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BUILDING PRACTICE CAPACITY FOR CHRONIC DISEASE MANAGEMENT IN GENERAL PRACTICE

DISCUSSION PAPER

for the

GENERAL PRACTICE PARTNERSHIP ADVISORY COUNCIL (GPPAC)

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1. EXECUTIVE SUMMARY

This report examines how to strengthen general practice capacity to deliver improved chronic disease care. Practice capacity is defined as the ability of a general practice to provide efficient, effective and sustainable care for patients with major chronic illness who attend the practice. The paper includes a discussion of the relevant literature and a summary of the current policy initiatives and how they are attempting to build practice capacity to improve chronic disease care.

The published literature suggests that improvements in a number of areas will enhance the quality of the care provided for people with chronic illness. The key areas are:

- Clinical information systems such as disease registers, reminders, feedback
- Decision support systems integrating clinical guidelines
- Delegation of roles and responsibilities from the GP to other health professionals
- Effective intra-practice team functioning and good team climate
- Linkages with community referral services and resources.
- Longer consultations
- Effective information management and data exchange
- Patient self-management support.

These elements of practice organisation are explored separately in the paper along with documentation of how existing programs and policy initiatives in Australia are fostering quality chronic disease care by improving practice capacity. There is evidence that to be effective any initiative needs to be multi-faceted, and to have a multilevel approach – single solutions are unlikely to be effective. The approach needs to be supported across five levels: individual GP, the practice group or team, Division/local community, State and National level. In addition, when implementing any changes, GPs/practices need to be involved in the planning and development phase to promote ownership and sustainability - a “bottom up” as well as “top down” approach, consistent with the philosophy of multi-disciplinary teamwork.

A series of recommendations completes the paper. These include the streamlining of the Practice Incentive Program (PIP) to create more flexibility and, in the long run, efficiency for a practice to develop improved capacity e.g. funding team-based care. There is a need to develop both a much more business-like approach to practice functioning and a more sophisticated analysis of the information currently available within a practice. In order to foster this development, Divisions of General Practice will need to be given carriage of the training for these developments across Australia. More research and analysis are required to look at the effect of practice changes and to document the current models that are successfully moving to a more business-like process within Australian general practice.

2. INTRODUCTION

2.1 BACKGROUND TO THE PAPER

This paper is in response to a request from the General Practice Partnership Advisory Council and the Department of Health and Ageing to develop a discussion paper on the practice structures and capacity required to improve the management of chronic disease in the general practice setting within Australia.

Effective chronic disease care has several elements, including:

- accurate diagnosis and appropriate treatment
- ongoing monitoring and risk factor management
- support of effective patient self-care
- attention to the patient's needs for illness care as well as disease management.

This paper focuses not on chronic disease management per se, but on practice capacity as one factor that is necessary (but not sufficient) for providing it. There are of course other factors that are essential – for example a coherent primary health care system with adequate referral and home support services – but these are not addressed here except as part of the broader context within which practice capacity operates.

This paper begins by reviewing the literature, the majority of which is from overseas, providing evidence for much of the discussion paper. To date, there is little specific Australian evidence around models of care for chronic disease generally, nor has there been much published evaluation of recent government initiatives. There has certainly been no comprehensive research into chronic disease care at the practice level in Australia, although such research is currently underway at University of New South Wales and University of Adelaide.

The paper discusses the concept of practice capacity and the role it plays in improving quality of care, taking into consideration features of the context in which general practices in Australia operate. Using key elements identified in the literature as contributing to the quality of chronic disease management and examining Commonwealth initiatives and programs implemented to support general practice, the paper identifies current barriers and enablers to improving practice capacity. A series of recommendations are presented that outline strategies for implementing and fostering improvements in practice capacity that would lead to improvements in the delivery of chronic disease care.

2.2 OVERVIEW OF THE LITERATURE

The prevalence of many chronic and complex illnesses is increasing in Australia [1] and a high proportion of general practice consultations are for the treatment of chronic diseases. Yet many patients are inadequately treated. Structured and organised care, including regular review, patient recall systems, education and support for patients in self-management of their condition, systems for auditing and monitoring care, has been shown to be effective in the management of chronic disease [2], but this model is not easy to implement in a general practice system oriented towards acute care [3]. Typically, consultations tend to be brief, acute symptoms and patient concerns crowding out less immediately urgent matters associated with patients' chronic illnesses. Little emphasis is given to the patients' role in management [4], with GPs often undertaking the main caring role with minimal involvement of other practice staff. Sharing care with other services providers is haphazard, and follow-up is often sporadic. Fragmentation of care and sub-optimal health outcomes are often the result.

Effective care of chronic conditions requires an evolution from such episodic, acute models towards a comprehensive system involving continuity of care across patient conditions, health care providers and settings over time [5]. This implies integrated pathways and collaborative working practices. In a general practice system oriented towards acute care, a re-design of the practice systems and changes in working practices are required. In some practices, this may involve a streamlining of existing processes, in others significant structural changes may be required.

There has been little Australian research about the specific organisational factors that contribute to effective chronic disease management. However, overseas research (particularly from the United States, e.g. Wagner's Chronic Care model) has shown that quality of chronic disease management is related to a number of key variables [6-8]. These include:

- Clinical information systems such as disease registers, reminders, feedback
- Decision support systems integrating clinical guidelines
- Delegation of roles and responsibilities from the GP to other health professionals
- Effective intra-practice team functioning and good team climate
- Linkages with community referral services and resources
- Longer consultations
- Effective information management and data exchange
- Patient self-management support.

These variables have been drawn from a range of research projects related to programs for single diseases such as diabetes, asthma, and coronary heart disease. In some cases, the number of studies has been small and they have been conducted under research conditions. Therefore, evidence is not strong for the effectiveness of the interventions when applied on a large scale under normal conditions. Nevertheless, various combinations of the elements described have emerged consistently, with no single component being either essential or superfluous [3].

There are clear indications that single solutions are unlikely to be effective. Ferlie & Shortel (2002) in their review of initiatives to improve the quality of healthcare in the United Kingdom and the United States conclude that a multi-level approach including consideration of the individual, group/team, organisation, and larger environment/system is necessary, with particular attention to issues of leadership, culture, team development, and information technology at all levels [9]. Similarly, Anderson Rothman & Wagner (2003) describe 'the need for multifaceted, interconnected changes to the organisation and functioning of practice to ensure routine performance of the tasks that are critical to chronic disease care'. Their review of literature suggested that the most effective interventions are complex ones directed at changing clinician behaviour, changing the organisation of practices, enhancing information systems and incorporating programs of patient support [10].

2.3 THE CURRENT AUSTRALIAN SITUATION

So how are we faring in Australia? For the most part, general practices in Australia are not performing at their maximum potential in managing and dealing with major chronic illnesses. National Integrated Diabetes Program data for 2002 suggests that less than 70 per cent of patients attend GPs who have signed on for chronic disease payments and PIP. While it is too early to draw conclusions from Service Incentive Payment (SIP) data for the specific disease areas, evidence from National Divisions Diabetes Program [11] and other surveys suggests that less than 50 per cent of patients with chronic diseases may be receiving optimal quality of care in general practice. Thus although our understanding of what are the ideal models of care to be implemented has grown over the last ten years, patients are still not benefiting from these advances.

It is recognised that there are features of the Australian health care environment which have hindered advancement in chronic disease care. One of these is the constitutional structure which impacts on the organisation of funding and the development of coherent national policies. A discussion of the difficulties imposed by the existing Commonwealth/State funding split is provided in Appendix 1.

