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REGIONAL ROUND-UP

A program to support general practice in managing asthma: an Australian experience

Christopher PEARCE, Marianne SHEARER, Leigh BARNETBY, Judith WICKING and Christopher ANDERSON

Whitehorse Division of General Practice, Melbourne, Australia

Abstract

General practice is the cornerstone of primary health care systems in developed countries, but increasingly is seen to need to be supported in that role to deliver appropriate population health strategies. In Australia, the Federal Government developed Divisions of General Practice, as geographically based organizations to support general practice. In the context of a national campaign to improve asthma management, an urban division in Australia developed a supported clinic-based asthma program. Evaluation revealed an improvement in patient indicators, support from the clinics involved, and financial sustainability of the program. Divisions are an appropriate vehicle with which to support General Practice.

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Key words: asthma management, health services, primary health care, resource allocation, general practice

General practice/family practice remains the cornerstone of primary health care systems in developed countries. In Australia, 50% of the population will visit their general practitioner (GP) in 6 months, 80% in 12 months.[1] However, it has long been realized that general practice alone cannot realize its full potential in a comprehensive primary care policy. The structure of general practice, with its multiple small business units (practices) has not lent itself to a co-ordinated approach to health problems. Thus, governments have sought to develop structures to allow general practice to better integrate with the primary health care system and achieve large-scale goals. New Zealand has had for many years Independent Practitioner Associations,[2,3] collections of primary care practitioners who hold clinical governance responsibilities for their area, but not funds. In the UK, after years of experimenting with fund-holding directly by GPs,[4] the National Health Scheme (NHS) has moved to Primary Care Trusts, organizations which fund-hold all primary care funding for a given area.[5,6] While the development of Hospital Maintenance Organizations (HMOs) in the US could be seen to also fill a similar function, their clinical governance role has been overwhelmed by their fiscal management.[7]

Correspondence: Dr Christopher Pearce, Whitehorse Division of General Practice, 13/317–321 Whitehorse Road, Nunawading, Victoria, 3131 Australia; PO Box 127, Blackburn, Victoria, 3130 Australia.
Web: www.wdgp.com.au
E-mail: admin@wdgp.com.au
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In Australia, since 1992, general practitioners have been supported by Divisions of General Practice.[8] Divisions were proposed as a support structure, similar in concept to the divisions of medicine/surgery and so on that exist in large hospital structures. There are 120 Divisions across the country, and each Division is responsible for a given geographic area. They receive funding from the Federal Government, and are governed, in the main, by their member GPs. They do not fund-hold, but are responsible for providing support for general practice to roll out programs, either in collaboration with other organizations or according to national guidelines.

One of the national health priorities in Australia involves asthma. In 2002 considerable funding was allocated to improving population health outcomes for people with asthma. The main objective was to promote best-practice guidelines for optimal asthma management to GPs. The program was promoted to GPs for people with asthma and the wider community. A major theme was the importance of regular, planned, asthma-focused appointments with GPs incorporating the National Asthma Council (NAC) recommended Asthma 3+ Visit Plan.[9] Central to the program was the involvement of Divisions of General Practice to support GPs in the implementation of this strategy. The Federal Government provided funding through the provision of a specific 'item number' to remunerate doctors who completed the Asthma 3+ Visit Plan with their patients. Key features of the plan are assessment of asthma severity, medication review, provision of a written asthma action plan, information and education.

The Whitehorse Division of General Practice is an urban division servicing a population of 400 000 patients and has 405 GPs. It has had a long association with running quality asthma education projects for both GPs and their patients. August 2001 saw the start of an innovative pilot program to place qualified and experienced asthma educators within clinics to support GPs in the management of their patients with asthma.

The basis for this program is the evidence-based Asthma 3+ Visit Plan promoted by the National Asthma Council and Department of Health and Ageing. The asthma educator provides the bulk of the education, spirometry and allergen testing (as clinically indicated) with GPs providing the expertise in the overall medical management.

The cost of the asthma educator was met by the individual practice. These costs are offset by rebates for GP attendance, care planning, spirometry and allergen tests, and the asthma Service Incentive Payment (SIP) introduced in November 2001. Appropriate use of these item numbers ensured that all the costs incurred with the asthma clinics were met and exceeded. For the duration of the pilot the Division offered a subsidy of 50% toward the cost of the asthma clinic program.

