

7 Discussion – GP Super Clinics Program Maturing

The GP Super Clinics Program is part of the Australian Government's health care reforms and, in particular, reflects an increased emphasis on and investment in primary care.³ Primary care reforms are being implemented in most developed nations due to the impacts of the ageing population and chronic disease.^{3,4,6} The objectives of the GP Super Clinics Program reflect these factors with a focus on multi-disciplinary and integrated care to support care for older people and those with chronic disease. They also focus on the need for infrastructure and capacity to support and sustain these models of care.

This evaluation aimed to describe the context, development and short term impact of the program. To achieve these aims a variety of methods were used in relation to the implementation, establishment and operations aspects of the program. These methods involved the review of documentation, and surveys and interviews with stakeholders relevant to each of the three aspects of the GP Super Clinics Program. The results of each of these data collection methods have been reported in previous chapters. This final chapter aims to describe the implications of these results for the GP Super Clinics Program in the context of its objectives, particularly those related to patients and clinicians, and those more broadly related to the primary health care system.

7.1 Implementation Aspect - Policy to Program

Optimal outcomes from policy initiatives are more likely to be obtained when there is early and systematic consideration of the practical aspects of implementation into programs and/or services.²⁵ The Australian Government has a range of guidelines and regulations to support a systematic approach to policy and program implementation.

The results of the desk review process and interviews with Department of Health and Ageing staff demonstrate a high level of compliance with government program implementation and regulation requirements. Indeed, it is the opinion of the evaluation team that the implementation aspect of the GP Super Clinics Program has potential as a model for other program implementation processes.

7.1.1 GP Super Clinics Branch Capacity

Ensuring the skills and resources in relevant departments match the requirements is recognised as critical in policy implementation.²⁵ The funding for the GP Super Clinics Program did not include funds for its implementation. This gap was addressed by the Primary and Ambulatory Care Division of the Department of Health and Ageing by the flexible re-allocation of staff within the Division.

Critical to the implementation of the GP Super Clinics Program was the early identification of skills and resources required for managing capital programs. Some skills were available more broadly in the Department, and partnerships with a focus on contract management, tendering and communication were established. The engagement of a construction advisor may have added value to the establishment aspect if it had occurred concurrently with the contracting for construction of GP Super Clinics in the 2007-2008 tranche. General practice advice was needed

and obtained as part of the development of the *GP Super Clinics National Program Guide 2008* and was included in the ITA processes. These partnerships were invaluable in supporting staff within the GP Super Clinics Branch.

Many of the successes of implementation appear to relate to the commitment, knowledge and now corporate history of staff in the GP Super Clinics Program. Succession planning, is of course, a routine component of management within the Department of Health and Ageing. However, there are significant risks to the Program if staff leave, necessitating the need for rigorous systems to ensure protocols are in place to manage staff turnover.

The learnings of program implementation appeared to have been incorporated into systems within the Branch and, indeed, in other branches within the Department of Health and Ageing. For example, training in managing construction projects is now standard in orientation within the Branch, and amendments to the tool-kit of the Program Funding and Procurement Service have been made, reflecting Program learnings. These are indicative of an evolving program willing to apply lessons as part of an overall approach to improvement.

The development of the *GP Super Clinics National Program Guide 2008* provided an overview of the national arrangements for the Program including the funding arrangements and processes for application.² The *GP Super Clinics National Program Guide 2008* was deliberately broad and demonstrated the flexibility within the Program. This was critical for attracting applicants and enabling them to propose models which they believed suited the needs and context of local communities. It was developed through a consultative process and in line with guidelines and requirements for probity.

There was some confusion about content, timing of requirements and expectations for Project Plans after the establishment aspect. This may in part relate to the evolution of the GP Super Clinics Program over time, and the evolution in requirements reflecting learnings as the program progresses. Availability of all documents for desk reviews was not possible, and confusion in terms of the different plans has occurred. Contractual arrangements, including funding and reporting requirements, have developed over time. While there was evidence of this development in documents, it is timely to review all requirements for GP Super Clinics beyond the 2007-2008 tranche.

Two critical factors in GP Super Clinics achieving program objectives are clinical leadership and alignment between the clinical and the business models. These factors are described in detail in Section 7.4. In at least one GP Super Clinic this leadership was not evident. While the ITA process was transparent and sound and included rigorous assessment, it is difficult to capture the qualities related to leadership and alignment between the clinical and business models. If future GP Super Clinics were to be established this suggests the need for ensuring these as factors in the assessment processes.

7.1.2 Managing a Long Term Program

Each of the GP Super Clinics has a designated use period of 20 years from the date of commencement of operations. This requires a commitment by the Australian Government to the management of the GP Super Clinics Program for 20 years from the date of the commencement of the provision of services of the last of the GP Super Clinics to be established. Managing this

program will necessitate monitoring how the activities of each of the GP Super Clinics contribute to achieving the GP Super Clinics Program objectives over this long-term period.

Reporting occurs through completion and submission of an annual plan and reporting templates by the GP Super Clinics to the Department of Health and Ageing at two, four and 12 monthly intervals. In their initial stages, these templates have been set up to provide cumulative reports of activity and progress towards achieving the GP Super Clinics Program objectives. This monitoring activity will gain greater scale and complexity as more GP Super Clinics become operational placing significant demands on GP Super Clinics staff and those in the GP Super Clinics Branch.

Reliance on template-based reporting is inefficient and this inefficiency will increase once all GP Super Clinics are operational. In addition, without handling by Department of Health and Ageing staff, the template-based reporting does not have the potential for providing selective or indeed overview reports. Alternative reporting mechanisms, such as those offered by internet data bases for example, offer much more efficient options for reporting for GP Super Clinics Program Directors and Department of Health and Ageing staff more broadly, and importantly, for analysis of data over time. There has been some development of key performance indicators which are currently under consideration for application across the GP Super Clinics Program.

The current funding agreement provides contingencies to ensure GP Super Clinics are providing services as intended under the operational plan. The operational plan is required to detail the proposed operations and details how these will meet the GP Super Clinics Program objectives throughout the Designated Use Period. The funding agreement includes options for repayment of funds or step-in rights of the Commonwealth in circumstances where the GP Super Clinics are not providing services in line with the operational plan.

7.1.3 Recommendations - Implementation Aspect

1. The Department of Health and Ageing should consider a review process which aims to consider, critically review and document the evolution of the processes applied in the management of the GP Super Clinics Program. It would be expected that the outputs of this process would clarify requirements for plans, and associated milestones at all stages of the GP Super Clinics Program, would support Departmental staff within the GP Super Clinics Program and other similar programs.
2. The Department of Health and Ageing should explore options for efficient reporting systems, and examine the potential for internet based reporting.

7.2 The Establishment Aspect - Managing Funding for Construction Projects

The establishment aspect differed from other government construction programs such as the Building the Education Revolution (BER) Program where land acquisition and, for school projects in the various state and territory education systems, many Planning Authority or Council approvals were not required. Rather, the establishment of the GP Super Clinics is more akin to the processes required in commercial property developments. As a result, the capital component of the GP Super Clinics Program had to deal with the complexities of the land transfer and title, planning and zoning systems of states and territories, and the interweaving of

citizen, business, and government regulatory relationships which occurs in these types of property developments.³⁵

The Program provided significant funding for capital development of GP Super Clinics. This required robust contract and risk management. The establishment phase was also undertaken in the period of the Global Financial Crisis (GFC). The GP Super Clinics developments were hence subject to the construction industry and economic challenges of those times. All but two of the 36 GP Super Clinics across 37 sites were completed, with the non-completions due to inability of the funding recipients to raise funds they required above and beyond those provided by the Australian Government. One of these is expected to be completed when negotiations regarding additional funding are finalised.

