Comments on consultation paper
March 2002

Primary Health Care Workforce and Population Health

GPDV welcomed the opportunity to attend the consultation workshop on Friday 22nd March, organised by the Australian Institute of Primary Care, as part of the Commonwealth-funded *Developing a Population Health Perspective in Primary Health Care* project. At the workshop, some concerns were raised by participants about the definition of population health in the paper *Primary Health Care Workforce and Population Health Activities: scope and potential.* Some participants criticised the representation (evident in Figure 2 on p.5, but also throughout the paper) of individual care and treatment at one end of the spectrum and policy/planning at the other, with population health in between, focusing on health promotion work, largely in community-based settings. One reservation voiced was about the policy/planning which is one of the activities (it was said) that the primary health care workforce does undertake. We would like to provide some more detailed comments about the other end of the spectrum: the individual treatment end, and the relationship between the population health work carried out by GPs and that carried out by the rest of the primary health care workforce.

Our concerns relate to:

1. The paper's message that population health does not apply to individual treatment/consultation;
2. The need for compatible frameworks for population health activities, whether carried out by GPs or other workers in the primary health care workforce;
3. The need for researchers and policy makers to understand the role of divisions of general practice when considering the divisions' role in population health.

1. The paper implies that individual-based work is not population health, yet some core activities defined as population health (e.g. immunisation) can be – and are – done in the context of individual consultations (as well as elsewhere). The Commonwealth definition cited in the paper mentions the individual as well as the community (page 3). The Joint Advisory Group on GPs and Population Health (JAG) has also produced a consensus statement which recognises social, cultural and political determinants of health and discusses "organised and systematic responses to improve, protect and restore the health of populations and individuals" which include "both opportunistic and planned interventions in the general practice setting." But this paper seems to imply that population health is always at the community rather than individual level.

   The focus of GPDV's work with general practices, through divisions of general practice, is on provision of individual services in a systematic, coordinated way to a delineated population. We do this by developing practice systems and enhancing practices' capacity to maintain a population health focus with the practice population, encouraging GPs to work with practice nurses and other health professionals to achieve this. Because the general practice system is built around individual consultations, we work to enhance that individual consultation, and use population-based approaches to do so, along with preventive and screening activities. In developing GPDV's strategy, we have used the JAG consensus statement on GPs and population health as a reference point.

Conceptualising population health as **always** divorced from individual consultation or treatment (which may include primary or secondary prevention) not only does a disservice to general practice, but will make it more difficult to encourage wide adoption of population health approaches in general practice. It will also reinforce the different 'cultures' in the primary care sector, where neither group has a good understanding of the other, which inhibits true collaboration.

2. We acknowledge the need for attention to be paid to settings other than individual treatment, for more emphasis on 'upstream' activities, and we also acknowledge that a substantial amount of work to develop general practice approaches to population health has been carried out elsewhere (through the JAG, Public Health Education for Clinicians Program etc.) so that the main focus of this project is on the non-GP part of the primary health care workforce. But it is important that the frameworks developed for the non-GP workforce and the GP workforce are compatible. Unless definitions and frameworks for activity are consistent, integration and coordination of the primary sector as a whole is unlikely to succeed.

3. Divisions of general practice are described in the paper (p.8) as settings with potential for population health approaches. This is quite true, although the focus of divisions might be to enhance the *GP contribution* to population health, rather than to run projects that resemble the types of examples outlined in the paper.

   The Divisions Program aims to:

   > *improve health outcomes for patients by encouraging GPs to work together and link with other health professionals to upgrade the quality of health services delivery at the local level.*

   Between 1992 and 1997 divisions conducted a range of one-off projects with all the usual problems that accompany funding of this type (inability to plan ahead; uncertainty about continuation of funding; problems of sustainability etc.) Project applications were often made on the basis of the areas of interest of one, or a very small group of GPs in the division. Divisions' move to Block Grant Funding in 1998 has allowed them to be more strategic in planning more integrated programs of activity.

   In this move away from project funding, Victorian divisions also moved away from health service delivery (in line with the policy directions coming from the Commonwealth). Generally, direct delivery of services to patients/clients is not a core activity of Victorian divisions. The Commonwealth's separately funded More Allied Health Services (MAHS) program is an exception.

   In their population health work, divisions emphasise enhancement of general practice systems, rather than provide broader community-level interventions. The aim is to involve all general practices, and to increase the quality of existing health services across the board, rather than to provide a new point of entry to the health system (e.g. through a health clinic for a specific group) with the involvement of only a few GPs. Although these sorts of projects may do excellent work, they may not generally enhance the quality of the GP contribution to population health. Their outcomes are also difficult to measure.

   Of course, measuring the contribution through a systematic approach in general practice is also difficult. Successful implementation requires signficant resources, such as those provided through the GP Immunisation Incentives Scheme, which provided incentives to GPs

to take a systematic approach to their practice population's immunisation status. (Features included systems for GPs to access information on immunisation status; prompts for GP to ask about status, reminder to patient about immunisations due; system for data management). The increase in immunisation rates that occurred through the promotion of a systematic approach, rather than the non-systematic approach which lacked all those features listed above, was measured through a national evaluation. GPII was one element of the government's 7 Point Plan to increase immunisation coverage, which resulted in substantial national immunisation increases from average rates of approximately 55% to average rates approaching 90%.[1]

The new Commonwealth incentives for chronic disease management provide an opportunity for general practice to adopt similarly systematic approaches to population health issues on other specific health areas (diabetes, cervical screening, asthma and mental health).

Chronic disease management incentives are a crucial part of the current primary health care policy context. It is important that the definitions underlying population health in this paper, and throughout the work developed as part of this project, are compatible with the JAG's. Although the work may differ in various settings, it is important to recognise that enhancement of the general practice contribution to population health is part of the wider adoption of population health approaches among the primary care workforce as a whole.

[1] KPMG Consulting, 2000, *Evaluation of the GPII scheme, Volume 1: methods, findings and recommendations.* Report prepared for the Commonwealth Department of Health & Aged Care. www.health.gov.au/haf/docs/vol1part1.pdf

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