Learning from other countries

Partnerships between primary healthcare and population health: preventing chronic disease in Australia

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Key messages

- The role of primary care in addressing lifestyle behaviours associated with chronic disease has developed incrementally over the past decade, and has led to greater calls for collaboration with population health.
- Major obstacles exist at the practice, local area, state and national levels to strengthen collaboration; strategies to address these obstacles have been identified as part of a joint public health and general practice framework.
- These obstacles have been especially evident for disadvantaged groups who receive 'inverse preventive care' from poorly resourced primary care and public health services in local disadvantaged areas.
- Health reform has created opportunities for extensive change. This requires not only good will, but also a mechanism to increase joint planning

with the aim of preventing chronic diseases, improving population health and reducing inequities.

Why this matters to us

We have a commitment to achieving improved public health and health equity through primary care. Mark chaired the joint committee which brought together the key organisations for general practice and public health between 2001 and 2004 and has conducted research on and contributed to development of guidelines for the prevention of chronic diseases in primary care. Elizabeth co-led the primary health care committee of the National Health Inequalities Research Collaboration and initiatives to improve primary health care as a strategy to implement health equity policy at state government levels.

ABSTRACT

In Australia, partnership working between public health and primary healthcare for the prevention and management of chronic disease has been developing incrementally since the 2003 consensus statement developed by the Joint Advisory Group of the General Practice Partnership Advisory Council and the National Public Health Partnership Group.

Australia's first national primary healthcare strategy (2010) provides a new opportunity to further develop this partnership, including multidisciplinary team-working in general practice for chronic disease prevention, and a new primary care organisation to oversee population health planning and health promotion. The needs of vulnerable and

disadvantaged groups will be a central focus of the new planning structures. However, major barriers continue to frustrate collaborative population based planning and service development.

Conclusion The jury is still out on how effective the partnership between state funded public health service and the new nationally funded primary care organisations will be. There is significant overlap in their functions, but few formal mechanisms for collaboration have been as yet established.

Keywords: chronic disease, preventive medicine, primary health care, public health

Introduction

In Australia the important role of general practice disease prevention has been recognised, as it has in the UK. This reflects the extensive reach of general practice into the community and the growing evidence of the importance of a strong primary care system. Increased focus on population approaches to prevention and early detection of chronic disease provides new and challenging opportunities for partnerships between primary healthcare and population health structures. While there are substantial health inequities in Australia and growing evidence that social gradients in behavioural risk factors such as smoking and obesity are becoming more evident the response by government and many professional organisations has been to focus on behavioural risk factors as a key point of intervention. There is recognition that behavioural risk factors play a relatively small role in creating health inequalities but they do represent practical action where primary health care and population health can work together.

Context

In Australia, most primary care is provided in the general practice setting by GPs, practice nurses, and allied health providers predominantly funded by a national, taxation based, universal health insurance (Medicare).¹ General practice works on a small business model, which is funded by patients, and by the government (Medicare) on a fee for service basis. Most GPs have no formal contractual arrangement with government. Over the past 20 years Medicare has increasingly funded annual cycles of quality of care that include general practice and allied health professions. Since 1993 many general practices have voluntarily affiliated themselves to local primary care organisations ('Divisions of General Practice') to improve quality through education and practice support; implement national initiatives; and link general practice with other parts of the health system especially hospitals.²

In 2010 these advances were built upon in Australia's first national primary healthcare strategy.³ The strategy aims to reform the whole health system and provide a blueprint for reform in four key areas: 1) improving access and reducing inequity; 2) better management of chronic conditions; 3) increasing focus on prevention; and 4) improving quality, safety, performance and accountability.

Mechanisms to achieve these reforms included: 1) new primary care organisations ('Medicare Locals')

to enable health promotion to be shared between primary care and other community and allied health providers; 2) personally controlled electronic health record system; 3) integrated primary care centres (called 'GP super-clinics'); and 4) practice clinical performance information (as a first step to performance payments).

Achievements so far

Partnership between public health and general practice has existed for a decade in the field of health protection, especially infectious disease control and immunisation. By 2001 there was increasing recognition by both general practice and the state and national public health services of the need to expand the scope of the partnership. In 2003, a joint consensus statement on population health was developed by the Joint Advisory Group (known as the 'JAG') of the General Practice Partnership Advisory Council and the National Public Health Partnership Group.⁴ This defined a broader population health agenda for general practice that included the 'prevention of illness, injury and disability, reduction in the burden of illness and rehabilitation of those with a chronic disease'.

The JAG acknowledged social, cultural and political determinants of health and disease. It envisioned population health being achieved through the 'organized and systematic responses to improve, protect and restore the health of populations and individuals'. It identified need for greater multidisciplinary working at the practice level. The JAG identified key areas for further development including organisational structures, communication, information management, workforce education and development, financing, partnership and referral networks and evaluation and research. Although the JAG was phased out in 2004, the framework continued to inform primary care programs and state and national governments initiatives.