A number of the sites were located on land owned by an authority, for example a state-based health service, which was provided under a variety of lease arrangements to enable the building of the GP Super Clinics. In a number of instances these were in locations which may not have been the preferred site of the GP Super Clinic Directors or may not have been optimally accessible for patients. However, the provision of land under these arrangements represented a significant investment at those sites in the GP Super Clinics and, as such provided opportunities which could not be ignored. However, in at least one instance, because of less than ideal access for patients, this may present problems in the longer term.

7.2.1 Evolution in Establishment Aspect

Managing programs with significant capital components is complex. It requires skills outside those normally available in government health departments. The GP Super Clinics Program has demonstrated evolution in the skills and understanding of the requirements for managing funding for construction programs. This expertise has contributed to the development of overall management and in particular to the development and evolution of the contractual requirements of the funding recipients as the GP Super Clinics Program matured.

7.2.2 Managing Delays in the Construction Processes

Delays in the various phases of development occurred in the GP Super Clinics Program. Many of these delays appeared to relate to inaccuracies in estimates, by the Directors and associates, of times associated with the processes required for the design, documentation and approvals for construction of the GP Super Clinics. Once the GP Super Clinics were committed to construction, the rate of completion almost universally aligned to contract requirements.

Given many of the GP Super Clinic Directors were medically trained it is hardly surprising that estimates of time for the other phases of development were inaccurate. However, particularly post-2010, most Directors contracted independent project managers who had a greater understanding of these processes and timeframe implications. These findings suggest the need, in this or similar programs, for funding recipients to include for the appointment of these management resources at project development stages much earlier than they might assume them to be required.

Land Acquisitions

Most GP Super Clinics developments that have included one form of land acquisition or another as an essential component of their delivery, have not progressed to the original program or Funding Agreement milestones. As with commercial property developments, it is common for construction projects that include land acquisition, to experience subdivision or consolidation of existing parcels of land commonly taking longer than the transfer of title in a single block of land because of the multiple processes involved.

Funding recipients should have an extensive understanding of these multiple processes and the resultant effects on final land acquisition. This was not evident and therefore is a potential risk not only to the funding recipients but also to the Department of Health and Ageing. The Funding Agreement approach of requiring a measurement of progress on land acquisition against only one milestone date – the date on which the funding recipient is to notify full and final tenure over the land - does not reflect a sufficient number of interim steps in the process for the Department of Health and Ageing to be able to monitor that progress effectively until too late.

Development Approval and Re-zoning

Development approval and re-zoning requirements are always unpredictable in any form of construction or property development. No-one is in a position to correctly anticipate planning approval times regardless of relationships with Council or Council members. Ultimately, the planning staff in the Council office, and the public in the case of public notification and consultation, will finally determine these outcomes.

In the GP Super Clinics Program 2007-2008, virtually all initial estimations of the timelines for DA approvals were inaccurate. In the initial design and development application submissions, funding recipients and/or their architects did not correctly anticipate Councils' requirements for these land uses. These errors in estimation have always led to delays, most of which were incorrectly blamed on the Councils.

The GP Super Clinics are generally classified in urban planning Law and Regulation around the country as a "Medical Centre" or "Health Care Building". Consequently, the GP Super Clinics have tended to be encumbered with significantly greater requirements for parking than other, similar land uses (e.g. professional offices). The relatively tight requirements of the GP Super Clinics within these two definitions (as opposed, for example, to "Shop" or "Office") has, in several cases, required some level of re-zoning because the existing zoning did not provide for this land use. In contrast, GP Super Clinics that have been or are being developed on "campus" land (whether university or hospital campus) have generally been delivered with fewer DA delays because "third party" Council approvals are not required.

Re-zoning (or Material Change of Use in some states) has always required additional, lengthier approval processes through Councils and has been a trigger for demands from Councils and Utilities for "extra-over" infrastructure works.

Funding

There is no evidence that any of the GP Super Clinics have been delayed by funding processes within the Department of Health and Ageing. The majority of funding delays have, in fact, been

budget over-run delays. The budget over-run delays have been, in the main, the result of non-existent, late or ineffective application of qualified design management or cost planning resources to the designs.

In a few notable cases, the legal securing of funding from third parties has been unreliable. The consequences of a shortfall of funds at or near the end of the construction phase of a project are always expensive and generally highly problematic for the progress of the project. This was evidenced by the circumstances behind the two GP Super Clinics which were not completed at the time of this evaluation due to their inability to secure additional funding .

Appointment of Contractors

Delays in obtaining Building Approvals (or Construction Certificates) to allow building commencement have generally been due to the “carry-over” effects of DA approval conditions into BAs. There has only been one instance of delays arising through poor documentation and/or tardiness on the part of a funding recipient. There has been only one instance of delays arising because the funding recipient chose a non-competitive construction delivery approach.

Construction Delays

There have been few, if any, major delays to practical completion during the construction phase, that have not been related to funding shortfalls. A significant number of GP Super Clinics have been delivered on program.

There has, however, been significant evidence of funding recipients not incorporating more “time is of the essence” provisions in their building contracts. Further, there has been significant evidence of funding recipients not using the preferred AS 2124 form of contract. In both these instances variation-driven delays and cost increases have resulted.

There have been a number of instances of funding recipients requiring design changes after construction has commenced or is well advanced. Design changes after commencement of construction always cost more than usual (because they are procured in a non-competitive setting) and nearly always delay the project. These design changes have been linked, in some instances, to problems with sourcing additional capital (by loan or other investment).

In summary, there are lessons and recommendations which are applicable more broadly for managing grants programs with capital funds for property development. Of all 36 GP Super Clinics across the 37 sites, which were commenced in the establishment aspect of the program only one is not continuing. This was due to the Funding Recipient’s inability to secure funding required in addition to the capital component provided by the Australian Government.

This failure to complete rate (2.7%) of the total number of GP Super Clinics committed or 5.6% of completions as at the date of the surveys needs to be viewed in the context of construction in Australia at this time. Given the financial conditions during the past three years this rate is very low. The Construction Sentiment Monitor published by Davis Langdon in August 2011 records: *“Worries about the GFC and a shortage of work have eased somewhat, while the relatively new problem in sourcing project finance persists.”*³⁶ Their projection of future risks included: *“Looking ahead, industry respondents do not expect financing difficulties to subside anytime soon. The cost, conditions and availability of debt are an ongoing risk to project viability.”*³⁶ The availability

of finance was the largest single risk to the property development and construction industries in Davis Langdon surveys (17%).³⁶

7.2.3 Recommendations – Establishment Aspect

The recommendations outlined in this section reflect the findings of the evaluation relative to GP Super Clinics established in the 2007-2008 tranche and the documents associated with this stage. Some of these recommendations need to be considered in the context that the GP Super Clinics Program has evolved and some may indeed have already been implemented. Importantly, in building on the lessons learned, these recommendations may have relevance to the development and implementation of other programs by the Australian Government, particularly, those which have substantial capital components.