The asthma clinics were set up with the assistance of the Division's Chronic Illness Co-ordinator and/or the Practice Manager Co-ordinator. Pre-clinic planning and support was provided for the GPs and their practice staff to ensure asthma clinic promotion, appointment and information systems were in place prior to the clinics commencing. An asthma clinic policy and procedure manual was developed and provided to each practice. The asthma clinics were offered fortnightly and the asthma educator met briefly with each practice before the clinics began. The asthma educator brought all equipment required for the clinic to the practice (spirometer, allergen test kit and patient information). The practice provided a suitable room with a telephone to conduct the appointments, access to patient records, reception and booking facilities. The practice was also responsible for referring patients to the clinic.

The asthma educator saw each patient a minimum of three appointments over a minimum of 6 weeks. During these appointments comprehensive asthma education, review of medications, device technique, spirometry, allergen testing (optional as clinically indicated) and a written asthma action plan was provided. At the end of each appointment with the asthma educator, a consultation with the GP, educator and patient occurred to review the overall management and set goals for the next appointment. Patients completed the program when their asthma management was optimized and they had a current written asthma action plan. Most patients achieve this over three visits but for those patients who required more appointments, these were accommodated through the program.

Method

Evaluation of the program was undertaken with the GPs and their practice staff at the end of the nineth asthma clinic. At this time a maximum of 15 patients per clinic could have completed a minimum of three visits. Each clinic was provided with a financial breakdown of the income and expenditure of the clinics. Patients were also asked to complete an Asthma Clinic knowledge quiz at first and final appointments and a satisfaction questionnaire at the final appointment.

Results

Costs

Central to the evaluation of the program was a financial analysis (**Table 1**).

General practitioners

General practitioners were asked to rank their responses to the statement: 'The asthma clinic and nurse educator has contributed to the following outcomes' in the three areas listed in **Table 2**.

Responses were coded on a Likert scale. The Likert scale had four elements to select; 1 – not at all, 2-a little, 3 – some and 4 – a lot (**Figs 1,2 and 3**).

Table 1. Financial breakdown

Average practice profit (Income generated through MBS items, less fee to Division for the asthma educator and equipment.)	$3566 (range $3088 to $4564)
Division profit (Income from practice fee for asthma educator service and equipment, less cost associated in providing the service)	– $79.00

Table 2 Questions on practitioner survey

Question	Patient outcomes	Personal/professional outcomes	Business outcomes
1.	Improved quality of care and health outcomes for patients	Increased satisfaction with asthma care and management	Minimal impact on their usual appointment schedule
2	Improved patients' understanding of their asthma		Increased use of MBS service payments available for asthma man agement.
3	Increased efficiency in patient asthma management		Increased awareness of the financial benefits of a coor-dinated approach to asthma management.
4.	Increased patient satisfaction		Increased income
5			Improved efficiency in the use of GP time spent in asthma management.