Accepting this constraint, and drawing on the overseas research, it appears then that the focus for implementing change must be at the practice level. This involves a number of key elements, one of which is the organisational capacity of the practice. It is imperative that research be undertaken in the Australian setting, in order to build an evidence-base relevant to Australian general practice, which will lead to improved models of care for chronic disease.

3. PRACTICE CAPACITY

3.1 WHAT IS PRACTICE CAPACITY?

Practice capacity is the ability of a general practice to provide efficient, effective and sustainable care for patients with major chronic illness who attend the practice. The requirements for practice capacity vary according to location and characteristics of the practice and wider population. Improving practice capacity to provide high-quality chronic disease care will require an integrated approach that embraces a number of key elements such as:

- enhancement of the resources, infrastructure and organisational environment (both internal and external);
- the building of partnerships within and outside of the practice; and
- the building of problem-solving capabilities, including strategic planning and change management.

As the role of practices develops to include a broader focus on population health, the definition of practice capacity may broaden to include a wider focus than patients who attend the practice.

3.2 A FRAMEWORK FOR RESEARCHING PRACTICE CAPACITY

Based on a detailed consideration of the general practice, chronic disease and organisational development literature, and drawing on the ideas of general practice organisations and key personnel, the authors developed a framework for their current research. This framework is shown as Appendix 2. The first page is a representation of the broad environment in which general practice operates, acknowledging the multitude of elements which contribute to quality of care and improved health outcomes. Central to this is general practice. The second page develops the factors within the practice which directly impact on the capacity of the practice to deliver good quality chronic disease care. This reflects the complex interrelationship between practice characteristics, practice sub-systems and the mediators of practice function.

3.3 GAPS IN PROGRAMS WHICH HAVE THE POTENTIAL TO IMPROVE PRACTICE CAPACITY

Currently, a number of Commonwealth and other initiatives are in place to enhance chronic disease care in general practice. These are summarised in Appendix 3.

Although many of these initiatives contribute to practice capacity, they have not been specifically designed with this in mind. Some of them influence capacity by changing the organisational environment and the system of incentives within which general practice operates (Enhanced Primary Care Program, Chronic Disease Program, Corporatisation of General Practice). Some provide greater resources within the practice by increasing the workforce (GPs, practice nurses) or by supporting better practice systems in specific disease areas or treatment areas eg diabetes register/recall systems, prescribing, etc. Some provide better access to external resources (More Allied Health Services), whilst others boost support for practice capacity by Divisions (Alternatives to Corporatisation, Building on Quality).

The strength of having a range of approaches is that they could reinforce each other. In reality, the effort to date has not been coordinated, uptake has also been variable, and in the case of some of the initiatives has been limited to the rural areas where they have been implemented. Furthermore, some of these initiatives have been designed in ways that are not consistent with the way in which general practice works. One example is the way they focus

on an individual disease or treatment area rather than on a holistic approach to chronic disease management. Another is the lack of balance in support for the clinical and business aspects of the practice. Capacity building is also limited by the fact that MBS only covers services delivered by GPs within general practice. Practice nurses and other non-medical practice staff who could take a much stronger role in chronic disease risk factor management and patient education if their services were covered by MBS.

In terms of the impact on practice capacity, therefore, many of the initiatives have been fragmented and mostly of limited duration, which reduces their generalisability and sustainability. Most importantly, however, the impact of the initiatives on practice capacity for chronic disease care has not been evaluated which is understandable, given that this was not their primary purpose. This would seem a priority in the next 18 months.

In contrast, the Building on Quality (BOQ) and Divisions' Practice Support programs took a more integrated approach to building practice capacity, but further work is needed for them to provide a coordinated and sustained approach to building practice capacity.

4. ELEMENTS OF PRACTICE CAPACITY

The following section looks at applying, in the Australian general practice context, seven of the eight key components related to the quality of chronic disease management listed in section 2.2. Patient self-management is not included here as it is not directly an element of practice capacity. Each component is discussed in terms of the current situation and drawing on lessons learned from recent initiatives/programs. These lessons are focussed on how well they inform the debate on improving practice capacity. Also provided are some options for implementation. Additional thoughts about barriers and enablers to improved support for chronic disease management are presented in Appendix 4.

4.1 CLINICAL INFORMATION SYSTEMS

There is a body of research evidence which shows that many chronic illnesses (such as diabetes) can be better managed with the support of information systems, in particular computerised systems. These systems include:

- disease registers, which allow for the identification of patients with particular diseases, or at risk of them, the recording of treatment plans, test results, etc. and the tracking of clinical outcomes;
- recall or reminder systems, which provide the facility for systematic recall and review of the patients on a regular basis, according to clinical management guidelines.

The BOQ project identified registers in general practice as prerequisites to quality improvement. In addition, the EPC evaluation found some level of practice capacity already exists in practices to set up registers.

The use of registers and recall systems alone is not enough to improve health outcomes for chronic disease. It is also not yet clear which areas they are most important for. For example, their use with asthma patients has not been fully researched. Whether there are generic aspects of these systems that are applicable to all chronic diseases, or whether there are specific needs to be allowed for in some illnesses, need further exploration. However there is enough evidence that any improvements in practice capacity for quality chronic disease care should include this element.

Current Status

- The majority of practices have some form of IT systems in place
- Most practice staff have been offered basic IT training
- Some improvement in quality and range of medical software now available
- Division capacity: approximately 30% of Divisions have diabetes and/or CVD register/recall systems

Examples from Projects

Building on Quality Project:

- Identified IT/IM as a key component across all models
- Age/sex and disease registers were seen as prerequisites to quality improvement

Enhanced Primary Care:

- Practice capacity in setting up registers to identify and track their >75 patients for health assessments and systems for recalling patients
- Increased utilisation of computer generated forms for developing care plans

CARDIAB register-recall system:

- Forty Divisions and three Area Health Services have implemented CARDIAB
- Used for quality assurance, Division program planning and service development
- Associated with improvements in diabetes and CVD care.

Options for Implementation

- Staff development to enable practice personnel to fully understand and utilise the potential benefits of clinical information systems provided by Divisions
- Extended use of Division register/recall system

4.2 DECISION SUPPORT SYSTEMS INTEGRATING CLINICAL GUIDELINES

Management of many chronic illnesses is assisted by clinical management guidelines which are based on high-level evidence. Easy access to these is vital for the GP, so the use of the guidelines needs to be integrated into daily practice, in a way that allows simple reference to them if necessary during a patient visit. Changes to clinical practice have more chances of occurring when guidelines are actively disseminated (including training/education) and use patient-specific reminders for the GPs. It is also important that implementation strategies are developed in consultation with GPs and take into account local needs.

BOQ and other project initiatives have found that computerised decision support systems are acceptable to GPs.

Funding is required to enable the further development of, in a consistent manner and in partnership with the software industry, computerised decision support systems, along with on-going rigorous evaluation of their benefit. Further research is needed to understand how general practice utilises information and how information can be used at a practice level to influence the quality of care provided.

Current Status

- A majority of practices have some form of IT systems in place.

Examples from Projects

Building on Quality Project:

- GPs were more inclined to have greater ownership and usage of the guidelines when they were personally involved in the adaptation and development of locally based protocols for implementing the guidelines
- Decision support systems integrated within a clinical software package can be used and found acceptable by GPs.

Computerised Decision Support Systems:

- There has been some development of computerised decision support systems, as with the ADAGE trial for patients with hypertension (Department of General Practice, the University of Adelaide) and the asthma program at Central Bayside Division of General Practice, but their effectiveness is still being evaluated. How to effectively link with clinical medical software is unclear.

Options for Implementation

- Incorporating guidelines into desktop software
- Research to gain a better understanding of how GPs actually use guidelines in their clinical work.