3. Funding recipients should be required, in the application and post-application stages, to detail their understanding of the land acquisition process and the deliverables associated with each of these stages.
4. Funding applications that involve land subdivision or consolidation should be subject to extra scrutiny and review to ensure the timelines are realistic. In this regard, Risk Assessments and Risk Management Plans submitted by funding recipients should not be accepted until they accurately and properly recognise and plan for these increased risks.
5. The Department of Health and Ageing should move to continue and expand the process now in place and evident from the desk review of the later funding agreements to increase the number of milestones, milestone dates and the details regarding what these milestones are to produce, as outcomes for the land acquisition phase. The Department of Health and Ageing will then be in a better position to monitor the delivery of these more regular, detailed outcomes, with a view to demanding corrective action from the funding recipients if slippages occur.
6. Funding applicants should be required to submit, with their applications, parking studies that are certified by traffic engineers to be compliant with the relevant Council's published Parking Guidelines and the relevant Australian Standards.
7. Funding applicants should be required to submit, with their applications, a statement from the architect or urban planning consultant (if engaged at that stage) setting out in summary form what the consultant believes to be the relevant planning rules that the proposed development has to meet. In the Australian Capital Territory this is a mandatory requirement for a DA submission and is called a "Statement Against Relevant Criteria".
8. Funding applicants should be required to submit, with their applications, a statement from the architect or urban planning consultant (if engaged at that stage) setting out in detail what they believe to be the processes involved in Council, other agency and utility approvals. For preference, this should take the form of a Critical Path Gant Chart and be coordinated, with respect of Critical Milestones, with both the Funding Agreement Schedule of Milestones and the primary risks in the Risk Assessment and Risk Management Plan. These Gant Charts should contain significant "float" for the potential delay effects.
9. All Milestone Schedules should be expanded in both number and detail to allow closer monitoring of progress along the lines set out under "Land acquisition" in Section 7.2.2.
10. Timeline programs that describe requirements for re-zoning of land (variously identified as

“Material Changes of Use”, “Variations to Local Environmental Plans” etc.) should be closely inspected and interrogated for compliance with statutory, regulatory and likely procedures and outcomes. In virtually all jurisdictions, re-zoning is a process that rarely requires less than six months to complete and can extend to two years.

11. Proposals that require re-zoning of land should also be required to engage the services of planning consultants at the earliest stages of the approval process. A template for monitoring and reporting of the steps involved in any re-zoning process should also be developed and made the basis for monitoring by both the funding recipients and the Department.
12. In the cases of both land acquisition and re-zoning, a more pro-active approach by the Department in providing the reporting templates to the funding recipients at the outset will greatly assist in ensuring that adequate time allowances are made in project programs, early warning of variances from the process and program is given, and appropriate reactions and corrections to slippages are put in place.
13. Funding recipients should be required to provide from their banks or financial Institutions, letters of confirmation of sufficient funding to commence and complete the projects.
14. Funding recipients should also be required to establish stand-alone bank accounts for the receipt and expenditure of all funding for the projects and should require submission of transaction records, on bank letterhead, every month.
15. Non-competitive contracting arrangements should be discouraged unless the funding recipient can demonstrate substantial benefits from a non-competitive process.
16. Bills of Quantities should be required for all construction projects valued in excess of \$3 million.
17. Form AS 2124 should be mandated for use in all construction contracts.
18. The Department should refuse approval to proceed with the engagement of contractors until acceptable “time is of the essence” clauses related to variations, delays and extensions of time are included in the construction contract;
19. The funding recipients should only be permitted to vary designs after award of the construction contracts, when essential to the compliance of the buildings with applicable Codes and Standards. All other design changes to the size, amenity or function of the buildings should only be permitted after submission and prior approval of a written Impact Assessment to the Department by the funding recipient

7.2.4 Value for Money

The value for money assessment in the capital component of the GP Super Clinics Program determined that six of the GP Super Clinics were outside the criteria for value for money. If the extra-ordinary circumstances of three of the GP Super Clinics had been factored into the value for money assessments, it is likely that they would also have otherwise met the value for money criteria leaving three remaining sites as out of range of acceptable value for money.

There has been considerable debate in the property development industry as to the appropriate criteria for the measurement of value for money outcomes of construction projects. In a recent

example, the BER Implementation Taskforce used a methodology that defined value for money “as a product of three elements that the Taskforce and its Industry Advisory Panel saw as essential”:

- Quality
- Time
- Cost.³⁷

In assessing cost, this Taskforce used a “regionally adjusted” (for remoteness from the major population and industry centres) \$ cost per m² of gross floor area (GFA), noting GFA is a term defined by the Property Council of Australia.

This evaluation does not, however rate either quality or time in the value for money measurement; the former because such an assessment would have required extensive and detailed inspection of those 18 GP Super Clinics projects completed at the time of survey. It would also have created insurmountable difficulties in comparing value for money on completed projects with those still in construction and those on which construction had not yet started.

Time was not included as a measure of value for money because, unlike the BER program where the projects were on land always already owned by the schools and with little or no requirement (except in relation to the private and independent school projects) for Council approvals, the GP Super Clinics have been subject to a multitude of varied, additional development stages that would again have created insurmountable difficulties in comparing, for example, a project that required land acquisition and full Council approvals with one on a university campus that might have required neither.

The one other element of a value for money assessment that may well be valid to both the BER and GP Super Clinics Programs is whether or not the buildings delivered under the program meet a need, or meet that need in a sensible way. This assessment is not canvassed in either the BER Taskforce Report or in this evaluation. By way of illustration in the GP Super Clinics context, one could validly ask, subjectively, whether or not the addition of a 700m² second storey to an existing GP Clinic for a cost of over \$4 million represented value for money in comparison with, say, an alternative development on a “Greenfield” site. The relatively simple evaluation of this project on a \$ cost per m² GFA suggests that it does, by a margin of only \$67 per m², but the more subjective evaluation of meeting need may conclude otherwise.

The measurement and assessment of value for money aligned with construction industry approaches. The measurement was reliant on data provided by funding recipients in the survey responses in relation to cost elements, including breakdowns to be used in the value for money assessment. These elements were not readily available in most funding agreements; hence there was reliance on self-reported survey data.

The value for money assessments did not include evaluations of two significant components of the development costs of these projects:

- Professional fees

- Land Purchase cost.

Professional fees were not assessed as part of value for money because a number of the projects, to varying degrees, were carried out under “Design and Construct” contracts with many of these professional fees, therefore, incorporated in the overall construction cost per m². In addition the range of professional services required by particular projects and, therefore, the cost of the professional fees, varied considerably across projects. As an example, complex property acquisitions requiring re-zoning will inevitably attract more fees (e.g. for legal advisors, surveyors, planning consultants) than simple developments on “Greenfield” sites zoned for the required land use. Given these variations any uniform or standardised assessment tool would have affected the accuracy of assessments by either under- or over-representing the value for money.

Land acquisition value can only be properly assessed on an individual, site-by-site basis, using registered land valuers and industry accepted valuation techniques. Such assessment was beyond the terms of this evaluation.

It was not, nor are tools available for, a broader assessment in the context of primary care. In the longer term its assessment in terms of the contribution to evidence-based quality of care, patient access and experience, and clinician experience will be a more ultimate assessment of value for money.

7.2.5 Recommendations – Value for Money

20. Funding applicants should be required to provide the detailed elemental cost break-ups of their projects as was required by the Funding Recipient Surveys for checking against the templates prepared as part of this evaluation.
21. The Department should commission a review of existing templates and the preparation of specific value for money criteria for future use in assessment of Funding Applications for GP Super Clinics.
22. The Department needs to consider options for ensuring that non-construction cost components of the developments, such as land and/or building purchase costs and consultant’s fees are not inflated by Funding Applicants
23. The Department should consider longer-term approaches for assessing value for money in the context of primary care.

