Strategic priority:
Supporting general practice as the cornerstone of primary care

What do we mean?

General practice is integral to a person-centred, efficient health care system as it is the central point of contact for most health care. An ongoing relationship with a general practice is associated with better health outcomes, better patient experience and contained costs.

Why is this a priority?

Australians rely on general practice more than any other area of the health system. Locally, 83% of residents visit their GP each year, slightly higher than the national average. The community's reliance on general practice will continue to grow as the population ages and the number of people who live with two or more chronic conditions increases.

There are currently more than 655 local GPs working in 205 practices, providing services to the 611,000 residents and 15 million visitors in south eastern NSW each year. In 2015/16, general practice in our region provided over 3.5 million services compared with 252,000 hospital presentations over the same time period.

What does the evidence say?

People with no regular GP or general practice tend to have poorer health outcomes. They are more likely to: be hospitalised; delay seeking needed and timely preventive care; receive care in emergency departments; to have higher subsequent mortality; and higher health care costs.

A survey of patient experience of general practice conducted by the Australian Bureau of Statistics identifies some of the country's best figures for our region. Almost 94% of adults in our region reported that their GP always or often listened carefully (the highest figure in the country). Over 92% of adults reported that their GP always or often spent enough time with them (the highest figure in NSW and above the national average).

Despite the high rates of people visiting their general practice each year, and the overall positive experience reported by patients, the full potential of general practice to improve overall health and wellbeing is not being realised. For example, a recent Productivity Commission Report has highlighted that very few patients talk to their GPs about preventative health, missing a valuable opportunity to address risk factors for chronic conditions.

To improve outcomes for people with chronic and complex conditions, the Australian Government is establishing 'Health Care Homes'. This initiative is in response to recommendations from Primary Health Care Advisory Group and is consistent with the international evidence on the benefits of a Patient Centred Medical Home approach. PHNs will be supporting local general practices in getting ready for this transformational change in primary care.

What have our stakeholders told us?

Members of our consumer panel have told us:

- they see their GP as key in supporting their physical and mental well being
- barriers to seeking help from their GP include waiting times, costs and not being fully aware of available services
- some would like to see more time taken to review their medical history and checking risk factors such as blood pressure
- they would like easier access to repeat prescriptions and test results, as well as being linked to support groups

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Local general practice staff, when asked about the support that they would need moving towards a patient centred medical home (PCMH) approach, spoke of the need for:

- building relationships between and across the sector
- improved engagement with Local Health Districts and allied health
- local clinical change champions to assist in building relationships and trust
- better information on the implications of change
- support for GP leadership and change facilitation
- better use of practice data and technology
- engagement of patients in understanding their role in a PCMH approach

What is our approach?

Our aspiration for this strategic priority is that general practice will be: person-centred; comprehensive, population orientated, coordinated, accessible, safe and high quality.

To achieve this, we will model our approach on Bodenheimer et al's ten building blocks of high performing primary care, and work with general practice to incrementally build capacity and capability to move towards the patient centred medical home.

Every GP and general practice in the region is a critical stakeholder for our organisation. Our local Health Coordination Consultants are dedicated to supporting all general practices to provide high quality care as well as implement system improvement and change.

Specifically we will:

- support the meaningful use of **practice data** so that general practices better understand the needs of their patient population
- work with practices to identify areas for **quality improvement** and support use of recognised improvement methodologies
- support roll out and increased use of **My Health Record**
- enable increased use of **secure messaging** to streamline the flow of relevant patient information across the health provider community
- continue to develop GP clusters and peer networks to build **local clinical leadership**
- offer **workforce and leadership development** opportunities
- use a collaborative approach to document **clinical referral pathways** and increase their use
- offer support and seed funding for **innovative projects** that enable general practice to move towards a patient centred medical home
- investigate the development of **health care neighbourhoods,** initially trialling the approach in a small number of clusters

We also actively seek general practice input into every aspect of our operations. This happens formally at three levels through GP representation on our Board, our two Clinical Councils, and through local clinical networks such as GP Clusters. As well, GPs and general practice staff provide input informally through regular contact with our Engagement and Coordination team, exploring how they can be involved in redesigning care models and implement activities that stop, slow, reverse and direct the flow of people in the system.