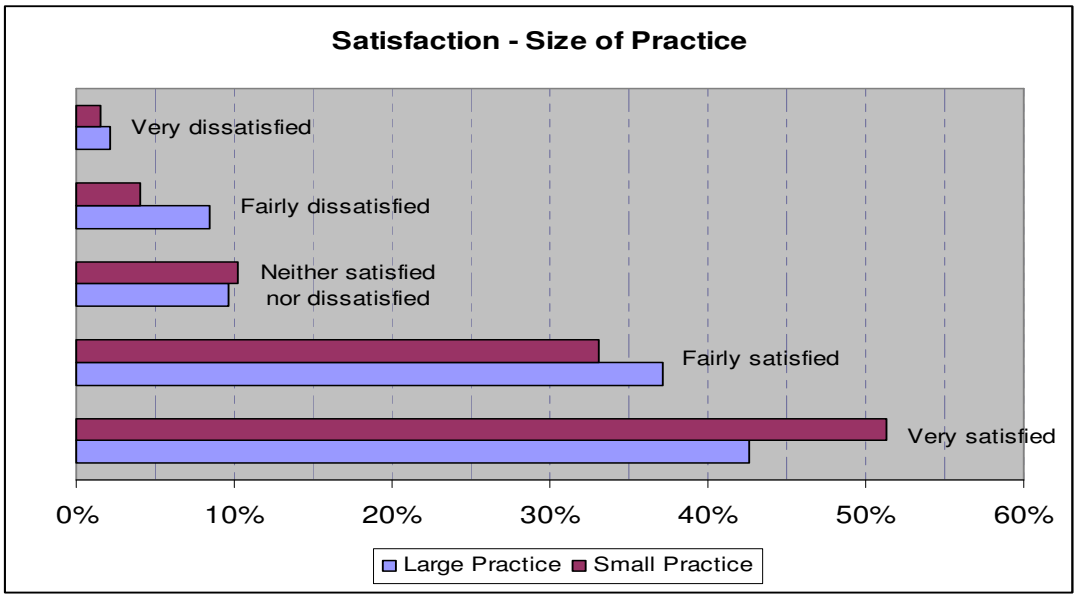
Corporate medical centres

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 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 concerns that consumer share are clearly demonstrated in *Helen's Story* (pp 31 - 32).

Consumers also reported a level of disruption to their health care with the closure of general practices and the 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. Not having one's own GP is seen by consumers as a significant health care issue affecting quality of care and health outcomes.

Consumers reported lower levels of satisfaction with large medical practices than with smaller practices as shown in the chart below.



> *… I have to queue for the first doctor available or wait even longer for my own Dr. On average I have to wait 3 hours to see a Dr, unless I am there at 06am in the morning to be first in the queue (which is what I usually do) I hate not being able to see my own Dr without a long wait or luck of the draw. I hate the medical centre and only stay there because my Dr is so good, I have been with him for a long time and he knows my family. I hate the fact that I have to drive to the medical center* [sic] *to book in and then, if I go home for a while and come back and have missed my name being called- I'm back at the end of the list again. There is no appreciation of the fact that patients can be busy too or may not feel like sitting in a waiting room for 3 hours. They will not even allow people to call and enquire about their position in the queue. I appreciate that it's a business, but it's certainly not patient centred and every visit is a frustrating experience* (Respondent 584)

> *The system is first come first serve – you go on the list, and simply wait. It is the norm to wait over 2 hours to see any doctor, and if you leave the medical centre and miss your name being called, you go to the end of the queue. The waiting room is full of people who are unwell, and are of all ages – including very sick children and older people. I have watched mothers of very sick children trying to soothe them for over two hours, and in the meantime everyone else in the waiting room (which would hold 100 people) is exposed to the viruses and colds brought in by others.* (Email Correspondence SM 15 June 2009)

Carers also reported dissatisfaction with large corporate medical centres. "*Supermarket GP centres are shockingly bad at continuity of communication*". Consumers and carers are endlessly explaining their situation and having to tell the story over and over again and in the retelling they can omit information. *"The bigger the practice the less the communication with carers."* This retelling of stories is also a problem with the turnover of GP's within general practices.

The analysis of the *GP Snapshot 2009* found a difference between the quality of interactions between consumers and GPs in these medical centres with those consumers who have a regular GP.

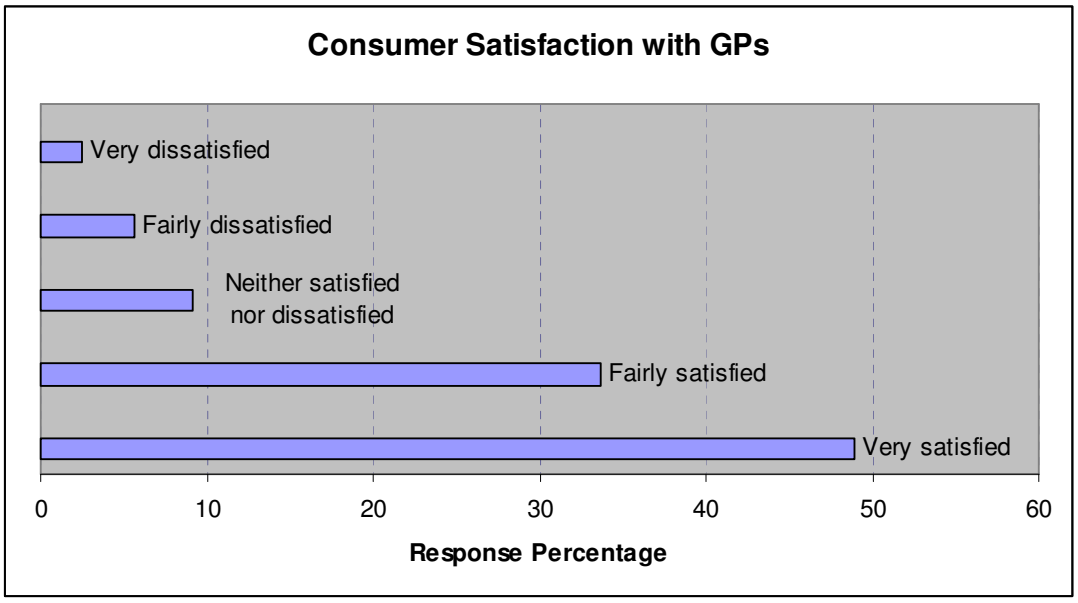
While consumers expressed concerns around the organisation of the large medical centres consumers did comment on the benefit of bulk billing and that if you are prepared to wait (often many hours) you can see a GP.

We need also make the point that not all large corporate medical centres are the same. Some large centres allow consumers to make an appointment with their doctor of choice and offer a range of services to provide a medical home for their patients.

Consumer experiences of consultations with GPs

Consumer satisfaction with their GP care

Overall respondents to the *GP Snapshot 2009* are satisfied with their GPs despite the many barriers to access. This is demonstrated in the table below.



Cross tabulating results has identified difference in rates of satisfaction between those consumers accessing small suburban clinics and consumers accessing large medical centre. This is presented in the table below:

How satisfied are you with the care you get at the GP surgery you usually use?				
	Large Medical Practice		Small Practice	
Answer Options	**Response Percent**	**Response Count**	**Response Percent**	**Response Count**
Very satisfied	**42.6%**	80	**51.1%**	141
Fairly satisfied	37.2%	70	33.3%	92
Neither satisfied nor dissatisfied	9.6%	18	10.1%	28
Fairly dissatisfied	8.5%	16	4.0%	11
Very dissatisfied	2.1%	4	1.4%	4

Do consumers have a regular GP that they go to see?

The majority (81.2%) of respondents have a regular GP. Respondents were asked to provide reasons for not having a GP. The main reasons given for not having a GP were that the consumers can never get into their preferred GP (17.5%) and that GP Clinics are not taking new patients (16.7%). People also provided comments to illustrate the reasons for not having a regular GP:

My regular GP is now nearly impossible to access since he moved to the Ginninderra medical centre (Respondent 585)

Appointments are so scarce I see whichever GP is free at my local surgery. (Respondent 547)

The *GP Snapshot 2009* identified a difference between older and younger people in having a regular GP. For example, than a third (34.7) of respondents aged between 25 -34 do not have a regular GP whereas around 10% of respondents aged over 45 reported not having a regular GP.

	Regular GP		No Regular GP	
Age	**Response Percent**	**Response count**	**Response Percent**	**Response count**
12 - 17	100	4	0	0
18 - 24	63.9	23	**36.1**	13
25 – 34	65.3	62	**34.7**	33
35 – 44	76.4	97	23.6	30
45 – 54	87.9	116	12.1	16
55 - 64	90.2	129	9.8	14
65 - 74	97.8	44	2.2	1
over 75	100	11	0	0

The *Snapshot* also found a difference between people who use small suburban practice and large medical centres. As demonstrated in the table below, consumers who attend large medical practices are more likely not to have regular GP.

	Regular GP		No Regular GP	
Type of Practice	**Response Percent**	**Response count**	**Response Percent**	**Response count**
Small Practice	**87%**	**241**	**13%**	**36**
Large Practice	**74.1%**	**140**	**25.9%**	**49**

How often do consumers see their preferred GP?

Consumers were asked how often they see their preferred GP. Most people (62.5%) always or almost always see their preferred GP. One respondent said that they always get to see their preferred GP as they are "*willing to wait three weeks for check-ups"* with their doctor and if the need is urgent, "*such as something in the eye, or needing antibiotics* they *to go to the nearest large surgery and take whoever is on"* (Respondent 269).