7.3 Progress towards Achieving the GP Super Clinics Program Objectives

The results of this evaluation have demonstrated that there has been considerable progress towards achieving the GP Super Clinics Program objectives. Where progress was less than optimal, opportunities for support for service development will need to be considered.

7.3.1 Multi-disciplinary Care

Multi-disciplinary care involves a range of professionals and commonly includes medical, nursing and allied health professionals. Multi-disciplinary care has been demonstrated to improve outcomes especially for patients with chronic illnesses.^{16,38} Key to the primary care

reform under the GP Super Clinics Program was improved care and outcomes for people with or at risk of a chronic illness, and for older people.

High quality chronic disease management requires “a longitudinal and preventive orientation manifested by well-designed, planned interactions between a practice team and a patient in which the important clinical and behavioral work of modern chronic illness care is performed predictably”.³⁹ Ideally, this requires an integrated and coordinated approach by a multi-disciplinary care team with regard to assessment, treatment, support for self-management and follow-up.³⁹

Evidence for multi-disciplinary care is derived from research on specific models and from the roles of particular disciplines. There is evidence that multi-disciplinary teams can improve outcomes in a range of patient groups.^{16,38,40} In both acute and primary care settings multi-disciplinary care is associated with improved clinical outcomes and other indicators such as reduced hospital admissions.⁴¹ Indeed, there is increasing evidence that the design of the care team and the contribution of disciplines are the primary determinants of quality of care for people with chronic illnesses.³⁹ Importantly, evidence exists that these outcomes accrue to disadvantaged groups within communities.²³

Primary care nurses undertake a multitude of tasks in general practice, only some of which are funded under some form of fee-for-service model.⁴² The funding arrangements changed in 2012 to provide incentives for practices to enable employment of nurses to undertake broader roles than those funded under the fee-for-service model. Nurses can provide the same quality of care and achieve equivalent health outcomes for patients with certain conditions as doctors, and given the right organisational climate can contribute to improving the quality of care in General Practice.^{42,43} Similarly, allied health staff in primary care have demonstrated improvements in quality of life and reduced hospital admissions for patients with chronic illnesses.⁴⁴

The elements required for effective and integrated models for multi-disciplinary care include flexibility and cooperative team-work with a clearly identified coordinator and supported by effective communication processes. These models are enhanced through the use of evidence-based policies, guidelines and protocols pertinent to the multi-disciplinary team.⁴⁵

The provision of multi-disciplinary care alone within a single practice will not ensure that care is integrated for patients across the discipline spectrum. The challenges facing most modern health care systems require integration between the elements of health care in order to meet patients’ needs, particularly those with chronic illness.¹⁷ Integrated care is defined as patient care that is “coordinated across professionals, facilities, and support systems; continuous over time and between visits; tailored to the patients’ needs and preferences; and based on shared responsibility between patient and caregivers for optimizing health.”¹⁷ Promoting the concept of integrated care assumes that patient experiences and outcomes are better under models where care is integrated among systems, facilities and clinicians.¹⁷

Integrated care goes beyond the sharing of information, such as provided through a shared electronic health record.⁴⁶ It needs to be complemented by formal and informal relationships among disciplines to support communication, and by shared care planning.⁴⁷ Mechanisms which have traditionally been applied to support integrated care, but were less than optimal,

have been sharing of written patient records, informal communication within practices, referral letters and visit summaries with providers external to the practice.⁴⁷

The GP Super Clinics are implementing multi-disciplinary care especially for patients with chronic illnesses. That is, patients are receiving aspects of their care from multiple disciplines. The high level of positive patient experience in relation to the care provided at the GP Super Clinics is an indication of contribution to patient need. In most but not all instances, this care was integrated within the GP Super Clinic setting. The co-location of multiple disciplines under one roof and the shared electronic health record were perceived as major contributors to integration.

The extent to which the models of multi-disciplinary care were evidence-based was not as obvious. Co-location and a shared health record alone may facilitate, but do not constitute, multi-disciplinary care. Indeed, there is a risk that in the absence of a greater focus on applying evidence-based guidelines which reflect the multi-disciplinary nature of care, health outcomes which are expected to accrue from this type of model of care may be less than optimally achieved. An over-reliance on corridor conversations and shared electronic health records has the potential to neglect evidence and quality, and thus limit patient outcomes.

There are a number of unanswered challenges in relation to the application of multi-disciplinary models in GP Super Clinics. Guidelines which are being used in GP Super Clinics, have commonly been adapted from those developed by the RACGP or other discipline specific organisations. The GP Super Clinics are a relatively new structural approach to provision of care and hence offer a range of opportunities for research questions and testing interventions specific to this type of setting. As they are sites of excellence in new models of primary care, GP Super Clinics have potential to work in partnership with universities and other research bodies to answer some of these questions.

Clinical Governance

Under the GP Super Clinics Program objectives, models of clinical governance and shared care protocols are expected. Clinical governance is defined as a systematic and integrated approach to assurance and review of clinical responsibility and accountability that improves quality and safety resulting in optimal patient outcomes.⁴⁸ As in other health settings, clinical governance approaches in primary care provide some fragmented evidence of impact on quality.⁴⁹

Involvement of primary health care providers in clinical governance at the local level is recommended as having most potential, particularly if supported by regional networks and structural changes nationally to allow for funding for time for clinical governance, and information systems to access clinical data.⁴⁹ A key concept in the GP Super Clinics Program objectives was that clinical governance would reflect the multi-disciplinary nature of care.

There are a range of approaches for achieving effective clinical governance, including: continuous improvement, quality assurance, audits, using clinical indicators, promotion of evidence-based practice, participation in accreditation processes, risk management, and a suite of other activities.⁵⁰ Reporting of clinical performance data to clinical teams, including those in primary care, as part of clinical governance initiatives, has been shown to result in significantly improved clinical outcomes.^{51 52}

Some of these approaches have been applied to some extent in all GP Super Clinics. However, there was very limited evidence of formal, systematic approaches to and multi-disciplinary involvement in clinical governance approaches. Implementing clinical governance in multi-disciplinary settings such as GP Super Clinics was reported by clinicians as being an area where they had limited previous experience. As such it is an area that requires close attention in the short term, and regular monitoring in the long term.

7.3.2 Responsiveness to Local Community Needs

Community participation is regarded as one of the key pillars of primary health care.⁵³ This is in part due to evidence of impact on the health of the communities and in part to notions of democracy and a civil society. In line with the GP Super Clinics Program objectives, the World Health Organisation (WHO) also emphasises the need for the primary health care sector to be responsive to local community needs through community participation and engagement.¹⁰ Similarly, a consensus process undertaken in Canada to determine attributes of primary care, identified a number of community-oriented dimensions including community participation, and responsiveness to the needs of the population.⁵⁴

There is a range of evidence to support the impact of community participation in achieving clinical and population health outcomes.⁵³ Despite this, community participation is considered one of the weakest strands in primary health care, requiring a strong policy and practice emphasis.⁵⁵ Importantly, evidence exists for the impact of participation on disadvantaged groups nationally and internationally. For example, chronic disease programs for Aboriginal Australians were most successful with a high level of Aboriginal community engagement and effective communication at all levels, with flexibility to meet local needs.⁵⁶ Strategies for enhancing capacity in community engagement for primary health professionals at local and national levels are strongly recommended.^{10,55}

All of the GP Super Clinics had undertaken some form of needs assessment prior to commencing operations, as part of the application process and in contributing to the operational plan. Approaches included examining local population health data and health service activity, as well as general and specific consultation strategies.