4.3 DELEGATION OF ROLES AND RESPONSIBILITIES FROM THE GP TO OTHER HEALTH PROFESSIONALS

Patients with chronic diseases require time with their GP, regular assessment of their health needs and access to other health professionals such as podiatrists, dieticians and physiotherapists. Characteristics of a successful chronic disease care model include having an organised practice team and allocated tasks among them, effective management of patient contact (appointments, register and recall systems) and access to the services of other health professionals.

Both BOQ and EPC identified multi-disciplinary teams as providing essential support to GPs. Enhancing the role of the practice nurse was seen as the first step in developing multi-disciplinary teams and the Practice Nurse and MAHS initiatives have contributed to facilitating this development.
In addition to recent initiatives, further research is needed to understand and broaden the nurse/GP practice model. Consideration needs to be given to providing resources (similar to those provided to rural GPs) to GPs in metropolitan areas to support the utilisation of practice nurses and other allied health providers. Improvements in practice capacity will require new

models of multi-disciplinary partnerships to be documented, particularly those that can be shown to be efficient and cost-effective, across all general practice environments.

Current Status

- Some practice nurses are extending their role in care coordination and service provision. Practice nurses can assist doctors by contributing to a range of services, including chronic disease management and population health strategies allowing the doctor to focus more directly on diagnosis and clinical care. Practice nurses can play an important role in coordinating services for patients both internally and externally to the practice
- Practice Managers play an increasingly important role in setting up practice systems to support chronic disease care.

Examples from Projects

Building on Quality Project:

- A major theme that ran through, to some extend, all of the Division models was a move towards multi-disciplinary teams
- Multi-disciplinary teams would provide support to GPs and free up some of their time
- Enhancing the role of the practice nurse was seen as the initial step in developing multi-disciplinary teams.

Enhanced Primary Care Evaluation:

- MBS items have contributed to the shift in GPs thinking about how they use their time, the staff they employ and the way they relate to other community health providers
- Employment of allied health professionals by Divisions and/or practices was seen as supporting the development of multi-disciplinary teams within practices
- The practice nurse and MAHS initiatives were seen as useful vehicles for encouraging this approach
- The capacity of GPs to delegate some of the technical aspects of health assessments and care planning and some of the coordination work around case conferencing to others in the practice were viewed as encouraging a multi-disciplinary approach to patient care
- The ability to delegate, mainly to a nurse, a majority of the information gathering process of the health assessment was seen as contributing to its high utilisation.

Options for Implementation

- Further training and continuing education opportunities are required to support the broadening of the practice nurse role. This will require the inclusion of urban practices in the practice nurse initiative
- Clarification around the practice nurse's roles and responsibilities, and mutual respect developed between all parties of the health profession
- Further exploration of medico-legal issues of accountability
- Research and modelling be performed of both the financial viability of employment of practice nurses within the current financing structure, and the feasibility of government re-imbursement of patient services provided by practice nurses
- Attention to the workforce implications: for example potential competition between practices and state health services for scarce nursing resources.

4.4 EFFECTIVE INTRA-PRACTICE TEAM FUNCTIONING AND GOOD TEAM CLIMATE

Traditionally GPs have worked in isolation and the concept of working in teams is unfamiliar. Even today very few general practices work within a team structure. Evidence suggests however, that teamwork in primary care can achieve high quality of care for patients.

Characteristics of an effective team include:

- Having participative leadership (leader who creates an interdependency by empowering all members)
- Shared responsibility (all members are responsible for performance of the unit)
- Aligned on purpose (a common purpose as to why the team exists and its function)
- High communication (a climate of cooperation, trust and cohesiveness)
- Future focussed (see change as an opportunity for growth)
- Task focussed (a focus on results)
- Use of talents/skills (applying each member's skills, abilities and training)
- Role clarity (an understanding of each other's role)
- Rapid response (able to identify and act on opportunities)

EPC and the Alternative Models to Corporatisation project have witnessed a shift in the way some practices are functioning which is towards a team-based approach.

Research needs to be undertaken to identify current intra-practice team functioning within general practice. Not only looking at the visible formal factors, such as, policies, objectives, communication systems and job descriptions but also the submerged informal factors, such as, informal relationships, power networks, values and norms. There is a need to develop and document models of good team structures that promote high quality care. This work is currently one focus of research being undertaken by the UNSW and UA.

Current Status

- Practice Managers could take a lead role in building a good team climate
- "Champions" are emerging within practices who are taking on a leadership role
- Some practices have become more aware of the need for human resource management systems.

Examples from Projects

Enhanced Primary Care Evaluation:

- EPC items instrumental, to some extent, in changing the environment in which general practice functions

Alternative Models to Corporatisation:

- The Practice Management Coordination model (developed by the Whitehorse Division of General Practice) resulted in improved efficiencies in the daily operation of each of the four practices and also contributed to improve quality of care and services for patients. The model required a culture shift to a "multiskilled team" approach which is in line with modern management principles. To achieve this GPs and practice staff needed to work as part of a team in the conduct, writing and billing for the EPC items and other recalls and reviews.

Options for Implementation

- Divisions to provide training and support to general practices (build practice capacity) to facilitate a good team climate
- Development of models of good team structures that promote high quality of care.

4.5 LINKAGES WITH COMMUNITY REFERRAL SERVICES AND RESOURCES

To assist in improving chronic disease management general practices need to be aware of and develop linkages with community-based resources, eg self help groups, senior centres and exercise programs, and including other allied health care providers.

The BOQ project identified the importance of developing links and building partnerships between general practices and other health care providers. The EPC initiative has been instrumental in opening up dialogue between the key stakeholders.

In order to build partnerships it is important to identify local champions, build trust and provide appropriate time for the process to evolve. Further research and evaluation is needed to identify the features of successful primary health care partnerships that actively involve local general practices. These models need to be expanded and duplicated in other areas.

Current Status

- As gatekeepers to the health system, and specialist healthcare providers, GPs are seen as vital participants in any local primary health care partnerships.

Examples from Projects

Building on Quality Project:

- Recognised the need for general practice to work in a more coordinated way with other providers as an important component of addressing barriers to quality care
- Divisions have the capacity to engage with other agencies to ensure general practices have access to resources that support integrative activity, such as local service directories and web based access to patient information.

Enhanced Primary Care Evaluation:

- Whilst no major shift to greater integration was identified, the items have assisted in opening up some dialogue between GPs, Divisions, allied health providers and other organisations

- Bringing GPs and allied health providers together for training, case studies and patient management issues would assist in breaking down negative stereotypes and preconceived ideas each had of the other
- Further strategies need to be developed to enhance the linkages between GPs and allied health professionals
- The approach to managing patients with complex needs through collaboration with other health care providers needs to be embedded in both undergraduate and postgraduate training.

Options for Implementation
- Divisions to support the development of local/regional resource directories in a form that is easily accessible to GPs and patients and up-dated regularly.
- Divisions to facilitate the setting up of local partnerships, encouraging use of open communication channels and common referral systems.

4.6 LONGER CONSULTATIONS

Dealing with patients with chronic illnesses tends to be more complex, with a number of aspects of care which need to be coordinated, and in many cases, a range of co-morbidities to be dealt with. This requires longer consultations in order to satisfy patient expectations, to provide more holistic, comprehensive, good quality care, and to allow time for health education and development of patient self-management skills.

EPC MBS items have provided the opportunity for GPs to extend the length of time devoted to dealing with the health of patients with complex and chronic conditions. They have also indirectly provided reimbursement for non-physician time.

Alternative models for payment for more comprehensive services to patients with chronic illness need to be researched and trialled, such as one based on a capitation-type system. While not specifically related to building of practice capacity for improved chronic disease care, the freeing up of time for a GP to spend longer with patients, because of improved practice efficiency is part of the longer-term aim of these innovations.