An initial area of focus for the new public health and general practice partnership was the prevention of chronic diseases such as diabetes, by addressing the behavioural risk factors (Smoking, Nutrition, Alcohol and Physical activity - SNAP).⁵ Clinical interventions have used the 5As approach (Assess, Advise, Agree, Assist and Arrange) with key links with patient education and support from services and programs outside of general practice.⁶

Over the past ten years, there has been increasing focus on preventive care for chronic disease in general practice and state community health services, and an incremental implementation of some elements of the JAG framework. Major advances have been in the increased attention to risk assessment and brief inter-

ventions⁷ assisted by evidence based guidelines and decision support tools. There has also been funding for health assessments at critical life stages and for at risk population groups (including indigenous Australians and refugees) and nursing and allied health providers. Evaluation shows no major differences in uptake on the basis of socioeconomic status as defined by place of residence, but there is evidence of significantly poorer uptake by those with lower educational attainment.

Evaluation of brief structured interventions within primary care in smoking cessation, dietary change and increased physical activity has demonstrated improvements in uptake of lifestyle behaviours.^{8,9} However, this effect has been insufficient to bring about sustained reductions in weight or prevent chronic diseases such as diabetes and cardiovascular disease.¹⁰

Referral to group services and programs outside of general practice is thus considered an essential element for high risk groups. An increasing number of referral services and programs have been established for individual and group interventions to prevent chronic conditions.¹¹ In general their uptake has been low due to barriers at the patient, practitioner, practice and system levels.¹² Further, patients at risk of developing chronic diseases (who are generally older, in poorer health and may be eligible for access to subsidised private referral) are not well-served by the referral pathways used by GPs (such as public hospital services or private allied health providers).¹³

Future challenges

There is an increased concern that the many vulnerable and disadvantaged groups may not have access to and benefit from many interventions compared to more advantaged groups. It is also recognised that many barriers to long-term behaviour change are outside the health system and there needs to be a greater focus on these wider determinants of health.

There is a 17 year life expectancy gap between indigenous and non-indigenous Australians. The government is committed to reducing this gap and also reducing inequity in the delivery of services for aged and disabled people. Socially disadvantaged groups especially indigenous Australians are at greater risk of chronic disease. This is partly due to their higher rates of smoking, alcohol consumption, poor diet and obesity in turn linked to past and ongoing alienation and social and material disadvantage. Although annual health checks for indigenous people are funded under Medicare and there is a package of incentives to support better chronic disease,¹⁴ there are low rates of identification of Aboriginality in general practice. This means many missed opportunities for preventive care in this group.¹⁵

Rural populations are most at risk of chronic diseases but have less access to primary care services. This reflects largely the mal-distribution of a range of primary health care professionals in Australia.¹⁶ Refugees struggle with high rates of long term illness often complicated by psychological problems, poor health literacy and poor knowledge of the Australian healthcare system. There is only 49% uptake of Medicare funded health assessments among new arrivals.¹⁷ Many asylum seekers have no access to primary care.¹⁸

Efforts to address these inequities have included funding for low income groups to get nicotine replacement therapy, nutrition and physical activity programs for indigenous and other disadvantaged groups, and training for health professionals to work with these groups. To date, most of the effort by Divisions of General Practice has been on supporting general practices to improve their preventive care rather than on establishing or collaborating with networks of services and community organisations to promote health in the community.

Future developments

The 2010 health reforms create new opportunities for primary care and population health to work together. This includes complementing a traditional focus on health protection with brief lifestyle interventions and other health promotion activities.

New primary care organisations called Medicare Locals³ will replace Divisions of General Practice and have a broader scope. They will encompass not only general practice but the full range of private and public allied healthcare providers. They have a mandate to integrate a range of primary care services and to address inequities in Aboriginal health, the ageing population, and the increasing burden of chronic disease especially diabetes and mental health. They will coordinate prevention and early intervention programs, after-hours GP care, patient held health records and e-health provision. Medicare Locals will identify health needs of local areas and develop locally-focused and responsive services. They will address gaps in primary care service provision and deliver health promotion and preventive health programs. These represent significantly new roles over and above those carried out by Divisions of General Practice in the past.

The collaboration between state funded public health units in the Local Health Districts and the Medicare Locals will be critical in establishing joint planning of health services and integrating the delivery of preventive care. Although there is good will and common need on both sides, there is no ready mechanism for the development of truly integrated and

jointly owned programs. Medicare Locals need population health expertise to conduct needs assessments and population based health plans. Public health services based in Local Health Districts need primary health not only for health protection but also as key vehicle for delivering programs to reach at risk population groups.

Conclusion

The core functions of Medicare Locals and the core functions of public health significantly overlap (assessing population health needs, promote and support healthy lifestyles and behaviours, supporting growth and development through the lifecycle and promote the health of Aboriginal and Torres Straits Islander people and other vulnerable groups).¹⁹ They offer an opportunity to deepen the partnership between primary care and population health.

However, without mechanisms for the development of truly integrated and jointly owned plans and programs, primary care and public health are unlikely to be able to address the fundamental challenges they both face in preventing chronic disease and reducing health inequities. It is widely recognised that addressing health inequality in Australia requires action to address social determinants of health at all levels of the health sector in collaboration with government, business, civil society groups and the community.

ETHICAL APPROVAL

All of our research which is cited in this paper was approved by the Human Research Ethics Committee of the University of New South Wales.

CONFLICTS OF INTEREST

None.

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