Selection of GP

Respondents also commented that they selected their GP based on their

- ability to diagnose *good reputation in diagnosis (532)*

- deal with specific conditions *his reputation was good for treating CFS (311), methodone prescriber (420)*
- *Trusted their credentials* (485)

A small number of consumers commented that they access general practitioners at a clinic their medical records were transferred to after closure of their regular GP: *Medical file sent to the clinic after GP practice closed (*Respondent *306) Taken over my previous doctors surgery (*Respondent *192) Have been a patient of this practice for over 35 years, Stayed with practice when previous GP sold practice (*Respondent *158) Practice sold to current GP. Had been a patient of former GP for over 10 years. (*Respondent *139)*

Results from the *GP Snapshot* identified that health professionals prayed a role in the selection of GPs with a small number of respondents commenting that they were referred by ADFACT (634), alcohol and drug service (633), known from cancer clinic (622), Psychiatrist referral (303), referred by my former retiring doctor (263), chemist referred (257). Helen's story also highlights this. Helen carefully selected her current GP after consulting with her specialists. She has selected someone with whom she has a good rapport, someone who takes a keen interest in her health, who is on top of his game keeping up to date and, above all, someone who is a great communicator.

Gender

The selection of a GP based on gender was more important to women than men. Only 7% of male respondents selected a GP based on gender whereas 33.6% of women selected a GP based on gender. Consumers commented that in addition to the reasons presented in the *Snapshot* survey they selected their GP based on gender:

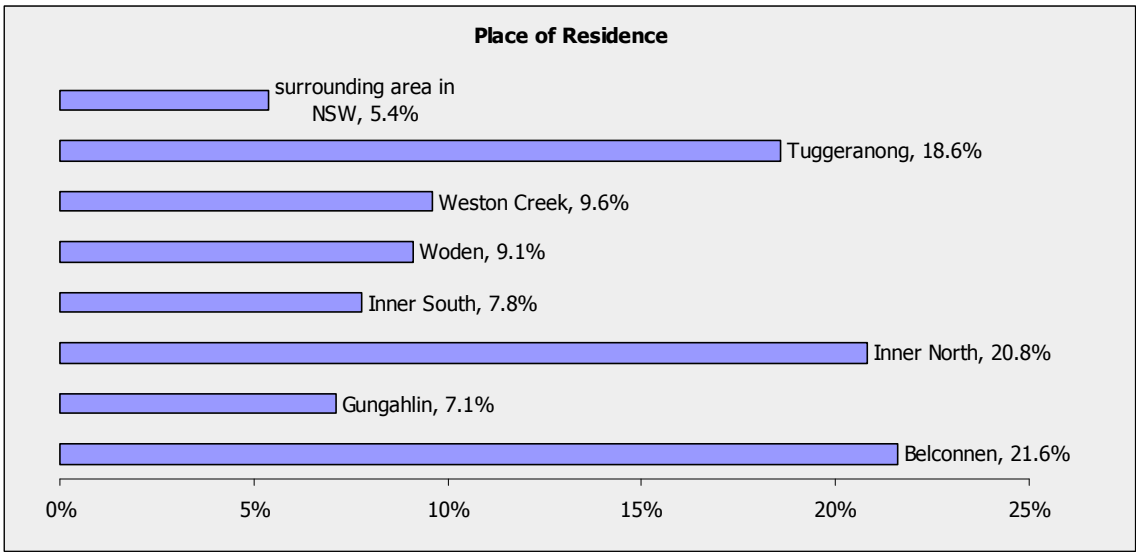
> *Recommended as a women's health doctor* (Respondent 326)
>
> *women only practice* (Respondent 231)
>
> *he is also an obstetrician and I have been going to him since having my first child. I wish that I could have gotten into a femael [sic] GP though, and as a result I do sometimes go to other GPs as well (female) for different things* (Respondent 102)
>
> *I would like to see a female GP, but none in my area are taking new patients. I may need to go to a sexual health clinic or somewhere like that for regular PAP smears etc. I'm not sure I'm comfortable with a male doctor doing those procedures...* (Respondent 44)

Who did they go to the GP for?

The overwhelming majority (79.7%) of respondents reported going to the GP for themselves and only 15% report the main reason for seeing the GP was for their children. The demographic profile of the respondents needs to be taken into consideration. Filtering responses according to age demonstrates a difference

Just under half (49.3%) of respondents have seen a GP in the past 12 months with someone they care for or support

Geographic location: where people live

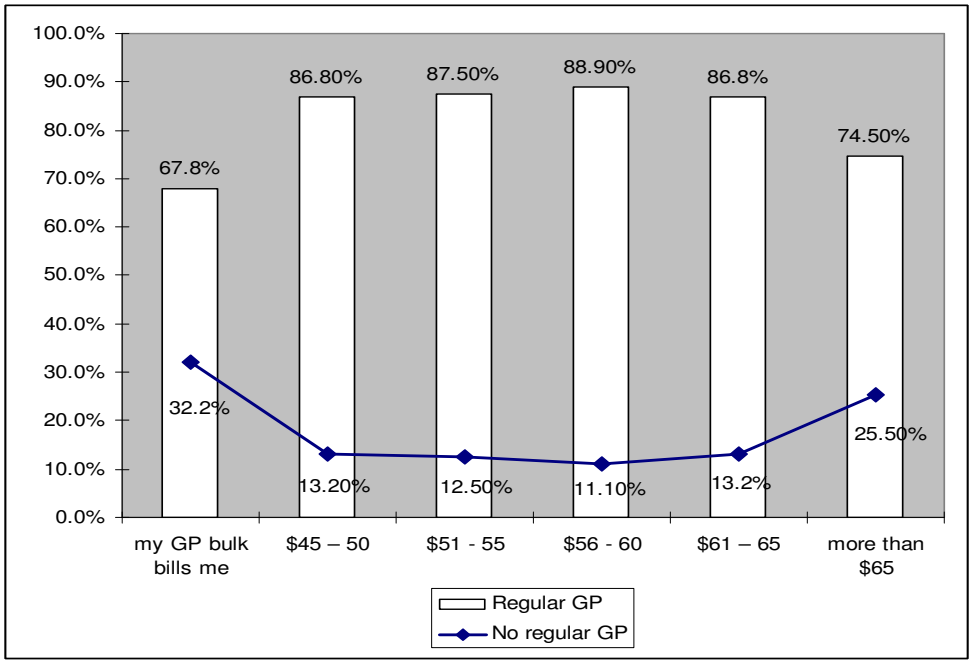


This *Snapshot* shows that a third of the respondents living in Belconnen and a quarter of respondents living in the Inner North do not have a regular GP. We would encourage the Government to undertake further research on this issue for consideration in the Government's decisions around the location of Walk In Centres.

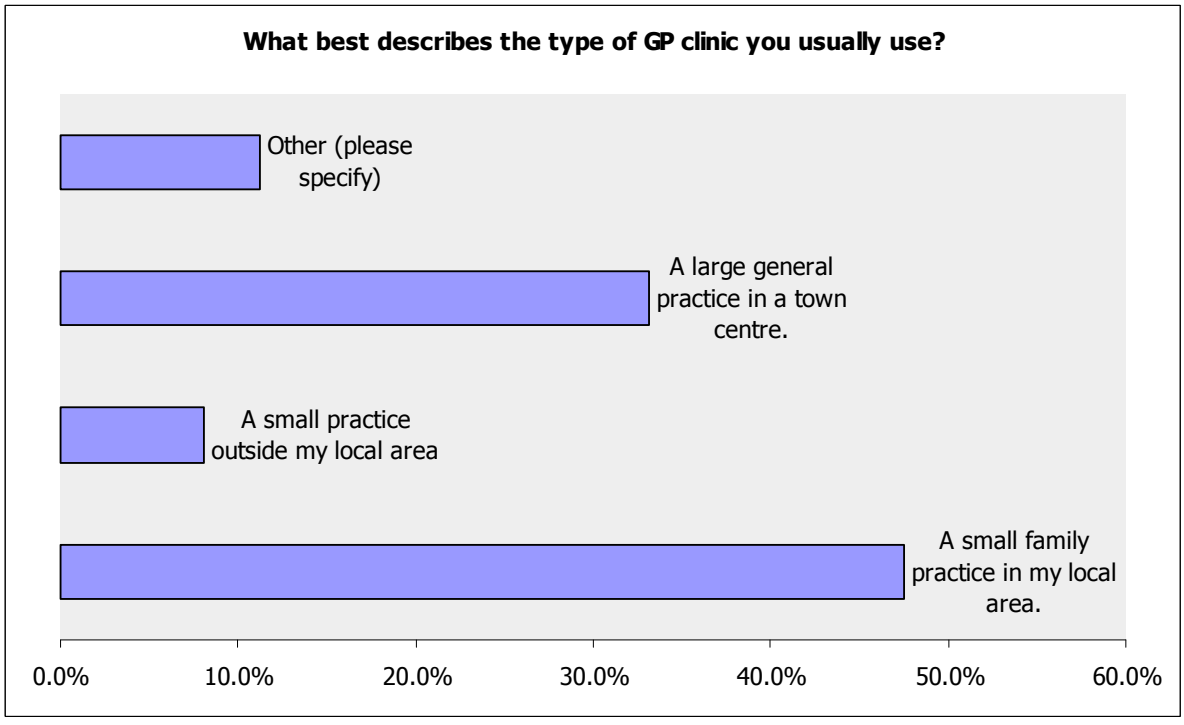
Place of residence	TOTAL respondents	No.	Have a Regular GP	No.	Do not have a Regular GP	No.
Belconnen	21.6%	128	19.6%	94	**31.1%**	33
Gungahlin	7.1%	42	7.1%	34	6.6%	7
Inner North	20.8%	123	20.4%	98	**23.6%**	25
Inner South	7.8%	46	7.7%	37	8.5%	9
Woden	9.1%	54	9.8%	47	6.6%	7
Weston Creek	9.6%	57	10.8%	52	4.7%	5
Tuggeranong	18.6%	110	19.6%	94	12.3%	13
Surrounding NSW	5.4%	32	5.0%	24	6.6%	7

43 respondents skipped this question

Anecdotally we have heard that consumers who access medical centres and are bulk billed have a lower rate of continuity of care. Interestingly, the *GP Snapshot 2009* did not find this trend but we consider this to be a result of the sample. Of the consumers who were bulk billed were 67.8% had a regular GP compared with higher percentage of consumers who have a regular GP who pay between $45 and $65 per consultation. This is highlighted in the table below where consumers who incur an out of pocket cost in seeing a GP reported they have a regular GP (86.8% – 88.9%). We are interested to see that there is a lower number of people who spend more than $65 on consultations who do not have regular GPs and we would be interested to completed further research to determine what proportion of these people have used CALMS.



