

Robyn Williams: The final keynote, Tony Hobbs. He is a GP, he runs a multi-disciplinary practice in Cootamundra, New South Wales, and he chairs the Expert Reference Group developing a National Primary Care Strategy. Dr Tony Hobbs.

A strategic approach to primary care

Tony Hobbs¹

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Thank you very much. Can I acknowledge the traditional owners of this land and their elders, both past and present, and can I also thank Gordon Gregory and Jenny May for the invitation to come and speak to you this afternoon? It's great that the National Rural Health Alliance is holding their 10th conference. Congratulations and well done.

What I'd like to do this afternoon is just contextualise this a little bit. I want to keep this brief so we have time for questions for you to the panel; talk a little bit about the process of the National Primary Health Care Strategy; talk a little bit about some of the submissions we've received from many of you in the room, both as individuals and representing organisations with whom you work; and then talk about the future.

This is a very odd little photograph, a early photography of the complex in which I work in Cootamundra which is on the south-west slopes of New South Wales, a small country town of about 6000 people serving a population of about 9000. I'm one of the GPs in town. We do obstetrics and a variety of other operative procedures at the local hospital which is just juxtaposed.

It's a little bit of an odd photograph because it's a little bit left of centre and I think that sends a bit of a story. It's incomplete, so there's an agenda here that this is an ongoing piece of work, and I believe that this will be ongoing into the future. There's no name on the building at the moment and that's really significant because, when we established this building, working very closely with our communities and other health providers in our town, we really wanted to capture a couple of things; a move towards health, so we wanted to capture health and not just disease in the work that we do and we plan to do in the future, but also that primary care concept, much more comprehensive than much of the reactive, episodic care of the past. So that's a really, really important thing and it is now emblazoned right across the front there.

The other really important thing for me is that this is a shell. Yes, it does enable co-location of GPs, private and public allied health, dentistry, physiotherapy and a variety of services which our division of general practice and primary health has been able to put into the practice and into our community. But it is who works in that building and how we work together and how we integrate and work in partnership with our community which I think is the real essence of what we are trying to do.

And that's what really drives me to be involved in my local division. At the regional level, I'm trying to really drive those improvements in health care in our populations and moving more towards that comprehensive primary care, so moving more into prevention, health promotion, and enabling and encouraging our GPs and other people in the primary care work to take that more holistic and more population-based focus.

The other key ingredient here is that our local division also provides management services. So this is a public/private partnership. Private enterprise has built the bricks and mortar structure. State government has put in money for much of the IT infrastructure. The commonwealth government has put in money for much of the fit-out. We have a partnership with our local clinical school that has fitted out a room for students, and we also have a partnership with our local training consortia training GPs.

So we have that vertical and horizontal integration of training going on as well, which is a really key principle and I think is a key principle moving forward with the primary health care strategy. We have undergraduate medical students, just finished with two sixth-year students after a long stay. We have our first two nursing students from our regional university, Charles Sturt University, just started with us. We have registrars. We are waiting on PGPPP, our newly-graduated doctor is looking to gain experience in primary care and, of course, the rest of the workforce, nurses, doctors, allied health, all working together as part of an integrated team.

And that leads me on to another thing that I've been involved with for nearly 12 months now. When Nicola Roxon asked me to chair the External Reference Group which is giving the department and her office strategic advice and direction in delivering Australia's first primary health care strategy, I was very delighted, and I have to say honoured, to take on that role because it's a very daunting task, as you could well imagine.

She tasked us with looking at these particular concepts, not exclusively, but she did want us to focus on these: better rewarding prevention, promoting evidence-based management of chronic disease, very importantly supporting patients and their families and carers to better manage the chronic diseases, supporting the role of GPs in the health care team and also, of course, as Ruth has pointed out, addressing the need to improve the way that we use our current workforce, and also looking at the role of other workforce areas such as nurse practitioners and practice assistants, and all of this around a multi-disciplinary team, because there is very good evidence that that drives improved health outcomes.

So there's a group of 13 people which I chair—a group of doctors, nurses, allied health and some experts from the university sector—and we've been meeting over the last 10 months or so. We released our first discussion draft in October of last year and called on submissions around 10 key elements that we thought were really important in any national primary health care strategy.