Few of the GP Super Clinics have developed or implemented ongoing processes for community engagement. Given the stage of development, this is hardly surprising. However, opportunities for more strategic approaches to community engagement and community involvement in organisational governance are required if the GP Super Clinics are to meet local needs.

GP Super Clinic Directors appeared uncertain as to the approaches for community engagement, which could be applied in an ongoing and strategic manner. As Medicare Locals develop, there is potential for collaborative approaches to community engagement to support GP Super Clinics to meet local needs. Similarly, it would be expected that partnerships with local health services and potential for shared planning could be achieved. These approaches would be dependent on relationships between the GP Super Clinic Directors and these other health organisations.

Aboriginal and Torres Strait Islanders

There were some outstanding examples of engagement with the Aboriginal community. However, these were in the minority. Where these outstanding examples of engagement had occurred, they were simple, consultative strategies which were ongoing. The importance placed on engagement reflected a commitment of the Directors to addressing Aboriginal health in the local areas. While the GP Super Clinics Program emphasises the importance of engagement with the Aboriginal community, greater emphasis is needed on this important area at local levels. There are also opportunities for sharing strategies among GP Super Clinics which have not yet been realised.

7.3.3 Accessible, Culturally Appropriate and Affordable care

There appears to be a net increase in access to primary care in the localities of the GP Super Clinics. This is evidenced from the numbers of additional GPs providing services at the GP Super Clinics who have moved to the area from another location. Further, there appears to be a net increase in other disciplines providing services to the area. These data are further supported by patient comments regarding ease of access for appointments compared with long waiting times at other clinics in the area.

All GP Super Clinics provided bulk-billing in some form, mostly to groups such as children less than 16 years and those on health care cards, with only one providing bulk-billing to all patients. The financial viability under a total bulk-billing model was questioned, with the structure of, and amount of remuneration under the current MBS system, cited as the most significant barrier.

The fact that the majority of patients surveyed indicated they were there to see their usual doctors contradicts criticisms about the GP Super Clinics suggesting that patients would not have regular doctors but would have to have appointments with any doctor available on the day. These results, which are reinforced by comments from interviews of patients and clinicians, indicate that most patients have “usual” doctors unless there is a need for an urgent appointment.

Most of the GP Super Clinics provided extended or after-hours services in some form. To date, none of the GP Super Clinics reported being at capacity in terms of patient numbers. Given that most of them had been operating for less than twelve months at the time of evaluation, this is hardly surprising. All of the GP Super Clinics were expecting to increase patient numbers over the next three years.

7.3.4 Preventative Health Care

The causes of chronic disease are largely attributable to risk factors such as smoking, misuse of alcohol, nutrition and physical activity.⁵⁷ There is a plethora of evidence indicating the impact of GPs on these risk factors at patient and population levels. Despite a range of initiatives in general practice including those related to MBS items for preventative care, uptake is less than optimal.^{58, 32}

The role of GP Super Clinics in relation to preventative health care has been mainly in relation to secondary prevention. In particular, it has been focused on reducing risk factors and improving self-management in patients with chronic illness.

The results from this evaluation suggest a number of issues in relation to preventative care in the GP Super Clinics. The first is potentially a lack of understanding of preventative care in the context of the whole patient population, particularly regarding primary prevention for patients without disease. Second, results suggest a lack of focus on preventative care in general in the GP Super Clinics to date. This may be understandable in the context of their maturity, with other priorities, particularly those related to chronic disease management, considered more important. Third, the lack of data about patient populations' risk factors, limits options for a focus on primary prevention. If these data were used they could potentially drive priorities and strategies for primary prevention. These data are potentially available in the GP Super Clinics' electronic health record systems, but their use in terms of the patient population and risk factors has not been realised. Last, financial reasons related to MBS items for preventative health care, were commonly quoted as barriers to preventative care.

Regardless of the reasons, these results suggest missed opportunities for preventative care, particularly for primary prevention. Hence, the potential for reducing the future burden of disease in the patient populations and in the communities served is not currently being achieved.

7.3.5 Effective Use of Information Technology

Electronic health records shared among disciplines, have the potential for achieving a range of practice, system and patient efficiencies.⁵⁹ Use of electronic health records enables sharing of data across the continuum of care, potentially across healthcare delivery organisations, across time and across geographical areas.⁶⁰ The electronic health record usually contains a range of patient information, such as existing health conditions, physician visits, hospitalisations, test results and prescribed drugs.⁶⁰

All GP Super Clinics were using some type of electronic health record, supported by appropriate levels of compliance with privacy requirements. The electronic health records were strongly supported by the majority of clinicians as facilitating models of multi-disciplinary care. More importantly, their use was supported by patients who commonly recognised the value in having their records accessible by a range of clinicians within the GP Super Clinics.

Evidence of the use of data from the electronic health records to contribute to health service planning, review and quality improvement was limited. There is potential for GP Super Clinics aggregate data to be used for these purposes and with maturation this may develop as an important opportunity.

The potential for sharing electronic health records with external providers has not yet been realised. However, plans for this eventuality are underway in two of the GP Super Clinics. The lessons in sharing of the electronic health record with externals have potential to be shared across all GP Super Clinics to support improved integration of care.

7.3.6 Impact on Primary Care Workforce

There are significant challenges for the primary health workforce in its supply, its distribution among metropolitan, regional, rural and remotes areas, and its changing roles.⁶¹ Workforce models implemented in primary care commonly involve a mix of substitution, delegation, enhancement, innovation and supplementation.^{16,62} Most new models have focused on

increased access to a broader range of primary health care providers, such as practice nurses and allied health staff.¹⁶ These models reflect the changing models of care within the primary health system.

Emphasis in workforce models where there is a broader range of health professionals has been on defining these roles individually, rather than on the way staff work as part of a team.¹⁶ Given the evidence that team-based approaches to areas such as chronic disease management have demonstrated better clinical outcomes and improved quality in general practice, a key element for workforce development should be teamwork.^{42,51}

One of the ultimate tests of the GP Super Clinics Program will be seen in terms of recruitment and retention of clinicians to work under this model of care. The question is - will GPs and allied health staff want to work in multi-disciplinary primary care environments such as those offered by GP Super Clinics?

In these very early days it appears that the answer may be yes. The results from this evaluation indicate clinicians of all disciplines and students have a high level of professional satisfaction working under this model. This is not to be underestimated in terms of a retention factor. Opportunities for teaching, training and research were also cited as factors impacting on recruitment and retention. Indeed, examples have been provided where GP Super Clinic Directors are being contacted by clinicians who want to work under this model. In combination with positive patient experiences of these models of care, and students being trained in these GP Super Clinics, these may be more telling long-term factors in driving reforms in primary care than a raft of other initiatives.

If the answer to the question is yes, this also has significant implications for the rhetoric of some of the professional organisations representing medical and other disciplines regarding GP Super Clinics. The representation of GPs is challenging with diversity in views, values and philosophies.⁶³ This diversity often relates to economics, ideology and the role of government in general practice.⁶³ Hence it would not be expected that there was universal agreement with or support for the GP Super Clinics Program. However, if the answer to the question regarding willingness to work in GP Super Clinics is yes, and it aligns with patients views about their experiences with health care suggested by this evaluation, then maybe it is time to review responses to new models of health care delivery, in the context of patient and clinician experiences.

