

**Andrew Bonney**

MBBS, MFM(Clin), DRANZCOG, FRACGP, is Senior Lecturer in General Practice, Graduate School of Medicine, University of Wollongong, and a general practitioner, New South Wales.

**Elizabeth A Farmer**

MBBS, FRACGP, PhD, is Roberta Williams Chair of Medicine and Dean, Graduate School of Medicine, University of Wollongong, New South Wales. farmer@uow.edu.au

# Will the NHHRC recommendations drive quality performance?

■ **General practice is the heart of the Australian health care system,<sup>1</sup> addressing the health needs of people, in their communities and in diverse locations and contexts across Australia. With over 100 million items of service claimed by general practitioners each year,<sup>2,3</sup> even small but incremental improvements in quality have the potential to translate into population level gains in the outcomes and safety of general practice care. In recent years, Australian general practice has undertaken significant work in quality improvement, with practice accreditation to The Royal Australian College of General Practitioners standards and the Australian Primary Care Collaboratives Program being examples. Will the recommendations of the National Health and Hospitals Reform Commission (NHHRC)<sup>4</sup> enhance this work?**

Around 40% of all GP consultations address a chronic medical condition,<sup>2</sup> with this figure expected to rise with the aging population. Chronic disease management reform is on the NHHRC agenda, with particular emphasis on collaborative care. This will have a significant impact on Australian general practice. Two areas of recommendation linked with this agenda are the e-health initiative, and a blended payment system for aspects of chronic disease management.

It is not disputed that communication between medical practitioners, hospitals and allied health providers could be improved. However, the holy grail of a nation wide, patient controlled e-health record has been long coming.<sup>5</sup> The recommendations of the NHHRC are ambitious where previous efforts have failed: patient controlled electronic health records by 2012. There is potential for a well designed system to provide safety, efficiency and quality gains,<sup>6</sup> however hard data on outcomes is lacking.<sup>7</sup> Even if an efficient system was implemented, there is no guarantee that information transfer alone will translate into shared understandings of the patient among the health team.<sup>8</sup> Notwithstanding GPs' concerns regarding time consumed in implementation,<sup>9</sup> if the e-health record is unable

to convey pertinent information because it is cluttered with reams of irrelevant data, then safety, quality and efficiency will be lost.<sup>8</sup>

As with previous debates concerning reimbursement, the NHHRC's recommendation of a phased blended payment scheme for complex, collaborative care will cause contention. These blended payments would include a mix of grants, outcomes payments and bundled payments. There is some evidence of improved quality of chronic disease management with blended payment use,<sup>10,11</sup> but more evidence is required before wholesale system change is implemented.<sup>11,12</sup> In the meantime, payment mechanisms should allow sufficient flexibility for practices to assess their local needs and resources, to tailor solutions to fit, and encourage innovation. The temptation for funders to rely simply on disease specific endpoints for assessing outcomes (eg. HbA1c or blood pressure) must be resisted.<sup>13</sup> Movement toward locally relevant, community agreed outcomes can and should, however, be rewarded. The framework of service quality innovation and improvement established by the Australian Primary Care Collaboratives Program is a model of how this might be operationalised.<sup>14</sup>

Such a framework would also provide a logical step toward encouraging a research culture in general practice as a means of achieving quality improvement. The NHHRC has lacked vision in this regard. The recommendation for the establishment of clinical research fellowships in primary care settings is to be applauded.<sup>15</sup> However, their potential will be under utilised without adequate academic support for general practice. Appropriate funding of the vertical integration of medical training across general practices, hospitals, university medical schools and general practice vocational training providers is critical. Herein lays a ready made pathway for progression from student to practitioner/educator/researcher. This pathway needs strengthening, and the commission's recommendations supporting this are encouraging. Building research capacity in general practice requires not only protected time and funding, but in bringing academia closer to general practice. General practice research networks,<sup>16</sup> university supported and

commonwealth funded, are one possible solution using a range of contextually relevant approaches.

Finally, the NHHRC recommends national targets for access to care, including in general practice. The initial recommendation of the NHHRC is for access to a primary health care professional in no more than 1 day, and 2 days for a medical practitioner. Indications are that patient access to Australian general practice is currently reasonable<sup>17</sup> in some contexts but varies widely. However, the issue is complicated, as patients' choices in deciding whom to access and when, are complex.<sup>18,19</sup> The access targets will be meaningless unless they are backed by the resources to fulfil them, especially in chronically underserved areas. Information management, preventive care, chronic disease management, quality improvement, teaching and research all have opportunity costs attached which must be balanced against the resources available for acute care. Few other sectors in the health system are called upon to balance these competing demands within a single service. If such targets are ultimately accepted, one valid use will be as a trigger for signalling that extra resources are required where targets are unable to be met.

Will the recommendations of the NHHRC drive quality improvement in general practice? There are some encouraging signs, but insufficient evidence to be confident, and not unless general practice has a genuine voice in their implementation.

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