Before I move on to those, I do need to respond to some quite strident criticism that we have received and I think it is just criticism, I have to say. There has been criticism that our first piece of work was really around service delivery rather than a more comprehensive primary care model. Now, I have to say that our remit and our scope was really around the service delivery model. However, as everyone in this room knows, you can't really talk about improving health outcomes seriously unless we talk about a much more comprehensive primary health care model that takes into consideration the intersectoral collaboration of those really important socio-economic determinants of health, so education, housing, empowerment both of communities, building community capacity and resilience, particularly in rural areas, and particularly in our indigenous areas, of course, and how you actually take that forward in partnership, both at a service delivery level with the individual patients, their carers and families sitting in front of you, with your local community and, very importantly, at a regional level.

So we have taken that on board—and I'm not writing the document—the department is writing that; we are giving advice—I do believe that that will be captured in the next draft document which is due to the Minister at the end of June, which is very close.

So there are 10 key elements, as I said. The first four are really around quality of care and health outcomes for those people we are serving in our communities whose health we are trying to improve—very key things. And, again, I think the second concept, for me, is really, really important. Again, you can't do this without improving health literacy, which is pretty abysmal in this country, and health literacy doesn't mean just about education; it really does mean about patient empowerment.

It's about safety and quality as well. We want to improve the safety and quality of our system and, by all means, we do have a very good system and that, indeed, was the overarching title of today's

presentation, How Can We Improve an Already Good Health System? So we want to build on what's working well at the moment, with quality and safety at a very high level. And, again, number 7, how do we better respond and reflect the needs and aspirations of our local communities?

And, of course, you can't take any of this agenda forward without talking about the workforce, who is in the workforce, how they relate to each other, and I think Ruth's presentation gave us some really key principles about how to do that work better and, of course, how we educate that workforce. And, of course, the strong message that we've got back wouldn't surprise you. It's about vertical integration and, very importantly, the interdisciplinary training of our undergraduates and also right through their work time. So for us older, grey-haired doctors and nurses, that's a really important concept as well.

And importantly, as we do have an aging population, as the second inter-generational report raised in 2007 suggests, we're going to have a shrinking workforce, working harder, supporting an older population, and with an increasing burden of chronic disease. So fiscal sustainability and efficiency and cost effectiveness is a very, very important consideration as well.

Submissions closed at the end of February. We received about 263 submissions. Nearly all of those are published on the department website and there it is for you. There were just a couple who wanted their reports to not be published. I won't go there.

Who made submissions? Well, a whole cross-section of the health community and other interested sectors. And they're the responses. Interestingly, from my perspective, number 10, which was around fiscal sustainability and cost efficiency really attracted the least interest and I'm not quite sure whether because people felt that they didn't have the knowledge or expertise to comment or whether they didn't think it was all that important. But, certainly, those key areas around access and community participation were very, very strongly represented.

So what I want to do is just distil some of these key issues out, particularly as they relate to our rural and regional populations, and then move to some of our thinking about how we can begin to provide solutions in a system that works for the whole country but here, with relevance today, for our rural and regional communities.

These are some of the key submission feedback that we got from you. It was about workforce to a very large extent. How do we improve recruitment? How do we incentivise people to come to rural and regional areas and, once they're there, how do we improve their experience and retain them in that local community for longer? How do we support our overseas-trained doctors, now providing around 40 per cent of primary care services in regional Australia or, if you live in an area like I do, more like 60 per cent, and that is a crucial factor. How do we best get our disciplines to work together in that model of care which is going to best meet the needs of our ageing population with their increasing chronic disease burden? And how do we educate that team?

Very importantly and something that's very dear to my heart and I know that came back very strongly in some of the feedback we had from many of you sitting around the room, including the National Rural Health Alliance, is around the concept of having regional planning and funding organisations so that, at that regional level, we can better respond to the needs of that local population because we know the population, we've looked at the data, we know where the gaps are, we can target those services and then we can measure it. So we can complete that feedback which is really important from not only improving health outcomes but also for accountability and transparency.

And, of course, as already has been pointed out, the critical nature of e-health is an important enabler in this, within the practice, between practices and then, of course, aggregating that de-identified data at the regional level so you know your population and you know then that you are improving health outcomes.