What types of GP clinics to consumers use?



The centralisation of services and the move away from small local general practices creates a problem for consumers because of the travel time involved in accessing the bigger central clinics. Consumers reported that *public transport networks don't cover places like Phillip* and public transport runs very infrequently at night and on the weekend. Even during the week it can take hours to get to a clinic by public transport where it might take only 20 minutes by private vehicle. This time spent in transit when

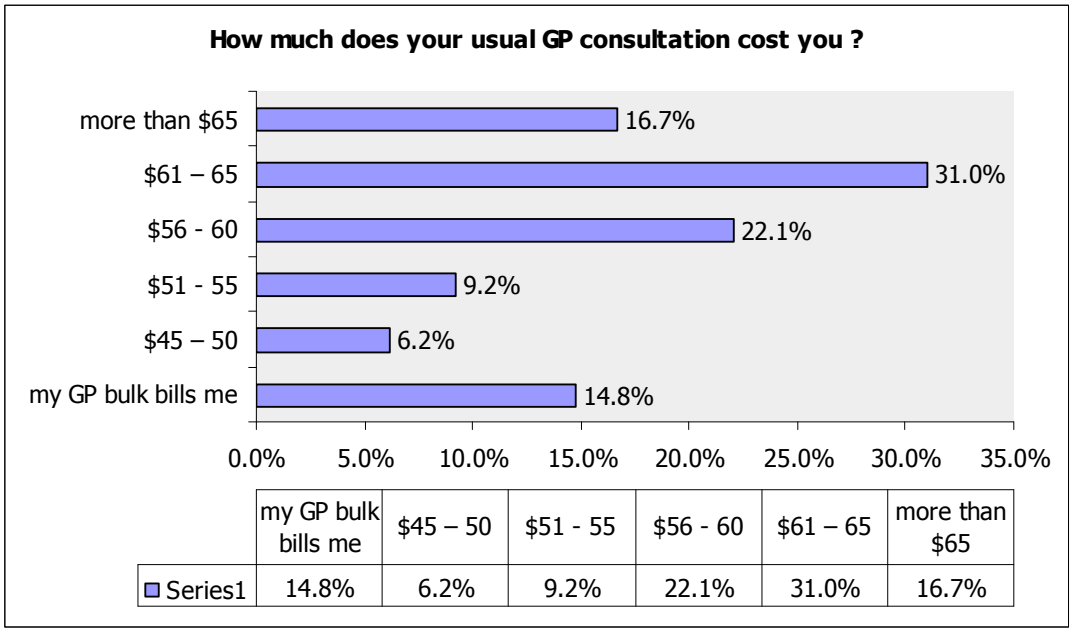
you are ill or you are travelling with a sick child can turn a visit to the doctor into an all day event, especially if there is a long delay at the clinic as well.

Cost of consultations

Cost is consistently one of the major barriers to primary health care.

At the Forum on Barriers to Primary Health Care participants identified cost as a major barrier. They commented on the high out of pocket costs for the majority of consumers. The main issues relating to cost of access identified at this forum were:

- low rate of bulk-billing by ACT GPs
- too few GPs adopting the Medicare electronic billing which would reduce the payment to the gap
- charges of up to $15 for writing of scripts
- very few bulk billing general practices. Most people in disadvantaged groups put off attending a GP simply because of the cost, the consequence of this can be a substantial deterioration in health status. One consumer commented that she did not take her children to the GP when they were unwell as she did not have the money to pay for the consultation. Instead she contacted health direct as this was affordable (Personal communication, 20 July).



Cost was also a barrier to access to other health services. One consumer commented:

> *it is really expensive and up until recently (although I have not experienced the new system) a real pain to then have to get to Medicare to get a refund. I have missed several refunds just through the inconvenience.* (Email Correspondence RS 18 June 2009)

Consumers reported that they did not follow up on referrals to other primary heath care practitioners such including podiatrists, physiotherapists, dieticians, psychologists

and occupational therapist as the cost is prohibitive. Consumers have also commented that at times they do not fill prescriptions and may substitute the prescription medication for an over the counter medicine that is more affordable.

Waiting Times

Time is regarded as one of the major barriers to accessing primary health care. The lengthy waiting time for an appointment, even for the very ill, is a major deterrent to accessing care.

Consumers report long waiting times to get an appointment and then often experience delays of up to one hour after the allotted time to see the GP.

HCCA will complete research into this issue based on the *GP Snapshot* and post it to the HCCA blog in August.

Transport

Transport is a major access issue in the ACT. There is limited public transport to many primary health care services; coordination and timing of public transport is an issue and there are additional difficulties for those with limited mobility, or travelling with children, especially sick children.

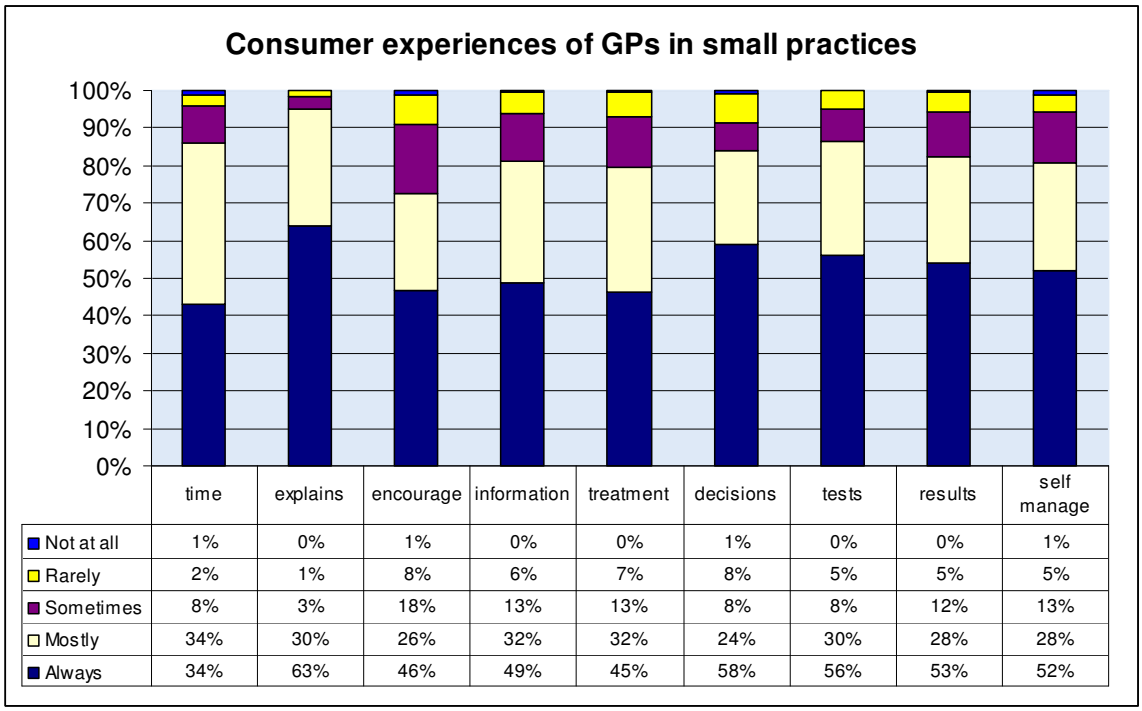
The time taken to travel to the GP, especially by public transport, can be both lengthy and difficult, in particular at night or at weekends. This is accentuated where the travel involves a sick child. Closure of local GP practices, with consequent centralisation of services makes this a major access barrier for many.