Current Status
- Only a small proportion of attendances are currently charged at the level C or D rate.

Examples from Projects
Enhanced Primary Care Evaluation:
- The community care plan item provided an opportunity and incentive for the GP to spend time in the assessment and review of patients with chronic and complex diseases without loss of income associated with use of the prolonged consultation item (Level D)
- GPs and patients see value in the GP spending extended time with the patient to allow for a comprehensive review of needs and issues and the development of an appropriate care plan for treatment and services
- Suggested that a new MBS EPC item be created for the development of a ‘disease management plan’ for less complex cases.

Options for Implementation
- An alternative model to separate payment for services by GPs and nurses, would be to consider a capitation model of funding for all services provided to patients with chronic illness
- In terms of practice organisation, avenues should be explored which may reduce the pressure of GP workload and free up their time so that a larger proportion of long consultations can be provided eg research into nurses taking more responsibility for triaging of patient problems (whether over the telephone or face-to-face), implementing telephone call-back systems, providing care for routine acute problems (following protocols) and taking a leading role in management of education of patients with diabetes, asthma, etc.
- Changes to MBS to allow increased rebate for long and prolonged consultation.

4.7 EFFECTIVE INFORMATION MANAGEMENT AND DATA EXCHANGE

Information management refers to the means by which an organisation efficiently plans, organises, collects, uses, controls, disseminates and disposes of its information. This could include such things as:

- feedback or audit systems, which provide performance information to the GP of his/her management of the practice population with the specified chronic diseases, such feedback leading to continual quality improvement and evaluation;
- the utilisation of electronic/computerised clinical management modules which allows the complete range of data captured within patient management cycles (as above) to be appropriately managed, presented and automated.

Routine collection of data and the provision of feedback to GPs has been shown to produce improvements in the process of care. Unless information is available to provide a baseline from which incremental change can be measured, there is no way of identifying deficiencies in quality of care or evaluating whether changes to processes have brought about improvement. The systematic use of such audit procedures can be useful also in highlighting variations in care within or between practices, and consideration should be given to potentially incorporating them into the practice accreditation process. An essential part of this process is deciding what critical factors are to be measured, developing appropriate tools for measurement and setting standards for the chosen performance indicators.

Both BOQ and EPC identified information management systems as essential to supporting general practice to better manage information which can assist in promoting improved clinical, patient and practice outcomes.

Underpinning all this is the need to develop common terminology, clinical data sets and messaging standards across the health care system. Further decisions need to be made around consistent structures for coding of data so that information management technology can be more effectively employed to measure and evaluate chronic disease management performance.

Current Status

- A majority of practices have some form of IT systems in place
- Most practice staff have been offered basic IT training
- The need for common coding in general practice is being addressed by the General Practice Computing Group.

Examples from Projects

Building on Quality Project:

- Identified IT/IM as a key component across all models
- Data collection provides the opportunity to feed back personalised comparative data to GPs so they can review and reflect on their clinical practice

Enhanced Primary Care:

- Increased utilisation of computer generated forms for developing care plans

Options for Implementation

- Staff development provided by Divisions to enable practice personnel to fully understand and utilise the potential benefits of information management systems
- Strengthening of linkages between practice and Division IT systems to support quality improvement and collection of data on quality of care and population health outcomes to allow targeting of population groups
- GPs to utilise their patient data to review and reflect on their clinical practice – development of clinical audit tools
- Greater collaboration between Divisions and State population health services in the analysis and use of health data in program planning and development.

5. THE WAY FORWARD

Improvement in the quality of care for patients with chronic diseases requires structural changes to the way in which practices are organised and managed. This can best be facilitated in an environment where there is a consistent policy framework which supports and rewards both individual practices and Divisions of General Practice in their efforts to implement change. Lessons from previous projects should be built on. At the practice level, the emphasis needs to be on applying efficient business principles to their structures and methods of working strengthening linkages with outside services, enhancing the maturity of the information management systems and improving multi-disciplinary team working. Improvements in quality of care can only properly be achieved if accompanied by appropriate means of gathering relevant performance data which can be used to monitor and evaluate the care delivered as part of a quality improvement cycle.

5.1 CURRENT OPPORTUNITIES TO BUILD ON

The Building on Quality (BOQ) program provides an excellent model for Continuous Quality Improvement with enhancements in practice capacity. According to King (2001) "BOQ offers the foundations of a systemic approach to quality improvement, led by GPs and with Divisions as the supporting vehicle for change" [12]. The models developed by the Divisions involved in the project identified key elements for a systems approach in Australia and presented a range of improved outcomes for individuals, GPs and the broader health system that might be achieved through such an approach. Many of the lessons learned from BOQ models have helped to inform and support functions of the key components related to practice capacity presented in this paper. The next step is to implement these models and evaluate their effectiveness.

Similarly, other initiatives (eg EPC, More Allied Health Services and rural practice nurses) have provided the opportunity for improving systems and establishing networks within and outside general practice. These outcomes need to be harnessed and built on through better coordination/integration of the existing initiatives, rather than introducing any new ones. They should be integrated and linked to a strategic vision for chronic disease care in general practice.

5.2 THE ROLE OF DIVISIONS

Divisions of General Practice are now well established and their value accepted by the majority of GPs, so they would appear to have a central and on-going role in assisting the development of practice capacity. Most have already played a part in helping practices implement information technology and information management systems, including the use of either divisional or practice-based registers and recall systems. Many are currently offering support in areas of practice management, either through practice support programs, training programs for GPs and staff, or through direct provision of services. Others are involved in promoting application of quality improvement principles.

Not all Divisions may currently have an equal level of capacity or skills to offer such support therefore, some consideration may need to be given to reviewing and enhancing their ability to do so. It could then be expected that they would take responsibility (given appropriate levels of funding) for facilitating change management within practices. They are uniquely positioned to harness the skills, knowledge and enthusiasm of progressive practices within their Division, and to combine this with their own expertise, in a climate of peer involvement and support.

5.3 THE NEED FOR LARGER SYSTEM REFORM

Some of the broader issues which have been discussed as inhibiting development of practice capacity include the split of funding and policy making responsibilities between Commonwealth and State, as well as between government departments. This has resulted in poor coordination across policy initiatives, and funding arrangements which have not been conducive to promoting practice reform.

Although difficult to achieve, it would be preferable if one organisation could take overall responsibility for developing a vision for where chronic disease management should be heading in Australia, and ensuring that coordinated and consistent policies are made that will ensure its achievement.

5.4 ADDRESSING BUSINESS ASPECTS OF BUILDING PRACTICE CAPACITY

If GPs are to make improvements to the effectiveness and quality of care of patients with chronic illnesses, they need to be convinced of the financial viability and sustainability of the requisite multi-faceted system changes. For this to happen, consideration must be given to both internal factors of organisation and ways of thinking within the practice, as well as the external environment of general practice in Australia, which is influenced principally by government policies, especially those relating to finance and reimbursement.

Some of these elements are described in further detail in Appendix 5, and include:

- A focus on strategic and business planning, so that decisions about implementation of changes can be made taking into consideration the goals, resources and organisational structure of the practice. Sound business management principles and specialised skills need to be applied to introducing and evaluating these changes.

- The role of the practice manager in developing the capacity of the practice to introduce system improvements resulting in provision of efficient and high quality care needs to be recognised and valued. There are many possible models for how this function could be provided, depending on the size and structure of the practice.

- Consideration of forms of business structure, with uncertainty about aspects such as forms of legal ownership and size currently acting as barriers to making a commitment to making major changes. Alternative models to corporatisation, which provide the benefits of better practice management, need to be considered further.