So these are some of the key themes that came back. This was from the AMA, really about valuing our overseas-trained doctors, about incentivising them about coming to rural and remote areas, but to make sure that they feel safe, culturally and medically, that their families feel wedded to those communities and to make sure that we support them there. It is a very, very important piece of work.

How we train the workforce—and I've already spoken to this. It is around vertical integration. It is around interdisciplinary learning starting at the undergraduate levels, and some of our universities have already taken that forward. And I believe the primary care sector has a really unique opportunity there, as long as we have the infrastructure, the space, that Ruth talked about, in our practices, and one of my delights already, after 12 months, is that we've not only had a medical students in our practice but, as I said, we've had our first lot of nursing students come from our regional university, and I'm looking forward to having allied health students into the future—so training the workforce of the future together so the teamwork becomes the expectation.

The National Rural Health Alliance talked very passionately and from an evidence base around the importance of regional planning and funding for the reasons that I pointed out, but also so that we can allow our communities to re-engage with our health system. One of the really strong points that came out as the National Health and Hospitals Reform Commission went around the country doing all that community consultation was how disempowered, disenfranchised local people felt from their health service delivery. And, again, if we are serious about improving health outcomes, if we are really serious about having a primary health care system, we need to be very bold about taking that forward and making sure that our local populations have a very important place in the governance of our regional organisations but also, I believe, in our local practices.

And, of course, the importance of e-health—one of the strengths of our practice is that every single practitioner, whether they're a nurse, an allied health person or a GP, has access to a computer, a dedicated computer. Now, that's a wonderful set up for us. Our nurses love it and it means, of course, that we can share information that people access according to their security level. Our patients are delighted because it means, within the practice, within moving from provider to provider, they don't have to retell their story, that all the information is there, and that has been excellent in the way that we have been better able to manage our patients and, obviously, actively help them look after their chronic disease. And also it's really important, of course, at a local population level if you're going to be talking about improving prevention and health promotion, knowing who smokes in your local practice, knowing who is drinking at at-risk levels, knowing those sorts of family histories so that you can target that and, again, measure that you're improving outcomes. And of course there's secure connectivity and of course, looking at our data both at the practice level to inform what we're doing and also at that regional level.

Now, some of this has been reflected in the budget and I know you've already had a presentation so I'm not going to dwell on that. But let me say that I think Nicola Roxon and her team have set some strategic direction in recognising a future role for nurse practitioners, in recognising an increased role for our midwives, working in a collaborative model so that we have better integrated care, that we improve access, and that's going to be very important and an interesting place to watch over the next 18 months or so.

Of course, there have been some budget announcements about changes to the geographic way in which we will be remunerated and incentivised, but just a caution here. These are very blunt instruments and I have some concern that there may be some untoward outcomes, particularly around some of our inner regional areas in which I now find myself. So I'll be watching that very carefully.

Of course, ongoing investment in infrastructure for local councils and divisions of general practice to build places so that primary care can be taken forward and there's some other ones as well. And I think, very

importantly and very excitingly, a new medical school in the Northern Territory and also those regional cancer research centres building on the CanNET agenda trying to link regional and rural providers with centres of excellence.

So what are the next steps? We're working very hard on developing the next draft of the strategy to present to the Minister by the end of June and, at this stage, I can't say a lot more about that. I'm thinking that there may be some limited opportunity to have further input and discussion into it. That will be up to the Minister. And, at this stage, I'm thinking that there will be a broad, overarching document with a much more detailed document as a compendium so that it captures the essence of the feedback, captures the journey to our first National Primary Health Care Strategy.

Thank you very much.

Robyn Williams: Thank you very much, Tony. Questions. Microphones in the usual places and you've got e-health, PAs and primary care to concentrate on with all our splendid speakers. And, Tony, I'll just get you a present.

Mr.....: Yes, a question about e-health. You mentioned there was some other—some different states having e-health already. Like, I work in Queensland in the hospital system and we have a discharge summary that's state-wide, or becoming state-wide—this is in Toowoomba. Will that kind of thing be used or will that be—something new will come over the top of that or what?