Communication

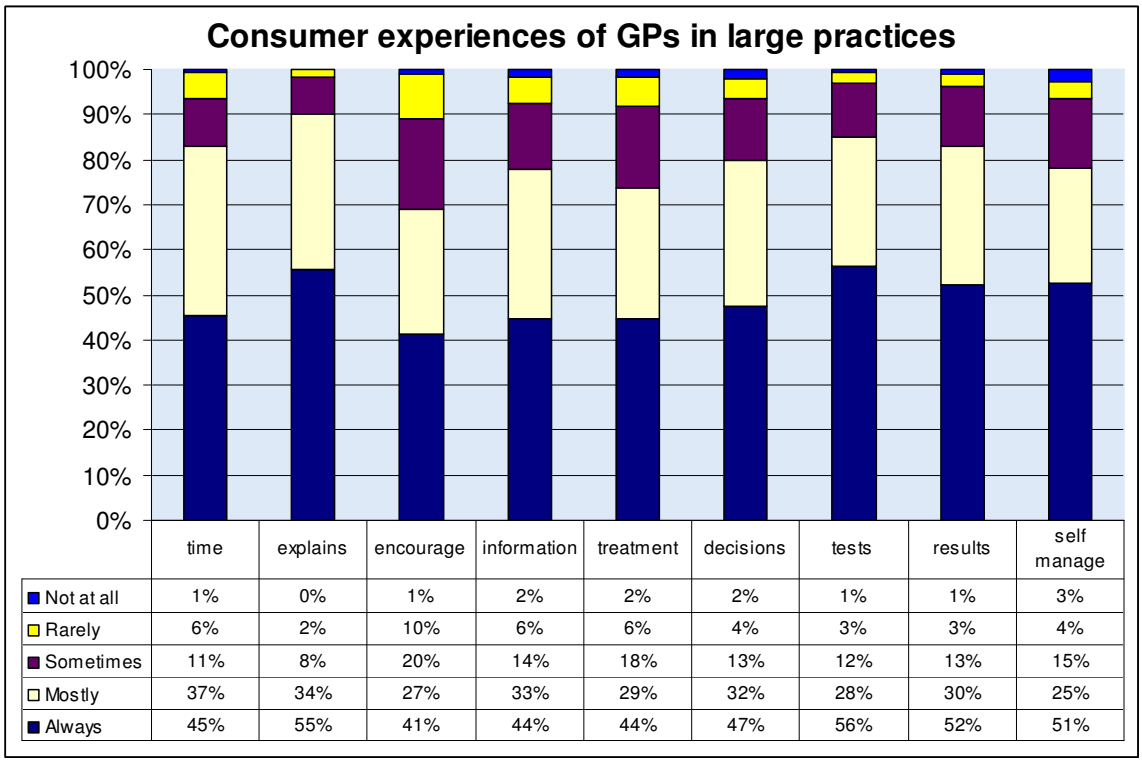
The need for good communication was seen as “absolutely critical” for effective care. Standard (ten-minute) GP consultations are simply not long enough to deal with the complex issues which many consumers and carers have. Often there is a need to discuss the impact of co-morbidities and the need communicate about care recipients. While longer consultations could be an effective means of improving the situation the additional cost then becomes a major barrier, given the low bulk billing rate in ACT. Email consultations and online access to test results would allow carers to explore issues and shorten the time they need to spend face to face with their GP. One respondent commented:

> *saw a local bulk billing GP - very poor service and crappy GP - didn't take any normal tests such as blood pressure. didn't ask many questions. very happy just to write a script and get me out of the room.* (Respondent 80)

The analysis of the *GP Snapshot 2009* found a difference between the quality of interactions between consumers and GPs in these medical centres with those consumers who have a regular GP. Below are two tables that have separated responses to this question based on the type of clinic they access.



	time	explains	encourage	information	treatment	decisions	tests	results	self manage
Not at all	1%	0%	1%	0%	0%	1%	0%	0%	1%
Rarely	2%	1%	8%	6%	7%	8%	5%	5%	5%
Sometimes	8%	3%	18%	13%	13%	8%	8%	12%	13%
Mostly	34%	30%	26%	32%	32%	24%	30%	28%	28%
Always	34%	63%	46%	49%	45%	58%	56%	53%	52%



	time	explains	encourage	information	treatment	decisions	tests	results	self manage
Not at all	1%	0%	1%	2%	2%	2%	1%	1%	3%
Rarely	6%	2%	10%	6%	6%	4%	3%	3%	4%
Sometimes	11%	8%	20%	14%	18%	13%	12%	13%	15%
Mostly	37%	34%	27%	33%	29%	32%	28%	30%	25%
Always	45%	55%	41%	44%	44%	47%	56%	52%	51%

A few points to note are the difference on the following aspects of care that presents some concern to consumers as expressed elsewhere in this document:

- spends enough time during my consultation to listen, talk and explain to me
- explains things to me in a way I can understand
- includes me in decisions about my treatment options.

Around a third of consumers who completed the *GP Snapshot 2009* had spoken with their GP I the previous 12 month period. There were slight differences based on the type of the practice.

How many times have you spoken with your GP on the phone in the past twelve months?

Answer Options	Large Practice Response Percent	Large Practice Response Count	Small Practice Response Percent	Small Practice Response Count
0	77.0%	144	71.5%	198
1-3 times	21.9%	41	25.3%	70
4 - 6 times	1.1%	2	2.5%	7
7 - 10 times	0.0%	0	0.0%	0
More than 10 times	0.0%	0	0.7%	2

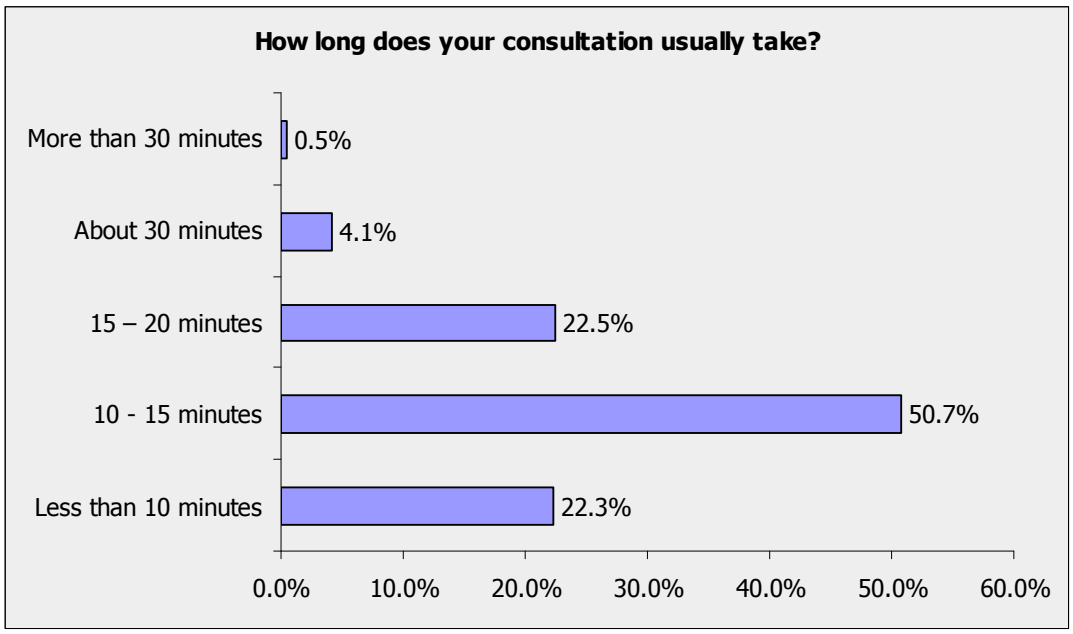
Consumers were asked if they would like to have email contact with their GP and the results are presented below. Consumers who access large practices are slightly more likely to want to email their GP. That could be related to the age of the people accessing these clinics.

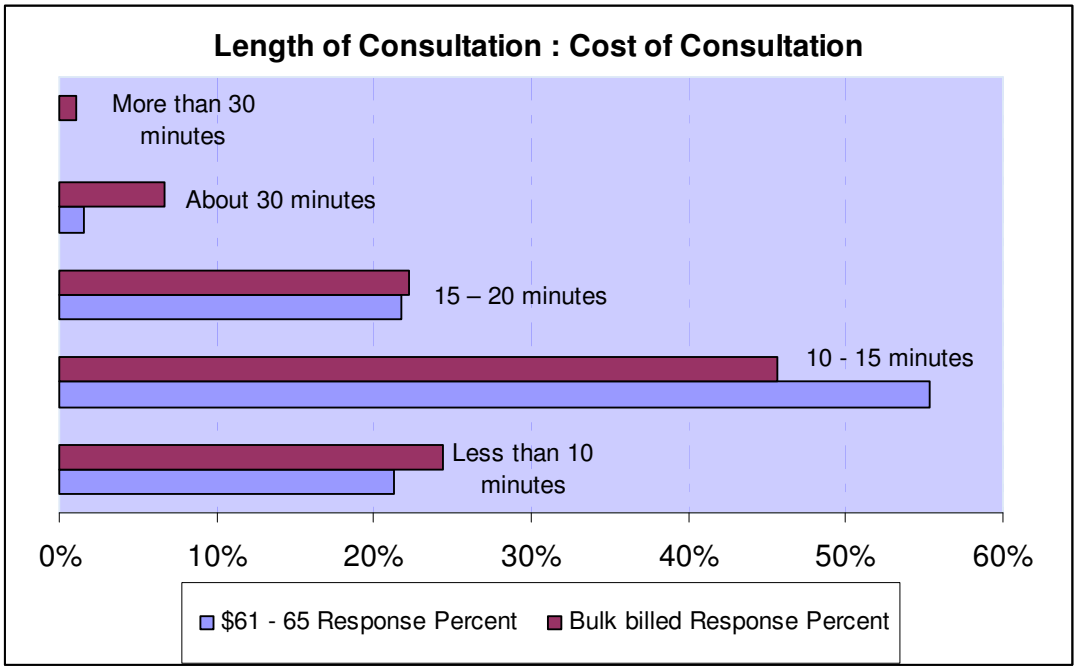
Would you like to be able to email your GP?