- Changes to methods of financing and reimbursement, with the aim of reducing the piecemeal and sometimes short-lived approach to initiatives which have proved confusing and inefficient from the practice perspective. This needs to be supplemented with a review of the options for reimbursing GPs and allied health for provision of direct services to patients with chronic illnesses. The new NHS General Medical Services contract may contain useful ideas for new forms of incentives and support for developing infrastructure and capacity at the practice level [13].

5.5 ACCREDITATION AS A MEANS FOR FACILITATING CHANGE

The process of accreditation has forced most practices to consider the quality and level of facilities and services provided to patients, and to review or create policies and protocols regarding clinical care and practice organisation. The need for re-accreditation on a regular basis will encourage continued implementation and improvement of these protocols, etc, within a quality assurance framework. It may be possible within the RACGP standards to place even greater emphasis on the specific procedures and features which enhance chronic disease care. In developing these standards, consideration could be given to the quality indicators included in the new NHS General Medical Services contract, which relate to clinical standards, organisational standards, patient experiences and additional services provided [13].

5.6 MONITORING AND EVALUATION

Continuous monitoring and evaluation of the processes of good chronic disease management allows for constant assessment, revision and quality improvement. In fact, improvement is impossible without measurement: data collection is integral to all steps in the quality improvement cycle [14]. However, due to the pressure of day-to-day care within general practice, it can be difficult for clinicians to collect data systematically over time. Support from Divisions of General Practice can help in this regard, particularly in terms of assisting GPs to set up simple measurements which are built into daily work.

A more active role in data collection on the part of the Divisions is also desirable for building capacity in general practice for chronic disease care. Currently lacking is a comprehensive quality of care data set, collated at practice level across Australia. This is a significant gap. A variety of data are being collected by different agencies (see below), but either access is difficult, other than by individual GPs, or the data are aligned for a different purpose.

Current data sources available include:

- HIC Medicare data – difficulties with accessing practice level data quickly. Not all practices are eligible to claim PIP and SIPs (based on accreditation). Not all relevant data are recorded (eg cheapest 3 pathology tests are recorded).
- BEACH – encounter level data only, focus on presenting problems
- SAND – encounter data about risk factors, health status in general and health service use
- CARDIAB – suitable data but only 40 Divisions are using it. Division-level data collection is needed more widely
- David Brookman's Diabetes Audit Program – still being developed
- ABS – practice-level demographic data but not quality of care data
- Accreditation data – AGPAL do not make it available
- HealthWiz – postcode level data from General Practice Division of DoHA and census data from ABS.

The capacity of general practices to undertake high quality and sustainable chronic disease care is hampered by the lack of comprehensive and accessible data. There is an urgent need for systems to be set up within general practices which deliver information in a more comprehensive way and for practice level data to be collected in a systematic and efficient way. This is a role that the Divisions of General Practice can carry out with general practices. The information collected in turn needs to be collated at national level, so as to enable key issues and trends to be investigated (such as the impact of specific practice capacity characteristics) and the systematic measurement of progress and improvements to take place.

6. RECOMMENDATIONS

1. That the current disease-specific PIP incentive payments be converted into a more encompassing payment to practices to enable them to develop the practice capacity and infrastructure required to provide generic, high-quality chronic disease care, and to encourage GP behaviour change. Financial modelling should be performed to illustrate the benefits of this to all parties involved.

2. That initiatives which will facilitate the development of multi-disciplinary teams within general practice be maintained and extended. This could include:
   - the extension of financial support to practices for employment of practice nurses and allied health professionals to all areas of Australia
   - funding for direct patient services by non-physicians
   - a focus on training in the principles of teamwork and development of a team climate
   - a review of the medico-legal issues associated with delegation to staff of clinical duties
   - development and documentation of models of good team structures
   - modifications of GP software to facilitate teamwork in general practice (e.g. modules for miniclinics and nurse clinics).

3. That there be an evaluation of the responsibilities and capabilities of Divisions of General Practice to provide consultancy services, direct delivery of practice management services or appropriate programs of practice development support.

4. That resources be provided to Divisions of General Practice to enable further training for GPs and practice staff focused on the following areas of practice capacity:
   - sound business and financial management
   - development of practice register and recall systems and other decision support systems
   - human resource management
   - facilitation of team development (within the practice and with other community organisations)
   - alternative forms of practice structure (legal and organisational)
   - strategic planning and evaluation of performance.

5. That research into the links between organisational characteristics, practice management systems improvements, access, quality of care, and health outcomes be encouraged and supported in order to build an evidence base that is relevant to Australian conditions. This should lead to the development of valid performance indicators.

6. That methods of development of practice capacity be investigated, evaluated and disseminated. A cohort of practices and divisions across Australia should be researched on a longitudinal basis. This may require the identification and encouragement of leaders or champions within practices, with those practices being supported by divisions and promulgated as best-practice examples to their peers. This may be based on the Collaborative Models* aided by a group with technical expertise in chronic disease management and information systems.

7. That a single organisation be established to take responsibility for policy development regarding chronic disease care in primary care, including:
   - development of a coherent vision for chronic disease management in Australia
   - review of the current division of responsibility between State and Commonwealth bodies
   - coordination of any future government initiatives.

**As developed by John Oldham with the UK National Primary Care Collaborative and Donald Berwick of the Institute for Healthcare Improvement in USA.*

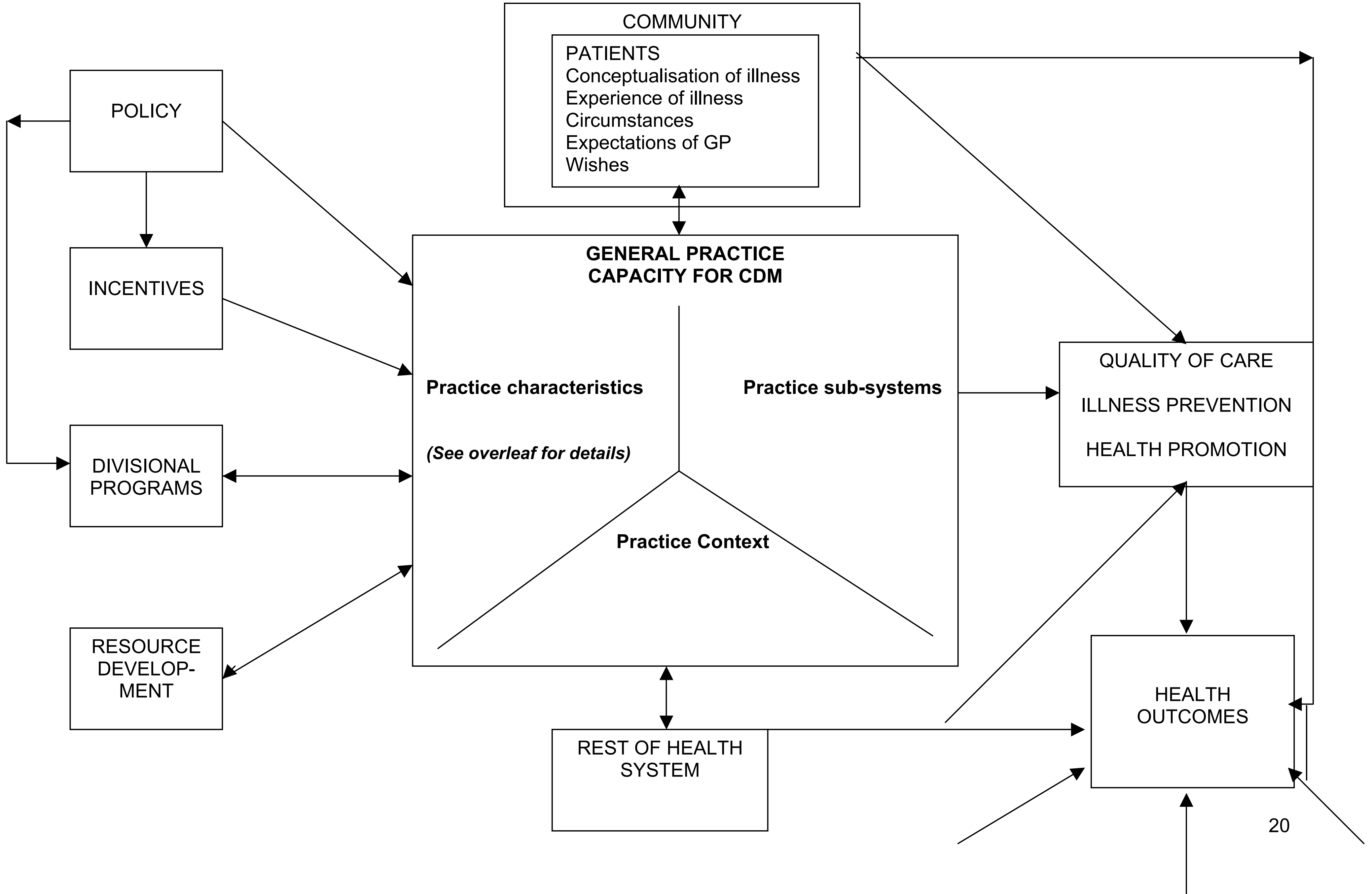
APPENDIX 1: LIMITATIONS TO ENHANCEMENT OF PRACTICE CAPACITY RELATED TO THE COMMONWEALTH/STATE FUNDING SPLIT

