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POLICY OPTIONS

Supporting Primary Health Care Providers in western Sydney areas of socio-economic disadvantage

April 2016

King M, Usherwood T, Brooker R, Reath J

Policy context

We examined the challenges experienced by Primary Health Care Providers (PHCPs) working in areas of socio-economic disadvantage in western Sydney. Based on the Scottish “GPs at the Deep End” projects, our research provides insights into support needs at health system, practice and community levels in this challenging environment. Our recommendations are informed by recent literature as well as participant accounts from interviews conducted with 57 PHCPs and patients.

Policy options

The triple aim for optimising health systems performance (improving patient experience and population health, and reducing costs) has been supplemented by a fourth aim to ensure long term sustainability - improving health care provider satisfaction. Whilst it is this fourth aim on which our research focusses, we have found that in order to achieve this aim, the original three also require consideration. Hence our recommendations address actions across all four aims and at health system, practice and community levels in order to improve the provision of high quality health care.

Strategies recommended at health systems level,

- Define what we want from health services and measure outcomes to provide evidence for the efficacy of new approaches
- Develop policies to ensure those at socio-economic disadvantage are provided with access to timely and high quality health services
- Continue and enhance strategies aimed at establishment of a Patient Centred Medical Home approach in primary health care
- Enroll patients in general practices to enhance continuity and reduce fragmentation of care
- Review of health care provider access to Medical Benefits Schedule items to support those working in primary health care to work at the top of their licenses
- Continue to support integration of health services between primary and secondary/ tertiary health care
- Value primary health care and those who work in this health sector including through remuneration that rewards quality of care as well as throughput and acknowledges the particular challenges of working in areas of disadvantage, and
- Support primary health care organisations such as Primary Health Networks to advance these initiatives.

Strategies recommended at General Practice Level include,

- Support multidisciplinary team-based practices and prioritise patient-centred, personal health care particularly in the transition from small practices to larger group practices
- Re-inforce the value of PHCP roles in health care provision and in communities in which they work as a means of re-framing the challenges of working in areas of disadvantage
- Encourage local practice networks and other forms of professional and personal support for those PHCPs working in areas of disadvantage
- Use interpreters, employ bilingual staff and train staff in cultural competence where health care is provided in Indigenous, refugee and multi-cultural communities, and
- Encourage students and trainees to consider careers in areas of disadvantage.

Strategies recommended in the community include:

- Community-led health literacy programs including information on health issues, healthy lifestyles, roles and expectations of GPs, other HCPs and local services.

Key findings

Working in areas of socio-economic disadvantage such as those in western Sydney presents challenges for PHCPs. Interviewees provided a detailed description of the populations of western Sydney, in particular the Blacktown-Mt Druitt area. Whilst noting differences between the various communities, many commented on the cultural diversity of the region and the high rates of socio-economic disadvantage, closely intertwined with poor physical and mental health. A key concern was the high prevalence of complex health issues, especially chronic illness and multi-morbidity including mental health issues. Diabetes was highlighted repeatedly as a major health challenge.

Interviewees described the pressures of dealing with these complex health problems. High rates of socio-economic disadvantage meant that patients had difficulty accessing non-GP specialist health care and GPs were often struggling to provide treatment without this support and spending time, seeking affordable care options. This difficulty was often compounded by poor health literacy, with patient understanding, motivation and self-management described as a challenge for PHCPs working in this region, especially when there were also language and cultural differences. Supporting our findings, recent reports show that people of low socio-economic status and those with chronic health problems experience barriers to access, with cost-related and language barriers being those most commonly reported. Out-of-pocket health costs in Australia, including costs of over-the-counter and prescription medicine are growing and this results in patients failing to fill prescriptions, foregoing seeing a non-GP specialist or delaying care with predictable health impacts experienced in the secondary/tertiary health sector. These findings reinforce the importance of having affordable services and treatments readily available especially to those with serious illness who can least afford them.