Answer Options	Large Practice Response Percent	Large Practice Response Count	Small Practice Response Percent	Small Practice Response Count
Yes	69.2%	126	64.4%	177
No	30.8%	56	35.6%	98

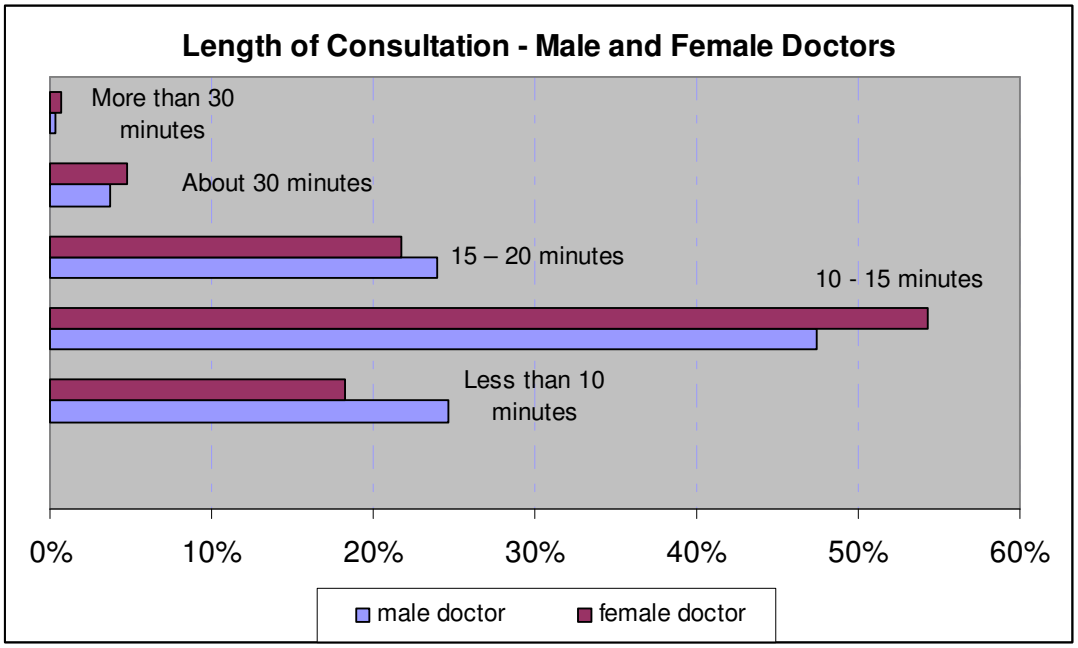
Length of consultation

As can be seen in the chart below, the cast majority of consultations taken less than 20 minutes.





The GP Snapshot found a difference in the length of consultation between male and female doctors. As can be seen below:



Primary Health Care Workforce

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.

Consumers have expressed preparedness to use new models of care that do not involve a GP at the centre of the care. At the Forum the development of a health care coordinator was supported. We think there is merit in raising public awareness about new models of care. For example, identifying the potential for nurses to develop care plans, provide education and support, prescribe continuing medication, conduct pap smears, and relay test results.

There was also support for an increased role of Healthdirect in triage and providing consumers with reassurance. Awareness of this service is limited. In the *GP Snapshot 2009* when we asked where consumers found health information only 17.5% had used Healthdirect and 8.7% had accessed the Healthdirect website. Five respondents referred to the service as Health First and gave the old phone number. They obviously valued the service enough to recall the phone number. We think that there is scope to increase the profile of this service and integrate it with other primary health services.

Health care workforce structures and roles are a basic part of limiting or enhancing change. The current roles of health professions are predicated on government regulation and funding, health professional education and training, control and attitude of individual health care professions and health care consumer awareness, advocacy and acceptance. Improved health literacy of the community and particularly health care consumers is one essential requirement to achieve change.

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 and we commend this to the GP Task Force.

Practice nurses

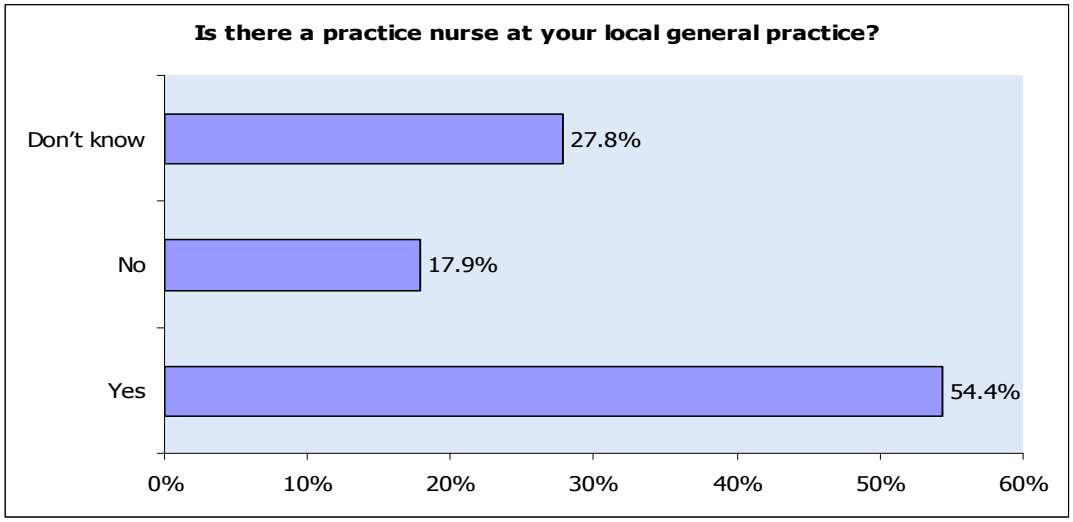
The Centre for Research into Nursing and Health Care completed a study into Consumer Perceptions of Nursing and Nurses in General Practice in 2002. Perceptions of consumers were explored during 20 focus group discussions conducted across Australia.

Findings of this study found:

- a widespread acceptance of nursing in general practice
- almost universal concern was expressed around nurses undertaking a diagnostic role – the dominant view was that diagnosis should be the role of the doctor.
- that the role of nurses from the perspective of consumers must not be as a substitute for doctors, minimise consumer choice or result in increased costs to consumers

- Nursing in general practice was perceived by participants to enhance the quality of their care, in particular through providing more time for the general practitioner to see more patients.
- Many consumers considered nurses likely to be more available, accessible, approachable and a 'comfortable presence' providing them with someone to approach when they did not want to 'bother the doctor' with minor queries or to seek the support and access to resources and other services.

In the GP Snapshot we asked consumers whether there is practice nurse at the GP clinic they attend.



The results from the *GP Snapshot 2009* show that of those respondents who knew that their GP had a practice nurse, 55.4% had seen a practice nurse. There is a slight difference depending on whether you are accessing a large medical centre or small practice. 53.6% of consumers using a large medical centre reported seeing a nurse compared with 58.7% of consumers using a small suburban practice.

Anecdotally we hear that consumers consider that their needs can be met to a degree by practice nurses.

> *I would be more then happy to see a nurse for thing like colds and flus and not waste the GPs time. As a Public Servant you are required to get medical certificates for more then two days off work so the visit it to obtain a certificate rather then a diagnosis.* (Email Correspondence RS 18 June 2009)

HCCA is interested in consumer perceptions of the role of nurses in primary health care and will be doing further research in the coming year. We have also been impressed by the Consensus View of the Australian Nursing Federation.

Options and innovations to improve access to primary health care services in the ACT

Self Management

The number of consumers with complex and chronic conditions will continue to grow and we need a health system supports us to be actively engaged in our own care. This means we need the skills and confidence to participate actively in decisions around our own care and support to self manage. We see that there is an active role for health professionals to increase the health literacy of consumers.

The *GP Snapshot 2009* provides an interesting reflection on the level of engagement consumers experience with GPs and demonstrates that there is room for improvement.

My GP supports me to self manage my health									
Always	**No.**	**Mostly**	**No.**	**Sometimes**	**No.**	**Rarely**	**No.**	**Not at all**	**No.**
52.1%	313	28.5%	171	13.1%	79	4.5%	27	1.8%	11

Consumer health organisations

Consumer organisations play an important role in supporting consumers to self management chronic conditions and "offer a valuable extension to the structurally limited 15 minute primary care consultation" (Boyle, 2004, p.5.) Consumer organisations, such as those small groups supported by SHOUT and HCCA, provide information and educational resources, peer support, and a range of skills development for people with chronic conditions. We would like to see GPs more actively promote self-help organisations

Provisions to improve access for vulnerable populations:

Innovation in community based primary health care

There is a need for different models to meet the range of needs of various groups and communities - no one model is the answer.

The input of the community is critical to the development of appropriate models of care, improving services and the health of the people living in the community. There are a range of innovative models in primary health care that have met the needs of the community.

There are a number of examples that show innovative approached to Primary Health Care that have been developed to meet the needs of communities:

Transitional Aged Care Nurse Practitioner, Port Macquarie, NSW

The north coast of New South Wales has a high concentration of older people, with a quarter of the population of Port Macquarie aged over 65 years. They have introduced a position of a transitional nurse practitioner who treats older consumers in their homes and residential aged care facilities. Working in close collaboration with doctors and the NCAHS, this Nurse Practitioner can treat chronic and acute, low-complexity medical conditions within residential aged care facilities, rather than transferring patients to EDs, as is the current practice. This project has been effective in keeping these people away from the Emergency Department at Port Macquarie Base Hospital.

Kootara Well, Narrabundah Primary School

Kootara Well was launched in April 2002 at Narrabundah Primary and was a health and well-being program to achieve health and wellbeing outcomes for the school population with extra needs. A clinic room and a health promotion room were set up to provide a variety of free health and support services to students, their families and the local community. The health promotion room was designed to be a welcoming place where families could access the internet, have a cup of tea, or have a chat with the intake worker or the doctor on roster, all while picking up useful health information.

Kootara Well was a partnership between Narrabundah Primary School, *Schools as Communities*, Winnunga Nimmityjah Aboriginal Health Services, ACT Community Care and Marymead.