The current health care system in Australia is fragmented with multiple services, and a range of funding and regulatory mechanisms. While the Commonwealth government provides the bulk of the funding (through grants to states, or payments to individuals and providers via the private health insurance rebate, the Medical Benefits Scheme and the Pharmaceutical Benefits Scheme), most health care services are delivered through the States/Territories. The complexity of funding responsibilities of the Commonwealth and State/Territory governments are barriers to the development of cooperative and flexible working relationships between the different primary care service providers. There are issues relating to cost-shifting and tensions in relationships because the division of roles and responsibilities are not clearly defined or understood by the service providers. Because of the various funding, reporting and institutional arrangements, general practice, community health services, Indigenous health services, non-government organisations and emergency departments are working separately, creating a siloed approach to service delivery [15].

The siloed nature of government departments has also been identified as contributing to the increased work-load placed on general practice. This occurs when government departments and sections within departments coordinating different programs and initiatives have differing information and paperwork requirements.

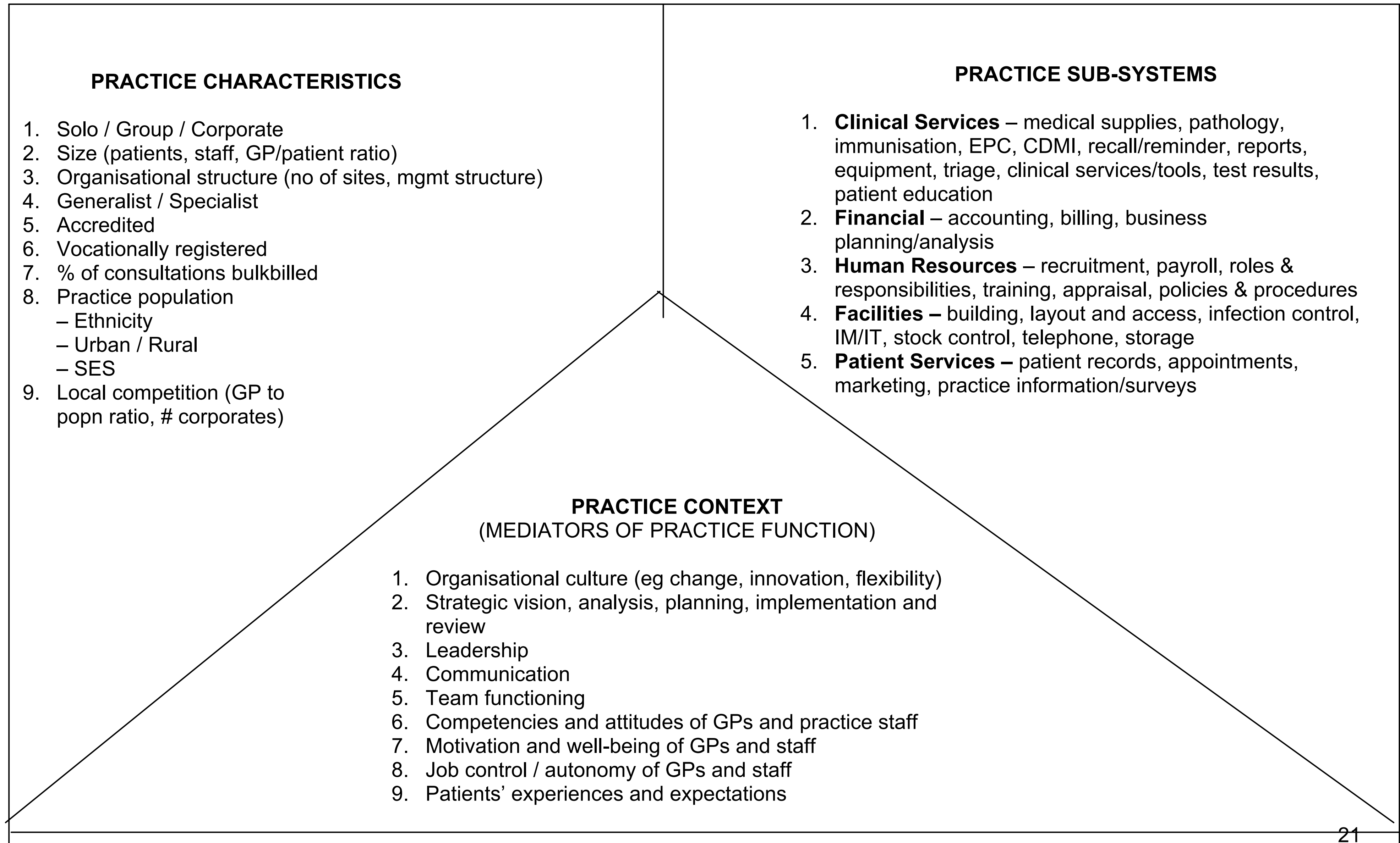
In a time when GPs are being encouraged to work within a multi-disciplinary approach funding arrangements are inhibiting the process. The introduction of the Enhanced Primary Care initiatives has provided the mechanism to improve links between GPs and allied health professionals, but the complexity of the system and lack of allied health services have been major barriers in their utilisation. While effective care of chronic diseases requires continuity of care, integrated pathways and collaborative working relationships between health care providers and their settings, lack of shared funding sources and shared professional culture and practice are seen as hindering this process [16]. Long waiting lists for publicly funded service providers deter GPs from referring patients and although private service providers may be available the cost of their services prevents many consumers from accessing them. Consideration could be given to alternate funding arrangements such as pooled funding [16] which can allow targeting on a regional basis to ensure adequate allied health and community care services, with the GP acting as coordinator. Increasing the co-location of services also has the potential to improve accessibility and integration of care between services.

APPENDIX 2: CHRONIC DISEASE MANAGEMENT IN AUSTRALIAN GENERAL PRACTICE



CHRONIC DISEASE MANAGEMENT IN AUSTRALIAN GENERAL PRACTICE

FACTORS AFFECTING PRACTICE CAPACITY FOR CDM



APPENDIX 3: SUMMARY OF EXISTING AUSTRALIAN INITIATIVES

A number of initiatives have been introduced since 1999 which impact on chronic disease management in general practice. A selection of those that have a bearing on practice capacity are listed below.