7.3.7 Quality in Primary Health Care

Quality in primary care is complex, and due to the nature of multi-disciplinary care and the many conditions treated, it is by its nature multi-dimensional.³⁴ Health outcomes, both in terms of positive health and absence of disease, are the ultimate measures of the quality of primary care, but also require appropriate structures and processes for their achievement.³⁴ The dimensions of quality have been the subject of significant debate. Recent work in the United Kingdom has attempted to articulate the core dimensions of quality as clinical effectiveness; safety, and patient experience.^{34,64}

Patient experience has not always been a key dimension of clinical quality, with the focus on effectiveness and safety. In general practice and in primary care, patient-centred care is a core value.⁶⁵ Despite this, there is evidence of less than optimal levels of patient experience and

patient engagement.³⁴ It could therefore be assumed that assessment of patient experience is an important element of any quality approaches in primary care.

Traditionally, many of the health system initiatives to improve quality have been implemented in the acute health care sector.⁶⁶ While a number of approaches to ensuring high quality health care in primary care have been reported, evidence for their impact is limited in part because of recency of focus in this setting.⁶⁶ Where evidence does exist, it suggests that larger practices have higher levels of performance than single practices.⁴ Clinical audits and significant event audits are commonly reported within general practices, but often in the absence of a systematic approach to quality.⁶⁷

Critical to quality improvement approaches in primary care, and important to accountability for funds provided by government, are a set of robust indicators.⁵⁹ Despite the evolution of primary care in developed nations, there is limited consensus on the indicators which are used to measure the impact and performance of primary health care systems.⁶⁶ Where evidence of a focus on quality improvements does exist, it is in areas where measurement is easiest, such as in prescribing practices.⁴⁹

Cross professional clinical leadership is considered a prerequisite for ensuring quality across the whole primary care team.^{66,67} Access by all members of the primary care team to robust data on agreed indicators is needed to determine areas for quality.^{66,68} The focus on team-work as part of the overall approach to quality is strongly recommended, given the inherently team-based nature of general practice.⁶⁸ Approaches should engage and empower staff in measuring and improving quality, accountability for improvement and continual, rather than periodic approaches to quality.⁶⁸

While most health care is provided in primary care there is evidence that the quality is variable suggesting considerable scope for improvement.³⁴ For example, an Australian study reported that only about 50% of patients with diabetes received care reflecting evidence-based guidelines.⁶⁹ Evidence also suggests that two errors occur for every 1000 Medicare items in general practice.⁷⁰

Many of the approaches to improving quality in primary care appear to be project-based, such as collaboratives and development of disease-specific protocols and guidelines. However, there is a view that these project approaches are not embedded into primary care as part of its inherent culture.³⁴ This is, in part due to lack of robust data and measurement tools, which can contribute to understanding variations in quality outcomes.³⁴ In Australia it is further attributed to lack of agreement on the outcomes for primary care and mechanisms for their collection.

There is evidence that attempts at achieving quality outcomes are occurring in GP Super Clinics but are focused on projects with little attention, understandably at this stage of their maturation, to embedding the systems in to everyday practice. There were examples of participation in collaboratives and adoption or some adaptation of evidence-based guidelines. The process of collaboratives has the potential, on a project basis, to support mechanisms for quality improvement. However, in the absence of their application in a more strategic framework their ongoing use and effectiveness are more limited.

In meeting the future health needs of the population, primary health care needs a strong research and knowledge base and research culture.⁷¹ To date, there has been an over-reliance

on research undertaken in hospital or specialty settings which do not reflect the models of care, patient populations or contexts of primary care.⁷¹ Where guidelines have been used they were mostly related to adaptation of evidence-based guidelines for particular conditions such as those of the RACGP. These are not necessarily multi-disciplinary in nature, and do not necessarily reflect evidence from multi-disciplinary settings. Given the close linkages with universities at some GP Super Clinics, there are opportunities for research on interventions in these unique settings, with the ability to shape the nature and quality of primary health care. The uniqueness of the multi-disciplinary nature suggests the potential for linkages in research, with a focus on intervention effectiveness, across all GP Super Clinics. To be of maximum benefit, such research should involve collaboration between researchers and clinicians from GP Super Clinics. Rather than just being points for data collection, the GP Super Clinics should have an active and strong role in determining research questions, measures and interventions.

7.3.8 Efficient and Sustainable Business Models

Most but not all of the GP Super Clinics indicated that they were on track to achieving financial viability. The models were commonly based on a model of price and volume – the combination of remuneration of MBS items (both bulk-billing and gap payments) and patient volume – achieved through patient numbers and appointment times. Where viability was most difficult was in GP Super Clinics where patient volume was problematic. This was not a function of appointment times but rather a function of insufficient patient numbers relative to the number of available appointments. Where this occurred, geographical access to the GP Super Clinic within the locality was expressed as a significant barrier.

The financial models of most GP Super Clinics had underestimated the proportion of patients eligible for bulk-billing. Given availability of these data on both demographic and bulk-billing rates per area, this was surprising. In these instances the financial models are, as they should be, under constant review.

7.3.9 Support for the Future Primary Care Workforce

Provision of and funding for clinical placements for medical and nursing staff are critical to developing workforce capacity in primary health care.⁶¹ Approaches should also include enhancing the focus on primary care in all levels of training for all health professionals to reflect the model of care being provided.⁶¹

The GP Super Clinics provide a unique setting for education and training of the future primary care workforce. Their multi-disciplinary nature has the potential for and presently provides placement opportunities for medical, nursing and allied health staff. In recognition of this universities are partners in three of the seven GP Super Clinics with specific space allocated within the buildings for these purposes.

Most of the placements provided were for medical under-graduate or post-graduate students. Plans were in place in most GP Super Clinics to increase placement opportunities for disciplines other than medicine. The space in most GP Super Clinics facilitated a range of teaching models enabling access for students from many disciplines. Importantly, patients recognised the value of students' roles at the GP Super Clinics.

7.3.10 Integration with Local Programs and Initiatives

Partnership approaches across all health settings have been growing in most developed nations, based on the assumption that integration improves outcomes of care.⁷² Primary care is the most common provider of health services in Australia but is one part of a complex array of services which meet the population needs.^{9,16} In Canada it has been demonstrated that increased access to primary care alone does not result in better performance.⁶ Rather, the organisational model of primary care and its integration into the broader health system are key factors in improved performance.⁶

There are significant challenges in developing partnerships between primary care and other health settings such as aged care facilities and acute hospitals.^{72,73} Given the complexity of patients' needs in aged care, partnerships with multi-disciplinary teams such as those provided by GP Super Clinics have the potential, strategically and operationally, to meet the needs of older people. Similarly, there would be advantages for partnerships with acute hospitals and community health centres.

Evidence for the development of partnerships with other health services was limited. Where they had been established they related mainly to specific clinical services such as providing medical care in aged facilities. The expectations of the GP Super Clinics Program far exceed this, with potential for partnerships in planning and delivery of health services. With maturation, it would be expected a more strategic approach to the provision of integrated health care to meet local health needs could be developed. Under concurrently occurring national reforms, new structures such as Medicare Locals (independent primary health care organisations) and local state health services, have joint responsibilities in the partnership with GP Super Clinics.

7.3.11 Recommendations – GP Super Clinics Program Objectives

These recommendations relate specifically to the operation of services within the current GP Super Clinics in the context of the Program objectives.

24. Support for service development for GP Super Clinics should focus on:

- a. Preventative care
- b. Evidence-based multi-disciplinary care
- c. Community engagement
- d. Partnerships with other health services.