> *Health services at Kootara Well are well used by parents, students, local residents and students from Narrabundah College. The variety and flexible delivery of services at Kootara Well is an invaluable resource and allows Narrabundah primary school to work with partner agencies to quickly identify and address health issues in the student population.*
>
> Legislative Assembly for the ACT:
> 2005 Week 5 Hansard (7 April) Page 1578

Coachstop Caravan Park Outreach Project, Maitland NSW

An initiative of the Maitland Community Health Service has an innovative outreach project for a vulnerable community that is improving health outcomes. Many park residents have been homeless, in prison and juvenile institutions, a number are from mental health facilities or refuges and some are transient moving from park to park in search of affordable housing. The project looks to build community capacity and build partnerships with a range of other services including drug and alcohol services, dental care, women's health services, immunisation services, and a volunteer general practitioner. The project has also included Centrelink, a, Department of Education, community businesses and charities such as the St Vincent de Paul food program. (Australian Nursing Federation)

The project has been successful in engaging socially and economically disadvantaged families and individuals living in the caravan park and delivering a high quality health service on minimal funding.

Companion House, ACT

Companion House is a non-profit community based organisation that works with people who have sought refuge in Australia from persecution, torture and war related trauma. They work with people who are newly arrived and longer term settlers. They work with adults, young people and children. Companion House provides a range of primary health services to the community. Companion House is an example of how not for profit organisations can complement the services of ACT Health and general practice to provide primary health care for vulnerable communities in Canberra.

The Medical Service provides general practice and primary health services for refugees in their first 12 months in Australia. Their medical team includes a Practice Nurse, Medical Coordinator, Clinical Director and three GPs. Consumers of this service continue to use the Companion House medical service until they can find a community GP to refer them to. Currently, as a result of the GP shortage, this process is taking longer than it has in previous years.

Directions ACT

The Althea Wellness Centre provides primary health care available to all people with alcohol and other drug issues, DIRECTIONS ACT clients and their families. They run a GP clinic and have a GP who is available for sessions on weekdays at the Althea Wellness Centre. A Triage Nurse assists each new client and takes details prior to the appointment with the General Practitioner. The GP clinic bulk bills people through Medicare with Healthcare cards and charges a small fee for those who do not have these cards in addition to the Medicare Fee. Clients should bring their Medicare card with them.

They also work in a partnership other agencies and organisations to deliver a number of complementary and allied health services including: Naturopath and Herbalist, a Liver Clinic, Hepatitis C Wellness Clinic, Mental Health Clinic and Youth Clinic. These Clinics are a free or low cost service. A small fee is charged for naturopathic services, to assist with the cost of the medicines. Some other clinics may require that a Medicare card.

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Attachments

Consumer Story: Peter and Louise*

GP's won't go to Residential Aged Care Facilities to see their patients.

Finding a GP who will visit a residential aged care facility in Canberra is close to impossible and the consequences for some of the most vulnerable in our community can be very serious.

Peter and Louise are a married couple who are both in their 70's and they both have Parkinson's Disease. Louise is very frail and needs help with all aspects of daily life. She had several falls which resulted in hospitalization and is very vulnerable to falls if she moves about without a wheelchair. They moved to a residential aged care facility in Canberra when Louise's care needs could no longer be met by her husband. Peter realized that while he could continue to manage most of his own daily needs at the moment, his condition was likely to worsen, and that to move into a RACF together would be the best option for him as well as his wife, so they decided to move into a RACF.

They have now been in the same RACF for six months. In that time they have had to see a GP in the GP's suburban clinic, and while the care has been satisfactory their GP will not visit the RACF. The GP told Peter and Louise that his experience has been that when he attends the RACF to see his patients he is then asked by staff at the RACF to see other residents who are in the same situation and he is not able to take on any more patients.

Despite great effort Peter and Louise have not been able to find a GP in Canberra who would see them at the RACF so they must go to the doctor's surgery. The problem here is that until now Peter has driven Louise to the doctor and then helped her while she uses a walker to access the clinic. Louise should be using a wheelchair as moving about is very dangerous for her, and she is likely to fall at any moment. However, Peter can no longer manage to either transport a wheelchair or push it. Louise is very vulnerable to falls in these circumstances and just attending the GP puts her at great risk. The RACF does not provide any transport and community transport can only be booked with two weeks notice and then at a cost of $37 an hour. Even this would be great if Peter and Louise could predict two weeks in advance when they will need to see a GP, obviously they can't.

While the Head of Care at the RACF is sympathetic, they have no solution to this dilemma. If Peter can't take Louise to the doctor and community transport is not available then the RACF will , when the situation becomes acute, call an ambulance. The experience of staff at the RACF is that it is unkiley to get a GP to visit the RACF and the emergency department at the hospital is equipped to manage the medical needs of their residents.

Peter and Louise's family are unable to provide transport as both offspring have vision impairments and do not drive. All of the family's concern, care and advocacy on behalf of the their parents cannot solve the problem. They cannot buy what they need for their parents. When Louise or Peter need care from a GP they can't access it without putting Louise's safety at risk. Recently Peter admitted that he shouldn't be

driving and that he puts himself, Louise and other road users at risk whenever he does drive. He has hung on to his licence because he felt he needed to be able to drive Louise to the doctor but has decided not to drive in future.

Without private transport Peter and Louise feel they have no alternative but to allow their conditions to deteriorate to the point that an ambulance can be called and they can be admitted to hospital.

** Names have been changed*

Consumer Story: Jessica

Presenting to the Emergency Department in Distress

Jessica is a young single mother of two, Abigail-3 years old and Joshua- 8 weeks. She has recently moved to Canberra from interstate fleeing a violent partner. Jessica and her children have been staying with a family member since she arrived in Canberra, but this can only be a temporary arrangement as the property is overcrowded and inappropriate for young children.

In the last month Jessica has presented herself on two occasions to the Emergency Department because she was concerned for Joshua's health. The second time this occurred the doctor decides to admit her in the hospital over the weekend. He did this as she was very distressed and anxious. While at the hospital Jessica spoke to the hospital Social Worker and tells her that she doesn't know anyone here apart from some family members and that she is very stressed, she doesn't know what to do. The social worker then referred her to a regional community service which helped her to access a GP, a counsellor and childcare.

The social worker was the link that Jessica needed to access the primary care services she needed. If she had presented to a busy GP it is unlikely that she would have been referred successfully to all the agencies she needed. Jessica didn't in fact have any health issues, but she presented to the ED which was equipped through the broad range of services at the hospital to help her. If this type of care could be provided at a general practice clinic Jessica may never have used the acute care services of the ED.

** Names have been changed*

Consumer Story: Helen

When you have a chronic illness you must have continuity of care.

When Helen's GP was forced to move his practice into one of the large, private clinics in a town centre Helen could not be sure that she would receive the continuity of care that she had enjoyed and really needed when her GP was at a local suburban surgery.

Helen has three chronic conditions: Chronic Obstructive Pulmonary Disease, osteoarthritis and an ongoing problem with her colon. She uses a mobility scooter and needs to transport oxygen wherever she goes. The medications for these conditions are prescribed by three different specialists. Without the careful monitoring of treatment, particularly medications, Helen's health could easily deteriorate.

> *"They (specialists) would often prescribe medications and it really was up to a good GP to act as a "gatekeeper" to ensure that I was not given conflicting medications…..my current GP had a really good relationship with my pharmacist and many a time, one or the other of them realized that there could be problems."*

Helen had carefully selected her current GP after consulting with her specialists. She has selected someone with whom she has a good rapport, someone who takes a keen interest in her health, who is on top of his game keeping up to date and, above all, someone who is a great communicator. At first Helen's doctor was working at a local suburban Canberra practice, but overnight this practice closed and he was absorbed into a centralised medical clinic in Phillip.

Helen felt that she had no choice, she had to follow her GP and see him at this large medical centre.

Helen has experience many issues as a result of the move:

- Her GP was working under a heightened level of stress, having little control over practice working conditions, the GP's new office was tiny and Helen's scooter could barely fit into the room, especially if her carer accompanied her to the appointment,
- Parking was a nightmare. The new location was so much busier, the disabled parking was usually full and it was necessary to park a long distance from the clinic.
- Public transport did not go past the door, so was out of the question for anyone who had a mobility problem
- The receptionists could not hope to know the patients and could not tune into their needs or trust that when they said they needed an appointment urgently that this was indeed so, which means that a new barrier had to be overcome in order to see Helen's GP when she needed to.
- Telephone access to the GP became harder, again the receptionists acted as a gatekeeper and would not put calls through, though they did deliver messages reliably to Helen's GP who did return her calls.
- While Helen is able to make an appointment to see her GP she understands this is a special arrangement for the doctors who came from the closed

suburban practice. Other consumers wishing to see a GP have no choice about who they see. What will happen if her GP leaves the practice? Helen is concerned that she will be forced to take pot luck in a long queue in an overcrowded waiting room and then see someone who doesn't know about her needs, her story and who won't be able to give her the quality of care she needs.

For Helen the closure of her local General Practice could have dramatic consequences for her health. She needs continuity of care from her General Practitioner and she needs to have a relationship with her GP which acknowledges Helen's knowledge of her situation, her ability to self manage and make good decisions in the best interest of her health. Helen feels strongly that she will never be able to get that from a large clinic, she is there under protest having followed her GP. If her GP moves on again, Helen may not be able to follow him a second time and worries that she will be cut adrift, with the only choice for GP services being delivered through large and impersonal super clinics.

** Names have been changed*

Summary of Discussions with Advocates

A summary of the main points raised in discussions held in May 2009 between Julie Derrett from HCCA and Dee McGrath and Anne Maree Ashton from Carers ACT, Caterina Giorgi, the Policy and Development Officer with the ACT Council of Social Services (ACTCOSS) and Sally D'Sousa who was speaking on behalf of Culturally and Linguistically diverse communities in the ACT.