Initiative	Relationship to Practice Capacity	Comments
RACGP standards and practice accreditation program	Establishes standards for effective practice functioning and encourages development of practice capacity.	Does not directly address all the issues critical for chronic disease management (it does address some such as accessibility, patient education, linkages).
Enhanced Primary Care	Encourages teamwork with other health professionals and development of systems for coordinated care.	Implementation difficult for many practices, some structural barriers to effective team work, paperwork perceived as disincentive, not all practices/Divisions have registers. Does not provide financial support for practice capacity.
Practice Nurse Program	Provides staff to support GP role in assessment and management, patient education, routine monitoring.	Implementation restricted to rural areas. Patient still has to see GP for Medicare claim. Roles of practice nurses in chronic disease management variable and not always well defined.
More Allied Health Services	Support for GP role by referral to an allied health provider. Building practice capacity by providing access to additional services.	Roll out restricted to rural areas. Hampered by shortage of allied health workforce in many areas. Some competition/lack of coordination with state-funded allied health services.
Chronic Disease Program	PIP payments to enhance practice capacity (eg diabetes registers). SIP payments for providing specific care. Best practice guidelines	Uptake has been variable (depends on quality of division support). No standards available for diabetes registers at practice level.

Building on Quality	Division program focussing on 8 areas for improving quality in general practice, including organisational structure, IM/IT, culture change. Underpinned by Division support in enhancing practice capacity.	Excellent model for Continuous Quality Improvement with enhancements in practice capacity. But models not implemented and limited to six Divisions in 2001, with no clear way of taking it forward. No wider Collaborative.
Corporatisation of general practice	May strengthen practice capacity (through economies of scale and stronger administrative focus).	May indirectly weaken practice capacity through changed GP perceptions of role and loss of local autonomy.
Alternatives to Corporatisation	Explored different roles for Divisions in providing services and support for practices whilst maintaining GP independence.	Has identified apparently successful and sustainable models. Evaluation not yet available and thus far limited to seven Divisions and an SBO
Support network for rural doctors	Enhances capacity through supporting GPs.	
Better Medication Management System	Gives practices access to prescribing data for individual patients.	Requires permission from GP, any other health provider and patient to record or access information. Data not held at practice or Division level and so may be harder to access.
Increased rebates for GP services	Encourages longer consultations.	Workforce shortages reduce the impact of this strategy.
Divisions of General Practice support programs	Integrated approach to practice capacity enhancement.	Currently in early stages. Lack of evidence about what is effective. Lack of standardised data collection. Variable quality of support provided by Divisions.
General Practice Business Advantage program	Assists GPs to develop practice capacity.	Well accepted and widely used, but requires ongoing support for GPs to apply to own practice.
State-based chronic disease programs	Development of skills in chronic disease self-management. Linking State health services with general practice.	Focus on high severity, low risk patients who are frequent attenders or admitted to hospital. Low prevalence in general practice and late in disease progression.

APPENDIX 4: SUMMARY OF IDENTIFIED BARRIERS AND ENABLERS TO IMPROVED SUPPORT FOR CHRONIC DISEASE MANAGEMENT

CLINICAL INFORMATION SYSTEMS

Barriers	*Enablers*
• Under-developed IT systems • GPs not utilising their IT systems to their full potential • Resistance to change • Concerns regarding confidentiality.	• New EPC MBS items (Diabetes) to fund setting up patient registers • IT/IM support from Divisions • Forthcoming GPCG projects to specify requirements for practice level registers and the scope for analysis and feedback of practice data at Division level.

DECISION SUPPORT SYSTEMS INTEGRATING CLINICAL GUIDELINES

Barriers	*Enablers*
• Guidelines are generally for a single disease, while many general practice patients have co-morbidities • Lack of clinical decision support systems • GPs unaware of how to access and what web based resources and services are available • Some resistance by GPs to the use/validity of guidelines • Guidelines may not be specific enough for immediate application in general practice.	• MBS items (SIP) providing incentives to GPs to follow national guidelines in managing patients with diabetes and asthma • Guidelines disseminated and supported with CME through Divisions

DELEGATION OF ROLES AND RESPONSIBILITIES FROM THE GP TO OTHER HEALTH PROFESSIONALS

Barriers	*Enablers*
• Concept of a multidisciplinary care team is not well advanced in Australia • Workforce shortages • GP still the main focus of care • Acceptance of practice nurses as integral members of the multidisciplinary care team will require a culture shift for both GPs and patients • A major disincentive to employing practice nurses, for many GPs, is cost and lack of remuneration for non-GP/patient contact time • Practice nurse roles are not yet well developed in Australia • Concerns of litigation • Limited or non-existent allied health services available in the local community	• EPC MBS items provides minimal indirect remuneration for practice nurse activities • The Commonwealth government has provided additional funding to increase the range of allied health services (including practice nurses, psychologists and podiatrists) in rural and remote communities to support GPs • Divisions have the capacity to encourage and support collaboration and integration of primary health care service delivery at both a local and regional level • CareLink Centres established to assist GPs in care coordination.

• Lack of effective links between general and existing allied health professionals, especially community health workers • GPs lack of knowledge and awareness about what is available and how to access allied health services • Lack of time to coordinate patient care services.	

EFFECTIVE INTRA-PRACTICE TEAM FUNCTIONING AND GOOD TEAM CLIMATE

Barriers	***Enablers***
• Working as part of a team is a new concept for many GPs • Practice is based on the “medical model” • Lack of training for GPs in this area • Lack of resources (including time) to invest 'up front' in team development	• EPC items which provide an opportunity for integration, coordination • Role of Divisions in practice development

LINKAGES WITH COMMUNITY REFERRAL SERVICES AND RESOURCES

Barriers	***Enablers***
• GPs struggle to keep up with what community services are available, how to access them and often don’t have enough time to coordinate the services required for a patient • GPs have difficulty in accessing appropriate allied health services outside the practice. • In many cases the services are either limited or non-existent • EPC items such as care planning and case conferencing have remunerated and encouraged GPs to work in partnership with other health professionals. However, lack of time to coordinate the process, undertake the necessary paperwork and be an active participant are still major barriers for a majority of GPs. • EPC rewards GPs for their work, but does not support the services with whom they are expected to work.	• Integrated care models within the primary care setting enable disparate activities and services to come together into a coordinated system. For example, GP Homelink in South Australia. • Divisions have the capacity to encourage and support collaboration and integration of primary health care service delivery at both a local and regional level. • The Commonwealth government has undertaken specific initiatives such as facilitating Coordinated Care Trials and introducing new EPC MBS items aimed at promoting primary care partnerships.

LONGER CONSULTATIONS

Barriers	*Enablers*
• The current structure of rebates for patient attendance tends to reward doctors for fast throughput, which may be appropriate for simple or acute problems, but not for chronic illness. Only a small proportion of consultations are claimed at Levels C or D.	• EPC MBS items

EFFECTIVE INFORMATION MANAGEMENT AND DATA EXCHANGE

Barriers	*Enablers*
• Lack of education and training for both GPs and practice staff around information management (eg setting up systems to collect data, analysing data and data interpretation) • Lack of systems to enable patient shared records or access to specific information across the health system • Lack of capacity within Divisions to support information management initiatives • Lack of consensus about the analysis of practice data at higher (eg Division) level and about the role of Divisions in quality improvement • Limitations of having practice level systems (rather than eg the IPA level systems in some parts of New Zealand) • Lack of connectivity to other information systems.	• IT/IM support from Divisions • New trials by HIC and others to facilitate data exchange eg Health*Connect* • Forthcoming GPCG projects to specify requirements for practice level registers and the scope for analysis and feedback of practice data at Division level.