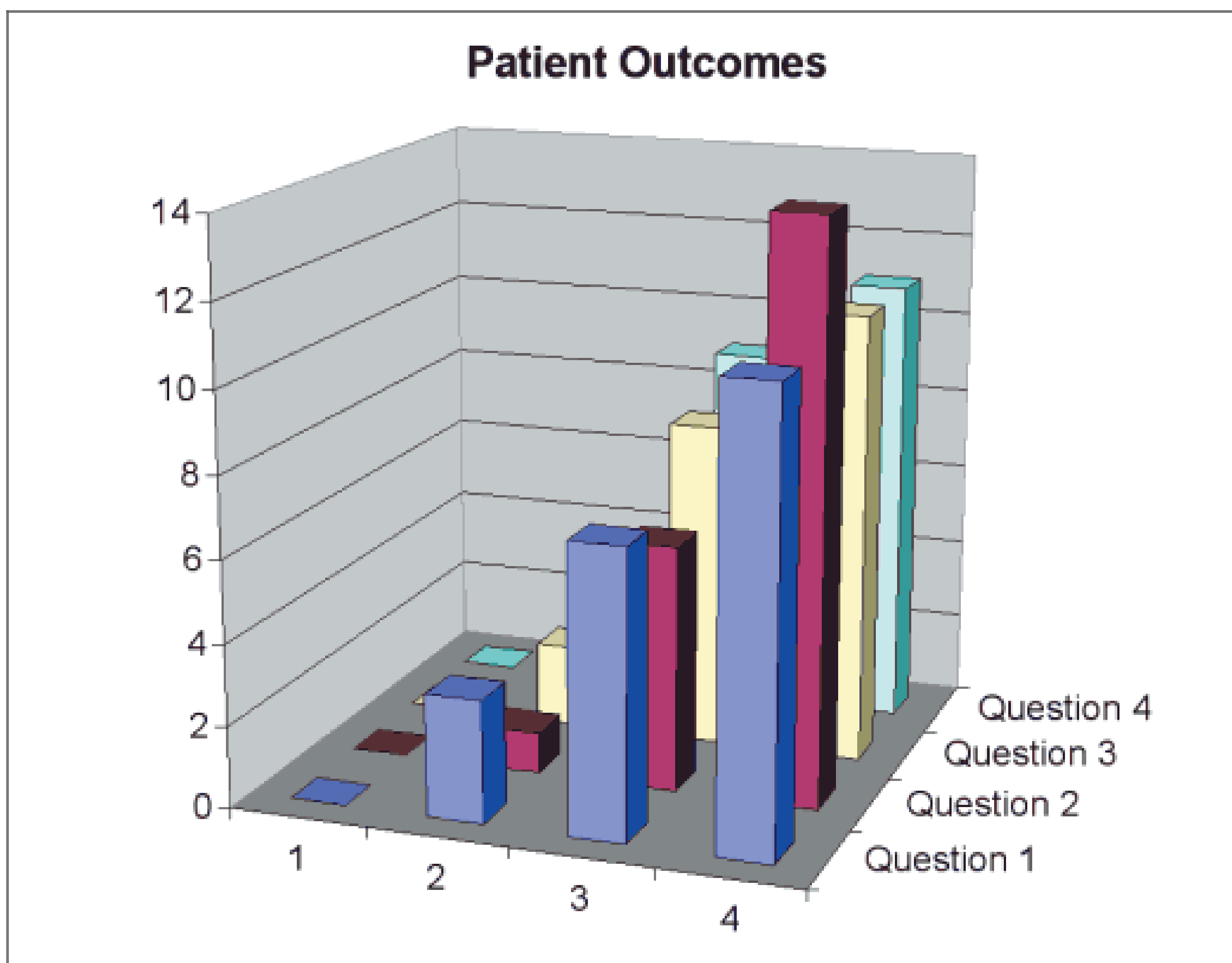

Fig. 1. Patient outcomes

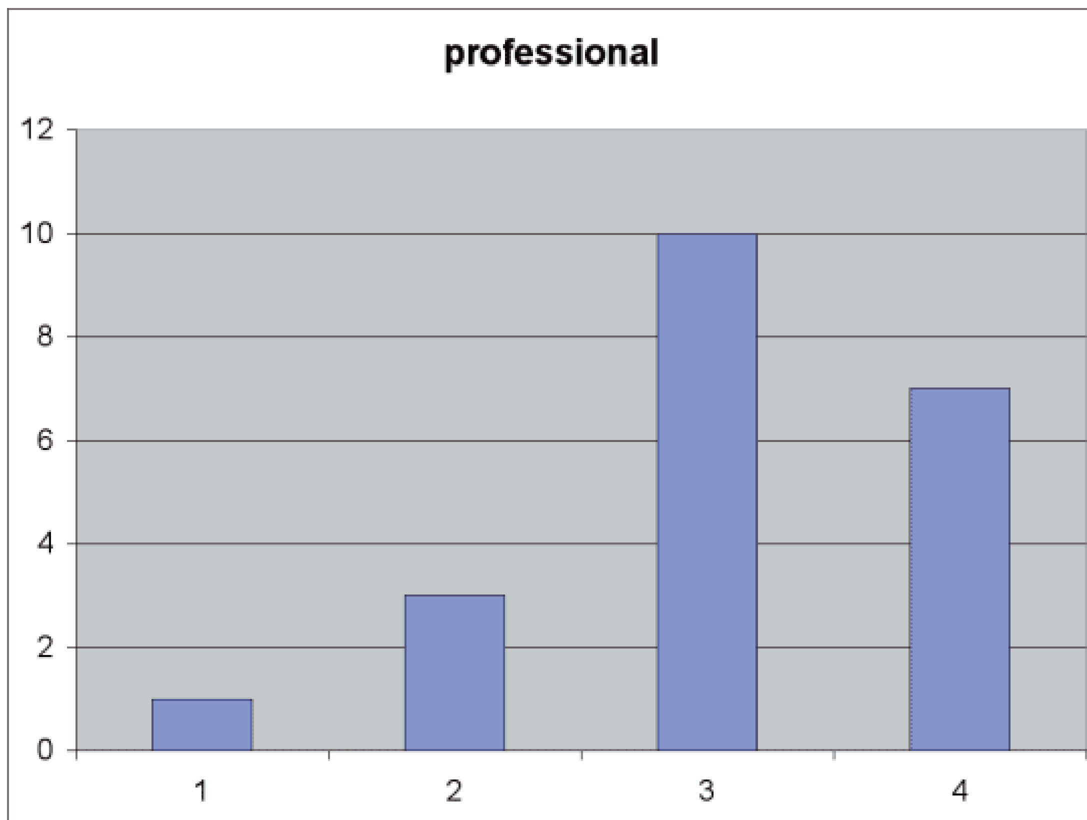

Fig. 2. Personal/professional outcomes