While separate discussions were held with the three organisations, there was considerable duplication and overlap of the issues and concerns raised. For the sake of clarity and brevity the outcomes of the discussions have been amalgamated.

Cost

Cost is regarded as one of the major barriers to good access to primary care in the ACT. In particular it is a barrier for disadvantaged groups; this often leads to deferral of a consultation which can lead to a substantial deterioration in health status. The cost is a result of the low rate of bulk-billing by ACT GP's. For many carers and care recipients finding the up front dollars ($65) to attend an appointment is a barrier to accessing GP services. The lack of the electronic in-surgery Medicare refund in many ACT practices exacerbates the difficulty in overcoming the cost barrier.

The cost of pharmaceuticals even through the PBS is substantial particularly for those with complex conditions and co-morbidities.

Time is regarded as one of the other major barriers. There are two major elements. The lengthy waiting time for an appointment, even for the very ill, is a major deterrent to accessing care. The other element is the time taken to travel to the GP, especially by public transport, this can be both lengthy and difficult, in particular at night or at weekends. This is accentuated where the travel involves a sick child. Closure of local GP practices, with consequent centralisation of services makes this a major access barrier for many.

Communication

The need for good communication was seen as "absolutely critical" for effective care. Standard (ten-minute) GP consultations are simply not long enough to deal with the complex issues which many consumers and carers have. Often there is a need to discuss the impact of co-morbidities and the need communicate about care recipients. While longer consultations could be an effective means of improving the situation the additional cost then becomes a major barrier, given the low bulk billing rate in ACT. Email consultations and online access to test results would allow carers to explore issues and shorten the time they need to spend face to face with their GP.

"Supermarket GP centres are shockingly bad at continuity of communication". Consumers and carers are endlessly explaining their situation and having to tell the story over and over again and in the retelling they can omit information. "The bigger the practice the less the communication with carers." This retelling of histories is also a problem with the turnover of GP's within general practices.

Consulting with marginalised groups is hard to do even for well linked groups such as ACTCOSS – there is a sense of consumer fatigue about issues of access to primary health care services

Health Literacy
Poor health literacy amongst the disadvantaged about where to go and what health care services and facilities to access is a major issue

Interpreter services
There is an enormous shortage of interpreters available over the phone. GP's expect non English speaking patients to turn up with their own interpreter. This is usually another family member, often a younger member. This has implications for privacy of the patient and of course there is no guarantee that the translation of medical information is adequate. There are also some health issues which an individual may not wish to discuss when a family member is present so they never get an airing. The issue of who pays for an interpreter is a major one as telephone interpreter services are expensive.

Availability of General Practitioners
Because of the lack of GP's, with existing GP's being overloaded, there are often difficulties in getting an appointment to see a GP within a reasonable timeframe, even in urgent cases.

Closures of general practices create an enormous barrier to accessing health care. This is particularly for consumers with disabilities and carers who have to find a new general practice, check out suitability, physical access, affordability, try and get on the books, transfer records (cost element here), assess parking and public transport options, as well as brief a new doctor. The task is big and time consuming. There is no facilitation and carers can really struggle to replace a GP.

Carer's Access to Primary Health Care
Carer's are under great stress both with time and finances, carers will put their own needs aside assessing the care recipient as more needy. Carers' ACT believe that carers should be recognized as a priority at risk group and as such should have access to long appointments, pathology, respite annual check ups and about free flu vaccination.

Transport
Many carers and care recipients rely completely on community transport to attend appointments, but this service must be booked at least two days in advance. This throws carers back onto inadequate public transport and taxis which are expensive, even with a voucher rebate and often very difficult to get if you need a wheelchair accessible one.

Physical access to General Practice
The centralisation of services away from small local general practices creates a problem because of the travel time involved in accessing the bigger central clinics. Public transport networks don't cover places like Phillip and public transport runs very infrequently at night and on the weekend. Even during the week it can take hours to get to a clinic by public transport where it might take only 20 minutes by private vehicle. This time spent in transit when you are ill or you are travelling with a sick child can turn a visit to the doctor into an all day event, especially if there is a long delay at the clinic as well.

The newer the practice the better designed it is. People vote with their feet. At many parking can be an issue and the equation is very simple, if carers and care recipients can't physically get to the surgery they just stop using it.

Continuity of Care

This only happens if you see the same GP all the time. In most bulk billing services you will see a different person every time. Lack of continuity is most pronounced in "corporate" bulk billing clinics where the consumer does not see the same GP.

Suggestions for consideration

Super Clinics

While it is desirable to have more services in the one place we need to ensure that it is well serviced by public transport and that the clinics are publicly funded. Super clinics in private ownership are fine as long as concession holders are serviced with bulk billing so they can access the service

CALD consumers need one centralised and dedicated service which has multilingual providers of health services as well as multilingual printed material available. This must be easily accessed by public transport

Supply of General Practitioners

CALD health professionals are a resource that is often underutilized in the community. There need to be more programs which allow overseas qualified people to upgrade their skills, English as a second language in particular. Recognition of OS qualifications needs to be streamlined. If this were done this would mean more multilingual doctors would be available to serve the community. "A doctor is a doctor." More pathways to practice health care professions are needed, perhaps an expansion of provisional registration arrangements could be established.

There are programs to facilitate nurses and midwives into the workforce, why not extend this to CALD doctors who are living in our community but who are not practicing?

E – health records

This is an idea whose time has come. They would need to be client managed and are seen as especially important for complex conditions, which have been treated over a long time.

There is a lot of fragmentation in the health information system. The first and most important thing is around privacy and confidentiality. It is also important for the consumer to own their own health information. Transitioning from one provider to another is problematic and standardization is imperative. ACTCOSS is not aware of any evidence of improvement in this area even though we are aware of initiatives at the government level there is no evidence of take up.

Referrals and information

People either find that they are given too much or too little information when they visit their GP." How much will be just enough must be judged individually, but it is important not to overload. "Need an array of Basic information and no more than three contacts at a time." It is not possible for the GP to be the lynch pin between the consumer and services because GP's are simply overwhelmed with the volume of

information about services and the pace of change as well as the number of patients queuing up to see them. Other pathways need to be promoted. An up to date database of services and linkages needs to be developed and actively maintained for all to access.

Privacy

This is a particular issue for carers and care recipients. Great discretion must be exercised as each situation will be different, but the empathy which exists between carers and care recipients, must be recognized by the GP.

New Models of Primary Health Care delivery

One approach to deal with the lack of GPs is to develop ways to provide primary health care that do not have the GP as "gatekeeper".. Developing a way of delivering care to address this issue requires new models of care different from the current GP centred model approach. Different models of care that have a reduced reliance on availability of GPs should be trialled

Triage and reassurance is available through Health Direct, but many people seem to be unaware of the service and the number. Health Direct can also assist in getting people past the gatekeepers of health services.

Use of Care Co-ordinators to streamline the progress of consumers through the care process.

This is a proposal that has not been put into effect in ACT and warrants consideration and trialling. There has been so much talk about care co-ordinators but it just doesn't happen. This is a new role, not exactly a case manager, more guide with a knowledge of the health system. Whether or not they need to be from the health system is debatable. This could enable many consumers to bypass the GP blockage caused by a lack of GP's.

ACTCOSS hopes that the taskforce consultation is not being held in isolation. For this taskforce to be effective they need to be across whatever else is being done in ACT Health and the Assembly committee looking into the shortage of GP's in the ACT, as well as what is being done at the federal level. The left hand of the bureaucracy needs to know what the right hand is doing.

Workshop Report: Barriers to Accessing Primary Health Care in the ACT

A workshop facilitated by
Health Care Consumer's Association of the ACT

Tuesday 23 June 2009 1 – 3 pm
Majura Community Centre, Dickson

Purpose

The purpose of the workshop was to gather members of Health Care Consumer's Association of the ACT, the GP Taskforce and representatives from community advocacy organisations together to identify barriers to accessing primary health care in the ACT and propose workable solutions to overcome these barriers. The timing of the event was chosen to closely follow the release of the GP Task Force's Discussion Paper which was released on Friday 19 June 2009.

HCCA intends to use the information gathered at the forum to inform our response to the GP Task Force Discussion Paper and the ACT Legislative Assembly Standing Committee Inquiry into access to primary health care.

While participation in this forum was by invitation only HCCA has also invited the general public to participate in an online survey designed to provide a snapshot of access to GP services in the ACT. At the time of writing there were over 600 responses to the survey indicating that there is enormous interest in barriers to accessing Primary Health Care in the ACT.

Attendance

Invitations to the forum were emailed to a network of HCCA representatives, community advocacy groups and the GP taskforce. Personal follow up calls seeking a representative from community advocacy groups were made in the week before the forum to ensure that representatives would attend the forum.

Format

The forum started at 1.10. Marion Reilly, Vice President of HCCA, officially welcomed participants, delivered an acknowledgement of country and outlined the purpose, scope and format for the forum.

Participants briefly introduced themselves to the room before the Chair of the GP Task Force, Ross O'Donoughue, gave an overview of the work of the Task Force and its Discussion Paper. Ross O'Donoughue, by way of background to the work of the taskforce made the following points.

- The ACT has a similar GP to patient ratio as the Northern Territory, and has a shortage of approximately 74 Full Time Equivalent GP's.
- A large proportion of the modern workforce of doctors are women and for a variety of reason many of them have chosen to work part time.
- We are experiencing a rise in chronic disease levels and our population profile is ageing.
- ACT Health is in the process of trialling a primary health care Walk-in Centre led by a Nurse Practitioner at the Canberra Hospital with the express aim of

improving access to Primary Health Care outside of The Canberra Hospital Emergency Department.
- ACT Health is in the process of enhancing health centres on both the North and South sides of Canberra with the express aim of improving access to primary health care.