APPENDIX 5: BUSINESS ASPECTS OF PRACTICE CAPACITY

Some of the elements of practice management which need further research and development are as follows:

A focus on strategic and business planning

GPs have tended to focus on their clinical activities and individual patients, with lesser emphasis on taking an objective, analytic approach to making strategic business decisions about their practice. While this may have been adequate in the past, the weight of evidence for the importance of practice redesign now necessitates a new approach.

If a practice is to be financially viable, efficient and effective in the care of its patients, it will need to apply strategic planning, sound business management of all aspects of organisation and service delivery, and regular analysis of its performance. Techniques which can be adapted from the business world include the Balanced Scorecard as a system of strategic management and reporting [17] and the Plan Do Study Act cycle for quality improvement and implementing and assessing change [18].

Training for GPs and staff is vital in creating an awareness of the benefit of taking a business management perspective, and developing the necessary skills. Further development of the activities of Divisions of General Practice in providing education sessions as well as direct practice management consultancy, should be facilitated. Also important is the recognition that many of the tasks and skills of management require specialised expertise, eg a qualified and experienced practice manager.

The role of the practice manager

A good manager can create an environment that supports the GPs in their provision of high quality care, and frees the GPs to focus on what they do best. A practice manager is more than an office manager/receptionist/bookkeeper. He/she should be able to implement the strategic planning processes so that the practice has a clear long-term vision of its mission and goals, who it is serving, what are the critical factors for success, what resources are needed to achieve this, and how it will be measured and evaluated. In addition, the practice manager requires the skills to be able to develop and implement protocols and processes in the 5 commonly described general practice systems – financial, patient services, human resources, clinical services and facilities – and to set up the information management systems and team structures which will facilitate this. He/she also needs to be able to develop business cases to evaluate the consequences of implementing any new chronic disease initiatives.

Employment of a skilled practice manager is a vital component of developing practice capacity and such a person needs to be adequately valued and remunerated. The profile of practice managers is being enhanced by the existences of formal training courses, and the Australian Association of Practice Managers. For a larger practice, the volume of activity is usually sufficient to justify employment of a manager on both efficiency and financial grounds. For smaller practices, this may not be the case, yet the functions still need to be performed - so other models need to be considered. These could include employment of part-time managers, sharing of a manager between a network of practices, or sub-contracting of management services by Divisions. The latter could be either as fee-for-service delivery of specific management tasks such as recruitment and training of staff or setting up register and recall systems, or as short-term consultancies aimed at setting up systems which could then be managed by existing staff. Some of these models were successfully trialled under the “Alternative Models to Corporatisation of General Practice” project [19]. Greater application of these models may be inhibited by lack of appropriate expertise within divisions themselves.

Consideration of forms of business structure

The application of business management principles and the employment of specialist practice managers would appear to be more appropriately linked to larger practice size. The desirable features of good chronic disease management are more easily implemented in group practices. However, there is no reason why a solo practitioner who is motivated and supported by others, cannot also introduce positive system changes. Research has shown that no one type or size of practice has a monopoly on good quality care, and that it is difficult to define the optimal size of a practice [6][20][21].

Apart from practice size there is a further, yet separate, uncertainty about the appropriate form of ownership of practices. Australian GPs have traditionally valued the freedom of choice to operate within a variety of business structures, with professional independence being paramount. Thus there has been much resistance to recent pressures towards amalgamation (real or virtual) or corporatisation (usually involving buy-out) of practices. Yet the realities are that fewer GPs are willing to invest in a practice as a business, due to concerns about economic viability, effects on lifestyle, risks involved and difficulties in selling out and realising their equity.

This climate of uncertainty about the ideal practice size and structure and caution about business ownership is hindering efforts to implement systemic changes to chronic disease management within practices. Evaluation of the outcomes of the "Alternative Models to Corporatisation of General Practice" project would be useful, so that GPs can see the range of options available and evaluate which ones are likely to suit their personal preferences and circumstances. If the benefits of larger size and better management skills are to be attained, workable models could include:

- networking or amalgamation of practices and sharing of managers, or
- the setting up of service trusts by GPs to provide practice management services to a group practice, or
- provision of practice management services by Divisions, or
- creation of GP co-operatives, facilitated by Divisions [22][23].

Changes to methods of financing and reimbursement

Some recent governmental policy decisions and funding initiatives have assisted practices in beginning to provide the infrastructure and processes which are part of the chronic care model. These include:

- funding through Divisions for information technology support to practices;
- PIP payments for creation of diabetes registers at the practice level;
- MAHS payments for employment of allied health professionals in rural areas;
- practice nurse initiative for rural and selected urban settings;
- EPC payments for case conferencing and care planning which has provided opportunity for GPs to be compensated for time spent outside of direct patient contact;
- EPC payments for 75+ health assessments which has often provided indirect funding for the employment of a practice nurse;
- SIP payments for completion of specific services of care for asthma, diabetes and mental illness.

However, evaluations of many of these changes [24][25] reveal deficiencies or problems:

- lack of permanency of funding for specific projects through Divisions;
- excessive administrative time and cost of complying with PIP/SIP/EPC items;
- difficulties of non-principal GPs sharing the PIP payments;
- confusing changes to the rules for applying the new items in practice;
- lack of clear guidelines and education about new items;

- the “ad hoc” nature of the implementation of new items;
- GP resentment of the need to “prove” they are performing these services for patients;
- no MAHS-type funding or practice nurse support for urban areas.

In addition are the difficulties presented by the existing fee-for-service system in Australia, along with the rules for MBS re-imbursement for GP services to patients:
- the perceived low level of MBS rebate for direct billing, which creates a dilemma for GPs about access by their patients vs financial viability of their practices;
- a fee structure which rewards fast throughput, so acts against the need to be able to spend more consultation time with chronic and complex patients;
- limited avenues for compensation for time spent in liaising with other health professionals about chronic illness patients, and other non-patient-contact activities;
- inability to claim for non-physician staff contact with patients e.g. asthma educators, practice nurses, diabetes nurse educators, etc.

GP and staff morale, practice viability, quality of chronic illness care and patient health outcomes could all potentially be improved through a change of focus by the government, and a simplification of the payment system. The focus should ideally be on creating the infrastructure which would support pro-active, multi-disciplinary, longitudinal, preventive care of patients, and reward practices (not just GPs) for providing this systematic care, in a manner which is cost-effective. There also needs to be a shift away from initiatives related to specific illnesses, to facilitating improved ways of working which are generic to all chronic disease.

A move towards a tiered payment system, perhaps adopting some of the features of the new NHS General Medical Services contract [13] may be the answer. Instead of the current plethora of individual items and silos of funding, a simpler system may be to create a grant payment to practices to enable them to provide the essential infrastructure and capacity for provision of good quality care, along with a re-vamped MBS fees rebate system for patient attendance. This may or may not be associated with some system of patient linkage to practices, and/or a method of payment based on a capitation system. The grant payment would need to be tied to attainment of some agreed targets relating to organisational performance, quality of care and patient outcomes. Monitoring of these targets could perhaps be done as part of the re-accreditation process.

Some of the benefits from this would include:
- a reduction in the level of “red tape” associated with the existing system, thus conserving resources being absorbed at both practice and government levels;
- a more appropriate focus on quality of care and improved patient outcomes, rather than on quantity of throughput by GPs;
- greater flexibility in the skill-mix of staff employed;
- acknowledgement of the importance of good business management and organisational features of practices, and the ability to use grant funding to employ managers; and
- more satisfying financial reward for GPs.

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