25. Partnerships between universities and all GP Super Clinics, potentially in the form of research networks, should be fostered to create strategic research opportunities, which address important questions about multi-disciplinary models of care and interventions which reflect patient needs.

26. The Department of Health and Ageing should establish a clinical governance framework for local adaptation and application in all GP Super Clinics, and link it's associated reporting into the regular reporting requirements.

7.4 Operational Aspect Learnings for the GP Super Clinics Program

There are a number of learnings which are specific to the Program as a whole, and not directly related to any of the ten GP Super Clinics Program objectives.

7.4.1 Program Maturation

The seven GP Super Clinics participating in this aspect of the evaluation had mostly been operating for less than twelve months. Most of these GP Super Clinics had clear, if not always documented priorities. In their first twelve months of operation these priorities understandably related to recruitment, systems and policies and providing services to achieve the GP Super Clinics Program objectives. This priority setting makes organisational and business sense. Most businesses, regardless of their nature, will set priorities for achievement, especially in their infancy. Indeed, evidence in health care indicates that successful organisations give themselves permission to prioritise.²⁷

In these GP Super Clinics, now that the first twelve months have been mostly successfully navigated, it is timely to determine strategic priorities for the next few years. There are some obvious priorities for the GP Super Clinics, including quality, engagement with specific groups, and preventative health care. Each GP Super Clinic may also identify additional, locally specific priorities.

Service development is the responsibility of GP Super Clinics as part of their strategic planning processes to achieve the GP Super Clinics Program objectives; this also make smart business sense. Undertaking an evidence-based approach to this will require leadership and engagement of clinicians and importantly, patients, local community and other health care providers in the area.²⁷ The role of the Department of Health and Ageing may only be in requiring this to occur and where relevant providing policy guidance.

7.4.2 Leadership and Culture

Leadership and organisational culture were key factors in the GP Super Clinics, in particular in relation to perceptions of clinicians and patients. This aligns with international evidence in health and other organisations which emphasises leadership and organisational culture as strong drivers of performance and innovation.²⁷ In a study focusing on change in primary care in the United Kingdom towards the establishment of Primary Care Medical Homes, leadership from both physicians and practice managers drove the change process.⁷⁴ Similarly the results of this evaluation show the GP Super Clinic Directors or clinical leaders, in collaboration with the practice manager, driving the models of care.

Organisational culture, and in particular, relationships among all members of the health care team, have been demonstrated to be associated with health outcomes, particularly those associated with chronic disease management.^{31,75} Not surprisingly, clinicians and administrative staff clearly articulated the importance of the culture, driven by the leadership of GP Super Clinic Directors, and supported by clinicians, as a critical factor in the models of care. Indeed, a number of the GP Super Clinics had recruited specifically on the basis of attributes of teamwork and commitment to the model of care. Conversely, a number reported that where staff turnover had occurred it was commonly because of inability to work as a member of a multi-disciplinary team.

The importance of leadership in the GP Super Clinics' model is also an inherent risk. In the absence of clear succession planning, problems could occur with service delivery under the agreed model if change in leadership occurs. This needs to be recognised within GP Super Clinics and succession planning supported within the Department of Health and Ageing.

7.4.3 Alignment between Clinical and Business Model

The two Program objectives which appeared to dominate in determining the focus of the GP Super Clinics were those related to the provision of multi-disciplinary care and the viability of the business model. In a business sense this is understandable, equating to ensuring the product and price achieve targets. Moreover, there appeared to be a genuine commitment by the majority of GP Super Clinic Directors, to the opportunity to provide multi-disciplinary care under this new model. However, it was recognised that the GP Super Clinics had to be financially sustainable, not only because it was one the Program objectives, but, possibly more importantly, because it was essential for recruitment and retention of the clinicians. Achieving a balance between driving the model of care and the financial model appears critical to the success of the GP Super Clinics in achieving all Program objectives.

7.4.4 Assessing Impact and Outcomes

The electronic health record was most commonly used clinically for individual patients. It was cited also by the majority of clinicians as an important facilitator of multi-disciplinary care. However, it was used less as a tool for organisational, administrative and quality improvement roles within the GP Super Clinics. This is a missed opportunity both within GP Super Clinics and across the GP Super Clinics Program. The potential for use of and linkage with data to measure performance, drive quality and determine achievement of the GP Super Clinics Program objectives exists, but has not been fully exploited. Reasons for this may relate to priorities and knowledge of the system and its use within GP Super Clinics. The potential for linkages and performance reporting could be further explored across the system.

7.4.5 Differences in Organisational Models

Organisational models in primary care have been demonstrated to impact on performance.⁷⁶ Criteria to assess performance included those related to patient experience, access, population coverage, response to vulnerable clients and a range of productivity measures.⁷⁶ Models of primary care which had population-based responsibility, strong integration into health network activities, a broad range of services and access through walk-in clinics or by appointment performed better against all criteria than other models.

All GP Super Clinics participating in this aspect of the evaluation provided multi-disciplinary care despite differences in the organisational and business models. Variations in structure, ownership and business models were noted. The *GP Super Clinics National Program Guide 2008* was deliberately flexible in describing the requirements for the organisational, business and service delivery models. This has proved critical in attracting a variety of applicants, who have demonstrated both a commitment to the models of care, and the adoption of business models to ensure a sustainable approach to enhanced primary care in the local communities.

The organisational model which appeared to have the most difficulties was where there was a third party contract arrangement. This occurred where a state health service was the successful

applicant for the GP Super Clinic but sub-contracted that arrangement to a third party or where the funding recipient split asset holding and operational entities to mitigate risks to ownership of the property asset should financial viability be an issue. As in any third party contractual arrangement, this model has inherent risks which need to be identified and managed, particularly in instances where the contractor's objectives and those of the GP Super Clinics Program may not totally align. This was further complicated by the indirect, third party communication and reporting arrangements between the GP Super Clinic and the Department of Health and Ageing, which in the opinion of the evaluation team was ineffective and inefficient.

7.4.6 Recommendations – Learnings from the GP Super Clinics Program

These recommendations relate to learnings from the GP Super Clinics Program beyond the program objectives

27. The GP Super Clinics should develop strategic plans within the framework of the GP Super Clinics Program. Their development should be required to be part of the reporting requirements of the GP Super Clinics Program. The format and content should be determined by the GP Super Clinics but should reflect priorities outlined in 7.3.11
28. Further evaluation of the Program should be explored when all GP Super Clinics have been operating for at least three years. Evaluations should focus on patient outcomes and experiences, the models of care in relation to evidence, and clinician outcomes and experiences.
29. Negotiation should occur between the Primary and Ambulatory Care Division and medical software businesses, to determine the potential for linkage between this software and reporting requirements of the GP Super Clinics Program and potentially other primary health care services.
30. The Department of Health and Ageing should critically review any third party contractual arrangements to review the alignment with GP Super Clinics Program objectives among all parties. Where this alignment does not exist, the renegotiation of the contract should commence. Where alignment exists, procedures should be implemented to ensure direct communication between the GP Super Clinics, and the Department of Health and Ageing.

7.5 Primary Health Care System Learnings

In addition to the GP Super Clinics there is a range of other reforms and investment in general practice and primary health care, presently in existence:

- Establishing Medicare Locals across Australia, to work with the full spectrum of general practice, allied health and community health care providers, improve access to care and drive integration among services
- Ensuring that communities will have access to GP advice and services after hours, with the capacity to put Australians in contact with GP services in their communities when needed

Some of the learnings identified in this evaluation are not specific to the GP Super Clinics Program and are thus outside the scope of this evaluation. However, they have implications for

the broader primary health care system and thus have potential to be considered in the context of these reforms.