Pre-print run copies of the Discussion Paper were distributed by the Task Force secretariat to those attending the forum. Ross O'Donoughue answered several questions from the participants before general group discussion began.

After signing in participants were allocated to one of three tables. This allocation was designed to provide each table group with a facilitator, a scribe, a member of the taskforce and a balance of HCCA members and community advocacy group representatives.

One hour was assigned for the group discussion. Each table was asked to consider the same set of questions. These questions were deliberately framed to be open ended and "naive" with the intention of stimulating discussion without limiting the scope. Facilitators were encouraged to allow the conversation to range widely, so long as it remained on the broad area of on primary health care. Twenty minutes in total was assigned for a plenary/report back from the table groups.

Marion Reilly, thanked all participants, facilitators, scribes and speakers for sharing their ideas and committing the time to contribute to the forum. The forum concluded at 3.00.

Questions
The following questions were distributed to each table.

1. The Big Picture

What are the barriers to accessing effective primary health care?

What would great primary health care in the ACT look like?

What do we need to do and or change to bring about these outcomes?

2. Models of Care

Is it still appropriate to have the GP at the centre of primary health care delivery?

Would it be better to devolve "routine care and ongoing maintenance" to nurse practitioners and practice nurses, professional counsellors, psychologists, health coaches and others without reference to a GP?

What do we need to do and or change to make this happen?

3. Need for Change

If nothing changes in the way that primary health care is delivered in Canberra what will care be like in another 5 or 10 years?

How do you think this will impact on health outcomes?
What are your fears?

The Forum ranged over many aspects of primary health care and related health care issues. This report covers the issues that were raised and the related discussions. Many of the issues were questions or proposals that need further development and consideration. Overall they represent the spectrum of views and concerns held on health care by those representatives of the ACT community at the Forum.

Access issues

These have been grouped together below under broad headings but in no particular order:

- Inadequate supply of GPs resulting in difficulties
  - in accessing a GP including for urgent appointments, scripts or renewals
  - for newly arrived residents being accepted on to a practice's books
  - for consumers needing to move from one GP to another
  - including long waiting times, also an issue with dental care

  Corporatised and locum services often not seen as an alternative because of access difficulties due to transport and cost.

- Cost to consumers of resulting from:

  GP services
  - low rate of bulk-billing by ACT GPs (less than 50%)
  - too few GPs adopting the Medicare electronic billing which would reduce the payment to the gap
  - charges of up to $15 for writing of scripts

  Out-of-pockets costs
  - pharmaceuticals and OTC medicines (over the counter)
  - diagnostic tests/specialist gap costs

  Inadequate coverage of primary health care by private and public health insurance
  - especially allied health care, mental health care, dental care and products eg hearing aids and insulin pumps.

- Residential aged care facilities in the ACT are not well served by GPs. Currently there is very limited access to GPs by residents in such aged care facilities. The need for improved access for consumers in aged care facilities to GP services is regarded as critical.

- Transport can be a major access issue in the ACT
  - limited public transport to many primary health care services
  - coordination and timing of public transport an issue
  - additional difficulties if travelling with children especially sick children

- Location of some GP practices and corporate clinics can be an access barrier, especially for disabled and other consumers relying on public transport

- Buildings in some cases provide an additional barrier to access, partly through location but also limited access because of design and access for disabled consumers eg stairs and corridors.

The Forum also made suggestions on improving current primary health care in the ACT. The objectives envisaged for primary health care in the ACT included:

- the need to improve continuity of care with seamless primary health care especially between GPs and a wide range of other health care professionals such as physiotherapists, dieticians, chiropractors and naturopaths
- continuity of care also needs to extend to home and community care as well as to the secondary and tertiary health care sectors
- that women should have a choice of the gender of the GP providing care, this is of particular importance for older women
- the removal/reduction of cost barriers to access primary health care.

The achievement of these outcomes depended on cooperative development between the governments, both Territory and Federal, the health care professions and health care consumers.

Health care workforce structures and roles are a basic part of limiting or enhancing change. The current roles of health professions are predicated on government regulation and funding, health professional education and training, control and attitude of individual health care professions and health care consumer awareness, advocacy and acceptance. Improved health literacy of the community and particularly health care consumers is one essential requirement to achieve change.

Models of care

The models describe how the system should work but then modified by taking into account the real world of workforce issues and budgetary constraints. A major concern raised in the Forum was that of the GP shortage. Much of the discussion was centred on whether the current role of GPs as the central figure in primary care and as the gatekeeper was still necessary or appropriate. Were there ways of organising primary health care that were more effective, that made better use of the GPs skills and training and utilised the enhanced skills of nurses, nurse practitioners and allied health care professionals?

The current models tend to be driven by process and management not by the objectives of health outcomes and presumably fairness and equity.
Comments and discussion on the models of care related to the need for flexibility to meet the needs of particular groups, populations and locations. The following comments emphasise the need to step back and think about what it is we, as a community, want from our health care system and the issues that warrant further development and consideration.

- Re-conceptualise how we think about health and well being to take in more alternate views; concentrate on health outcomes not process.
- model of health care to be based on social determinants, this would develop linkages with housing and disability services
  - this will also require improved liaison and coordination between government agencies and portfolios eg housing, community services and welfare agencies
- the health care system and health care context is changing: many things a GP once did are now done by others, e.g. pharmacists can write sick leave certificates, allied health care professionals such as nurse practitioners can now issue prescriptions and psychologists can access medical benefits payments

- Increased emphasis on effective illness prevention and health promotion
- Any new system should include a capacity to change and manage that change
- Need for different models to meet the range of needs of various groups and communities - no one model is the answer, there is a need for flexibility and a range of options to be available
  - consumer input into fitting the model to the need is essential
- New models should look new or expanded roles for health care professionals and the possibility of different roles depending on the needs of the community
- An essential component of the primary health care system is an integrated care system; a critical requirement is an integrated and comprehensive health information system (the role of e-health).
- Care needs to be integrated with continuity of care tailored to the needs of individual consumers
- Improved health literacy of health care consumers is an important requirement for most models of care

Issues

- GPs are not necessarily the "centre" of primary care – rather they can be a member of a primary care team
  - role of GP as gatekeeper is potentially a problem – resulting in restriction of access to other primary health care
- Develop new models that do not involve a GP
- Development of a health care coordinator was supported
  - possibly a role for nurse practitioners in close relationship with GP
- Try a Nurse Practitioner led Walk-in Centre
- Use of nurse practitioners and physician assistants
- Expand the range of allied health care professionals available within the primary health care system
- Consumers should not be financially disadvantaged if an alternative model of care is used
- There is probably a need for a GP at the centre of care management for chronic conditions.
- GPs should be required to go to aged care facilities and places of need
- A public awareness campaign should be undertaken to have the community on side for positive change so consumers understand the rationale for new models of care
- Demographic maps need re-evaluation to take account of communities that are not necessarily obvious, for example, Sudanese women and changing demographic flows.
- Continuity of care should take place across specialised areas, e.g. disability and aged care.
- More scholarships should be available for training in allied health professions.
- Dentistry should be included in primary care as is has implications for other health issues. A mobile dental unit could be put into action. See Victorian model already in use.
- Increased role for self management/treatment and self triage
- Models need to take account of the consumer eg routine monitoring of chronic care could be done by a nurse practitioner
- There may be some negative impacts from changed models – increased specialisation of care is likely to work more cost effectively but with increased centralisation of services

Fears about the future without changes

The Forum expressed concern that if there was to be no change the health care system and health outcomes would deteriorate.

- Reduced access to primary health care by consumers because of increased cost and poor health education and health promotion
- Access to health care will be increasingly linked to ability to pay
- Health status will increasingly reflect socio-economic status
- Good health outcomes will be skewed towards higher income consumers
- Increased specialisation in primary care – GPs need to retain a generalist approach and remain involved in "general" practice
- The health care system will move towards a USA system with increased division between public and private health care

Necessary steps

Rather than looking narrowly at the supply of GPs the task force should be reviewing how best to achieve the desired health outcomes. This review should look at the impact of restructuring the roles of the various health care professionals in overcoming the current access barriers caused by the lack of GPs.

- Develop a general practice team approach to primary health care
- Establish a strong consumer input not only to the development process but also to ongoing implementation and monitoring roles
- Develop a range of models of care that provide alternatives to a GP centred structure
- Provide GPs with a health care role that draws on their strengths not as a convenient financial manager through their "gatekeeper" role
- Ensure current e-health information developments are consistent with improving health information and providing timely access to that information to consumers and health care providers
- Make every effort to have ACT primary health care changes incorporated in the current round of national health "reform" initiatives.

GP Snapshot 2009 Summary of Results

The *GP Snapshot 2009* was designed to capture a snapshot consumer experiences and expectations of general practice in the ACT.

The survey was developed based on discussions with consumer representatives and members of HCCA. Secretariat to the GP Task Force had seen a draft of the survey before publication. The survey was piloted with a group of HCCA members. . It included issues such as whether consumers have regular GPs, waiting times, the quality of the interaction and demographic material and included a number of questions that the GP Task Force had asked practicing GPs

The survey ran from 15 June - 3 July 2009 and was publicized through HCCA members and networks, and media coverage in *The Canberra Times*, ABC Canberra and 2CC. There were 635 responses. We think that the number of responses demonstrated a strong interest in the community around this issue. Our preliminary analysis is included throughout the document.

HCCA will continue to analyse the results of the survey and post this to the HCCA blog at http://hcca-act.blogspot.com.