Kate Ebrill: Yes. No, that's a very good question. This is one of the key things around the strategy is how we already build on the work that's already happening in those jurisdictions. So we're working very closely with Queensland Health. Obviously, the head of Queensland Health sits on our board, and we also have the CIOs involved actively in our work program. So that discharge summary that's being rolled out was actually based on one of the earlier drafts of the NEHTA specifications and we're looking to work with the jurisdictions on how we take that and migrate that progressively to full compliance over time so that it's not -- not throw it away, invest all that time in change management and the infrastructure and throw it out. It's how, actually, we can move that over time. And the key thing is with rolling out the electronic discharge summary, the key thing is that the change management processes, you'll already be doing that and what the improvements will be over time is actually the foundations that support it which should really be invisible.

Robyn Williams: Okay. Up here, and then I'll go over there.

Mr.....: A question for NEHTA. You mentioned that one of the benefits of the IEHR was that it could be used as an information source for evaluation and analysis and so on. I'm wondering if there's an intention to also provide research access to the de-identified data on a broader front such as NHMRC- type projects?

Kate Ebrill: Yes, certainly, one of the documents that we released last year was a privacy blueprint around an IEHR and looked at the different access controls in it and how that would happen. So one of the key benefits is actually having access to that de-identified data for research analysis for population planning. That privacy blueprint is available on our website.

Ms: My question is very similar. I was just going to say that the Australia Card was a spectacularly unsuccessful. I'm just wondering how you're going to sell this in terms of consumers to accept this version of e-health rather than that?

Kate Ebrill: Yes, that is something that we do grapple with. I think there's been a lot of movement in terms of consumers' views around electronic health and identifiers. Certainly, when it started, as I said, seven

years ago when I started in Tasmania, there was a lot of work to actually allay fears and describe the benefits and get consumer input. Through the work and the research that we've done last year through both the national poll and also a series of consultation, we had an overwhelming response for actually support for it and I think there is recognition that to have something like an individual electronic health record, you do need that identifier.

The most important thing is this identifier is only used for health purposes and there will be strict legislative controls around it. So the government will also be undertaking consultation which I think was a big lesson around Australia Card.

Robyn Williams: Tony, do add.

Tony Hobbs: Well, it's really a question, actually. I'm really interested in who is going to control the health record. Will it be a patient-controlled health record? Will they be able to actually add things to the record? Not alter the record, obviously. And I think that, then, will help you market it because, obviously, it is in the marketing. All our patients want their health care improved by improved access to information in a timely and seamless manner. So I think it's how you market it, but I'm interested in the question around who has control.

Kate Ebrill: Yes, I absolutely agree it's how you market it and I think one of the key things that comes out through the consultation is, when you speak to clinicians, it's very important that they know that the clinical information has come from an authorised, validated source, but they also see the benefit of having consumers being able to enter their information. Consumers want to have access to the information that their providers have provided, but also want to be able to enter their own information into the record. Consumers wanted to be able to control access to the record and nominate which providers can view it, but they are very—in terms of the analysis and the research being done, they are very open to being able to provide that record to others to be viewed, as long as there are audit controls around it, that they're authorised viewers and they know that they're the people who are providing their care who are viewing it.

Ms: How do you actually get around the fact that, in Western Australia, for example, most medical practices -- there's about four different softwares they use. They're not compatible. It's very difficult to get information from one to the other. For example, pathology services can't access certain programs and vice versa. So how are you going to have a standardised software program though all medical practices to actually access the information?

Kate Ebrill: Yes, that's where NEHTA is at the very boring end of it. We are at those foundations and those specifications and developing those standards. So that's where we are developing the specifications to say this is how you must send a pathology result from one system to another. This is how a discharge summary should be sent, regardless of whether it's coming out of a SRNA(ph) system or an ISOS(ph) system or an Orion system and whether it's being sent to a medical director or to a Communicare(ph) or to a ferret or to a genie, this is the way that you exchange that information so that it is both human and machine readable.

The challenge is getting the industry to take that on and do it. This is where the government is stepping in around incentives. Starting with the foundations around secure messaging is one step in that. It's getting the end users to want to drive that change, and I think the announcements around the e-health strategy and giving the industry, who are calling out for standards themselves—because it's very expensive for them to keep building plug-ins for different initiatives—to actually have one set of specifications they can build on and having those specifications being international standards as well.