In spite of these challenges the PHCPs interviewed set a high priority on quality care, addressing patient needs despite the time constraints and lack of financial remuneration for doing so, addressing needs beyond physical health, and maintaining an open and trusting relationship with patients. They described the rewards of their work in these communities, but also the toll it sometimes took. They suggested approaches to primary health care that assist in delivery of high quality patient care and support PHCPs and practice staff. Interviewees highlighted the role of the Primary Health Network in providing support and driving change.

According to our interviewees, multidisciplinary teams and team-based care assisted in reducing time pressures for GPs, improved access to services, also coordination and continuity of health care, as well as patient adherence. These comments align with recent evidence indicating that team-based care, particularly incorporating principles of the Patient Centred Medical Home model of primary health care, is associated with better coordination of care, more comprehensive care, improved access to services, shorter wait times and enhanced resource utilization. Barriers to optimal implementation of team based care in the Australian context which were highlighted in the interviews, included access to prescribing rights and Medicare items for Allied Health Providers

contributing to team care plans. Another challenge observed by some interviewees was the potential loss of a personal relationship with patients as practices grew larger. This personal relationship with the GP was highly valued by patients interviewed.

A key factor impacting on PHCP satisfaction raised frequently in interviews was a perceived failure of government to recognise the importance of general practice and primary health care. Interviewees noted the international evidence that primary health care has an indispensable role in preventive care and reducing hospitalisations and GPs reported anecdotal evidence of health care cost savings related to their role. Some however recognised that measurement of the savings would be required to justify a shift in allocation of funding away from secondary and tertiary care towards primary health care. Patient-Centred Primary Care Collaboratives approaches and Program Logic Models developed to evaluate health services integration projects may provide useful methodologies addressing this need.

Primary Health Care Providers in our study were also concerned about dysfunctional communication between general practices, hospitals, non-GP specialists and Allied Health Providers, often described as resulting in fragmentation of patient care. Other studies have reported similar findings and described adverse impacts on patient care, including higher rates of re-admission related to lapses in communication. Whilst implementation of health information technology and electronic health records have shown promise in coordinating care and improving efficiency, implementation of such technology has proven challenging and requires time, effort and adequate resourcing. Patient enrolment was proposed to facilitate health care coordination and continuity of care and suggested to assist in reducing health care costs through reduction in duplication.

Patient enrolment was also proposed to address another health systems factor reported by interviewees to be impacting negatively on primary health care. That is the fee-for service remuneration model for general practice. Participants commented that this model of payment encourages quantity over quality of service and doesn't cover non-face-to-face work undertaken by GPs. The requirements for MBS consultation items discourage task transfer from GPs to other staff that would enable all clinicians to work at the 'top of their license'. Patient enrolment payment as supported by professional organisations and recently proposed by the Australian government was widely held to be a step in the right direction.

Many of the health systems reforms suggested by PHCPs interviewed including payment reform, patient registration, team-based care and an electronic health records align with the "building blocks" of the Patient Centred Medical Home. This model has informed the recently announced Australian trials of the Health Care Home. Financial modelling and a pilot implementation study by Western Sydney Primary Health Network has produced a similar model incorporating flexible practice structures and approaches to team-based care. The blended payment system proposed includes fee for service payments, complexity payments for team-based care accounting for socio-economic disadvantage and cultural barriers, performance-based payments to recognise quality and equity of care provided, and capability and capacity-building payments to support general practices in their transition to this new model of health care provision. This approach to health care is a key strategy in the Western Sydney Integrated Health Care Program currently being implemented in partnership with the Western Sydney Local Health District with funding and support from the NSW Ministry of Health.

Our research provides insights into the needs of PHCPs working in challenging settings and recommends strategies at health systems, practice and community levels that are grounded in the research literature and informed by the experience of interviewees. It is clear that change to address these needs requires support from State and Commonwealth Governments, as well as cooperation from primary, secondary and tertiary care sectors.

The research reported in this paper is a project of the Australian Primary Health Care Research Institute, which is supported by a grant from the Australian Government Department of Health under the Primary Health Care Research, Evaluation and Development Strategy. The information and opinions contained in it do not necessarily reflect the views or policies of the Australian Government Department of Health.