7.5.1 Measuring Primary Health Care Performance

Measuring the performance of the primary health care system is important, for a number of reasons. From a democratic perspective, return on investment of public money should drive performance measurement. Performance data also allow a more thorough understanding of primary health care and enable system and service improvements.⁷⁷ Primary health care performance data also have the potential for broadening the public debate on health care, one which is dominated by acute care, in part because of availability of data on hospital-related issues.⁷⁸

There is considerable debate about how to capture accurately the breadth and complexity of activity and outcomes in primary health care. However, in their absence the ability to build improved primary health care systems is limited.⁷⁸ A number of developed nations have been struggling with the challenge of measuring performance in primary health care.⁷⁹ Both the United Kingdom and Canada have progressed performance measurement through systems such as the Quality Outcomes Framework (United Kingdom) and the Pan-Canadian Primary Health Care Indicators project. In addition to measuring impact and outcomes these systems also measure patient experiences.⁸⁰

Specific indicators are only now being considered for application across the GP Super Clinics Program. These indicators understandably are program-specific. They will enable assessment of the extent to which the models of care and activities of the GP Super Clinics achieve the GP Super Clinics Program objectives. They do not, nor are they intended to, provide an assessment of the activity and outcomes associated with this model of care. Clinicians expressed frustration at the lack of systems to provide robust and comparable activity and outcome data, but also recognised that this was a system rather than a GP Super Clinics issue. The processes being developed as part of the delivery of the broader health reforms and in particular the National Health Performance Authority may consider the measurement of broader primary health care systems and outcomes.

7.5.2 Medicare Benefits Schedule

The MBS primary care items support a range of primary care services.⁸¹ These items now allow GPs to refer patients with complex, chronic illnesses to other disciplines for up to five subsidised services per patient per annum and provide financial incentives for general practitioners to coordinate the care of a patient with a chronic condition with at least two other care-givers.⁸²

The MBS items have been consistently raised as barriers to the success of multi-disciplinary care in the GP Super Clinics. In particular, it was perceived that there was inequity in access to MBS items between GPs and allied health staff. Claims for more equity in provision of financial incentives for allied health and nursing staff were raised consistently, particularly in relation to case conferencing.

Policy changes to MBS items are difficult in the context of limited evidence on patient outcomes and on the provision of effective multi-disciplinary care.⁴² The GP Super Clinics Program cannot address this problem. Rather, it is a broader health and primary care system problem which

needs to be viewed in the context of evidence for achieving patient and population health outcomes, and effective multi-disciplinary care.

7.5.3 Role of the Universities

Primary health care is increasingly focused on the provision of chronic care illness under a multi-disciplinary care model. The capacity to continue to provide this model of care will, in part, depend on the training of future health professionals. One of the GP Super Clinics Program objectives relates to teaching and training of health professionals. Most of the GP Super Clinics have developed or are developing relationships with universities. Indeed, some have structural relationships and co-location of academic units with the GP Super Clinics. This is expected to facilitate a partnership approach to teaching and training of students in various disciplines.

Where relationships have been established between GP Super Clinics and universities, they appear to mostly one-way relationships. The GP Super Clinics have enabled the universities to provide much-needed placements for under-graduate students in a multi-disciplinary environment, which is consistent with the GP Super Clinics Program Objectives.

However, it does not appear to have changed the way students are trained in the university settings. It has been argued that teaching students at under-graduate level the importance of and skills in working in a multi-disciplinary environment means greater potential of application in their clinical experience.⁸³ On return to the universities, students still undertake single-discipline learning which does not necessarily reflect patient profiles or future models of care under which they will provide services.

It is recognised that there are logistical difficulties for universities in introducing inter-professional education into the curricula. While single discipline teaching is obviously needed at times, there are many opportunities, such as through problem-based learning, where inter-professional learning could occur. Similarly, gaps between models of care for primary care and, in particular, chronic disease management and post-graduate training have been identified.⁸⁴

The relationships between the GP Super Clinics and universities are in their infancy, and examples of teaching, training and research partnerships were not evident beyond co-location and provision of clinical placements. There are opportunities for universities and relevant colleges to show much greater leadership in teaching and training of health disciplines to reflect the demands of 21st century primary care practices than has been demonstrated in this evaluation. This will require a fundamental rethink of the way multi-disciplinary education can be provided in a way which more closely mirrors modern health care practice thus challenging the status-quo in current programs. Universities should be challenged as to why much of their problem-based learning approaches still occur in discipline silos, thus further perpetuating the silo mentality of health care.

Similarly, there are opportunities through partnerships with GP Super Clinics to undertake research with members of teams, where clinics are not merely points for data collection, but are places where questions can be determined collaboratively and research which meets needs of modern practices can be undertaken. Through a collaborative approach there is an opportunity to answer questions of relevance to patients, clinicians and policy makers in relation to primary care.

Key Learnings – Primary Care System

31. If there is a commitment to increasing investment in primary health care by the Australian Government, measurement of its performance through efficient systems and robust data is required to determine return on investment and to drive quality through improvement of the system and services.
32. Universities and relevant discipline-specific colleges should be encouraged to review their models of teaching and training to reflect the realities of modern day primary care.

7.6 Strengths and Limitations

This evaluation attempted to assess three aspects of the GP Super Clinics Program: the implementation, establishment and operations aspects.

The results of the evaluation should be interpreted within the limitations of the methods. Samples in patient and clinicians surveys which provided quantitative data were volunteer samples suggesting caution in attempts at generalisation. General practitioners completing the survey represented 55% of participants in the clinician survey while representing 42% of the FTEs employed in the seven clinics. The higher proportion of GPs responding the survey is likely to cause biases in results. Patient selection was potentially influenced by reception staff and is thus another source of bias.

The community stakeholders selected for the interviews were provided by the GP Super Clinic Directors. These were those that had worked with the GP Super Clinics in their early stage of their development. The small numbers that participated in interviews, and that they were identified by the GP Super Clinics is a further limitation of the evaluation. The evaluation did not and did not intend to capture broader views of stakeholders.

The results of the surveys were complemented by and aligned with results of interviews held with a large number and diverse range of clinicians and patients. A process of thematic analysis was used to identify common themes to optimise rigor in the qualitative data.

Despite these limitations, many of the results accord with those identified empirically. However, the GP Super Clinics Program is in its infancy and will require time before more robust evaluation to assess outcomes can be applied.

7.7 Conclusion

This GP Super Clinics Program is fundamentally a reform program. It is a reform program aiming to change the way primary care is delivered in Australia. These reforms align with those internationally. Reform by its very nature means change; change to the status quo, change to structures and organisations, and changes to the way people – in this instance clinicians, patients and the community - behave.

With change comes resistance. However, these reforms are ultimately about patients, the quality of patient care and the ability to meet community needs. While the Program is in its infancy, this evaluation suggests that ultimately patients are being enabled to access multi-

disciplinary primary health care, in buildings that support patients and staff, in an environment where care providers are working collaboratively and where care is well-supported by the use of electronic health records.

The GP Super Clinics Program is, has been and will continue to evolve. This also is in line with reform programs. Part of the evolution in the GP Super Clinics Program should arise from other reforms in primary care occurring concurrently. Maximising these opportunities for aligned evolution with the range of reforms is a key responsibility for the Department of Health and Ageing, for the GP Super Clinics and for the raft of other reform programs.