Robyn Williams: Tony, and then we'll go up to there.

Tony Hobbs: A really quick plug for the local boy, don't forget best practice.

Kate Ebrill: Not at all. Sorry.

Monica Persson: Monica Persson, Audiology Australia. I actually have a question for Tony but I can't resist a comment for Kate as I sort of visualise my ageing relatives being either interested or capable of looking after their e-health records. I suspect that some of the relatives I'm thinking of won't know where to find it, let alone take it to anybody. But, anyway, aside from that I wish you luck and we'll support you.

Kate Ebrill: I think the most interesting this is a trained 1000 consumers on how to access their record and most were over the age of 65.

Monica Persson: I'm thinking of my grandmother who's 92 who probably can't find a coffee cup let alone a USB or whatever it's going to be on. But as I say—maybe stick the USB on the coffee cup?

Tony, you mentioned the students and the like coming to Cootamundra. It's been brought to my attention that a number of students who have been planned for the future for NT will no longer have any accommodation. So I guess what I'm asking you to do in your auspicious position is to remind some of the government that one of the ways of actually getting student support and getting them to get the breadth of regional and remote experience is to be able to provide accommodation, and given that Darwin Hospital has had a fire warning over its accommodation and, therefore, I know our audiology students are at risk into the future and other health areas, can you please see if somebody can at least invest in some tents or something that might allow the education to continue in the areas that we want it?

Tony Hobbs: That is really important and one of the things we have been able to do, because we invested in it some time ago, is to provide accommodation for our students and registrar, and we saw that as a really important enabler for training and, of course, looking towards the workforce of the future. So I couldn't agree more.

Robyn Williams: Ruth, do your guys have to go camping in tents in the States, in Seattle?

Ruth Ballweg: Pardon me?

Robyn Williams: Do your guys have to go camping in tents?

Ruth Ballweg: Well, actually, not quite but the biggest issue we have for our rural students is whether or not they can take their dogs, actually. There you go.

Robyn Williams: I hadn't thought of that one. Yes, please?

Tony Smith: Question for Ruth. Ruth, the physician assistants' agenda, and I'm not sure whether the model is entirely right for Australia. I mean, just taking a model and transplanting it from one country to another with different health care systems doesn't necessarily work for me, anyway. Sorry, I should introduce myself. My name's Tony Smith. I'm from the university Department of Rural Health in Tamworth in New South Wales.

My question is, we talk about nurse practitioners and we talk about physicians' assistants now. I don't hear you talking about advanced practice roles for allied health practitioners or allied health professionals. I mean, is that a different agenda, or where are we with advanced practitioner roles for allied health professionals? You say that you used to be a social worker but now you're a PA. Why can't we have extended practice roles for people who can stay within their allied health profession?

Ruth Ballweg: That wasn't my assignment to talk about, but I actually know quite a bit about that. In the US we have advanced practice for physical therapists, occupational therapists, some mental health workers. The issue has been, however, that the more education they got, the less likely they were to be in rural communities. So they were more likely to stay in urban areas based on the number of years of training they had. And some of that had to do with who their spouses were. Anyway, so what people felt very optimistic about ended up not working as well as they would like it to have worked. However, I think there are models worth looking at and I support them.

Robyn Williams: Tony.

Tony Hobbs: Look, I think that's a really good question and I think it's a two-part response. One is, we need to utilise our current workforce much better than we do and that is for each of the separate disciplines working in a team to their competency and skill base. And that means we need to enable that to happen, and that's around allowing people to have the space, the infrastructure to support that, both bricks and mortar and IT, but also the way we fund that team. The way we fund it at the moment is very restrictive in allowing that to happen and, of course, that is exactly right. So what we need to do is have some more practice-based funding to give practices flexibility to do that better.

Rob Curry: Tony, Rob Curry, from the Australian Physio Association from Darwin. Listen, your ideas around the primary health care strategy were largely—and feedback you got—were largely doctor-specific. This probably sounds like bellyaching after some of the other questions that are allied-health related but it seems that we need to get much more serious, not just say the word “multidisciplinary” but actually have specific plans, ideas, initiatives around a genuine sense of the multidisciplinary team. I think Nicola Roxon sounds fairly serious about this and she's attempting to work on Medicare, etcetera. What's your view and what do you see the future in terms of a more genuine response to multidisciplinary care?

Tony Hobbs: Sure. Okay. Our response to this, really, was to look at the model of care that would best suit the needs of our ageing population with its chronic disease, and all the evidence would suggest that that is a multidisciplinary team and that's a team of generalist doctors, primary care physicians, ably supported by nurses working to their full competency base, and allied health specialists as well working as part of the team.

There are two problems, as I've said already. One is that we have a very disconnected, unintegrated system, and part of that is because of the funding system that drives it way. So we have commonwealth/state divide. We have private and public systems and people employed by NGOs. It's a very unconnected system. But certainly around our table we have had long discussions and we had several allied health people sitting around the table—psychologists, physiotherapists and nurses—so we will take that forward.

One of the interesting things is that we have a discussion that interactions and health care delivery needs to be evidence based. I think that confronts and challenges the medical fraternity and also allied health, and then how you actually fund that, but how you actually pull it together and integrate it for people with those chronic diseases. And we looked at the Wagner model of chronic disease management, for instance. So for those really very complex, very complicated people that may well need managed care in its good sense, not in its bad sense—others where it's really, really important for improved health literacy and education to help them take that forward, and the vast majority of people with chronic disease who do most of the work by themselves quite successfully.

So that's our approach to that and, as I said, in our own setting we work with allied health and I certainly acknowledge and appreciate their expertise and what they bring to the team and the patients' outcomes.

Robyn Williams: Any comment in response? Yes, he seemed happy with your answer. By the way, if there's one more question and you'd like me to come to you if you're a long way from a mic, just wave. Yes, please.

Ellen McIntyre: Thanks. It's Ellen McIntyre, from the Primary Health Care Research Information Service. I'm a researcher, this time. Kate, I really got very alive with your presentation. It was very vibrant and I'm not sure if I blinked and missed the opportunity when you spoke about the e-health record and the private health sector. How are they going to work together in terms of the data that they collect that, at the moment, they own but we don't see?

Kate Ebrill: In terms of the electronic health record, that is the thing in our national system of EHRs, is that you actually can have both the information being provided by the public sector, whether that comes through public hospitals, community health, information from general practice, and we're also working with both private hospitals and private specialists. So the key thing around individual electronic health record is that it's a consumer-controlled record where they can pull that information or it can get pushed in from those sources that they authorise. We are working with the private hospital sector to also get them to take up those standards as well. So it's certainly not public-sector based. It's across the whole health care system.

Ellen McIntyre: Final question up there. Thank you.

Shelagh Lowe: My question is to Tony. It's Shelagh Lowe from Services for Australian Rural and Remote Allied Health. There's a lot of rhetoric and discussion about multidisciplinary team practice and rural and remote health and workforce and the words out of Canberra and Nicola Roxon are very positive.

Recommendation after recommendation over the 20 years of this conference has been about incentives for getting practitioners into rural and remote Australia, and I must confess to being somewhat disappointed at the budget statements last week and the slide that you put up about the incentives for rural workforce all focusing still on our medical workforce and the need to extend those incentives for locum support and HECS reimbursement to other members of the health workforce as well as the medical practitioners.

Tony Hobbs: I couldn't agree more, Shelagh, and I think—well, my feeling is that what Ms Roxon is really waiting on is for the reports to come through and I think you'll see that agenda taken forward because, if we are serious about improving health outcomes, particularly in the more rural and the more remote areas, then we know from both locally and internationally it's very difficult to get doctors there and we need to build a team which best suits the needs of that local community. And that certainly means scholarships for allied health undergraduates. It means incentives to help them get there and other things such as housing, relocation, everything that's being offered to the medical fraternity at the moment. So I certainly take that on board.

Robyn Williams: Well, thank you, Tony. Thank you, Ruth. Thank you, Kate.

Presenter

Dr Tony Hobbs is a GP obstetrician at Cootamundra in the NSW Riverina district, where he has promoted an innovative model for integrated primary care. He is Chair of the Riverina Division of General Practice and Primary Health and the immediate past Chair of the Australian General Practice Network. Dr Hobbs chairs the National Primary Health Care Strategy (NPHCS) External Reference Group (ERG), which was established to assist the government in establishing the Strategy.