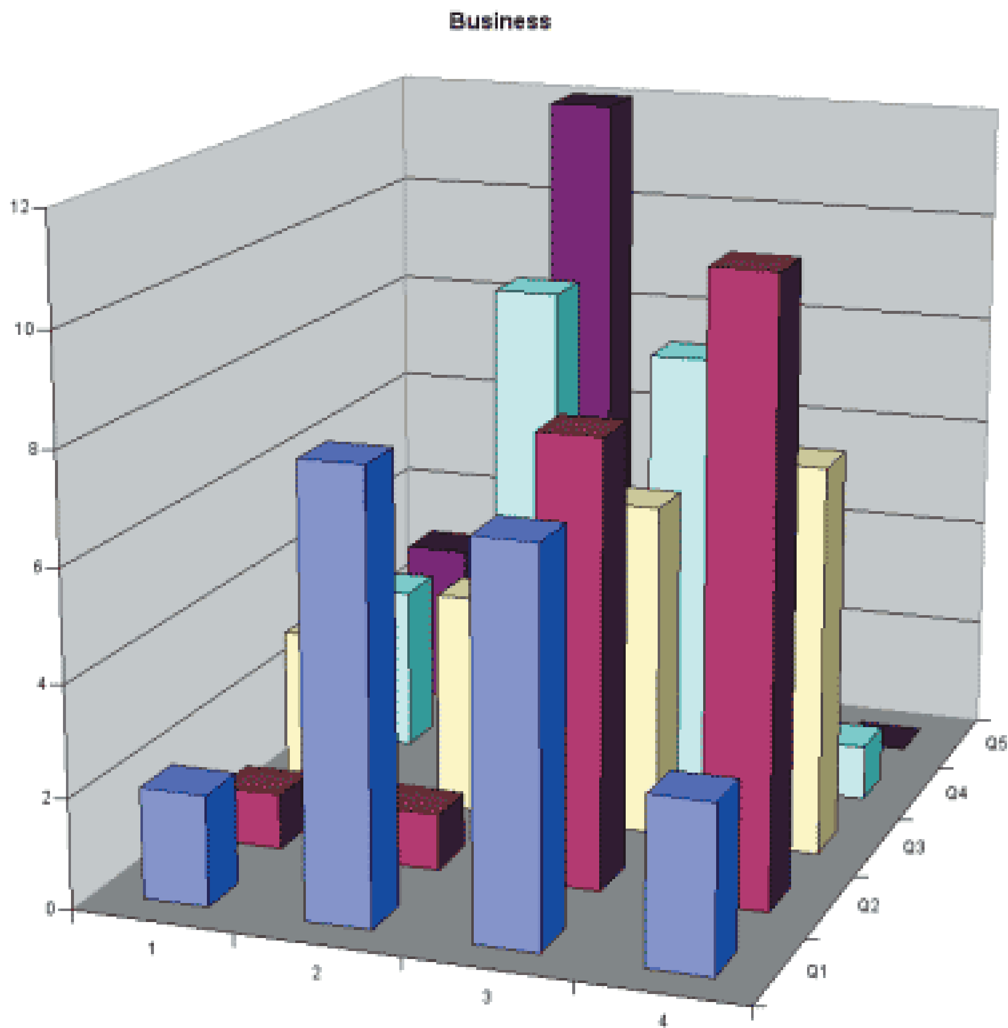

Fig. 3. Business outcomes

Patients

Patients attending the asthma clinics were asked to complete a knowledge quiz at first and final visit with the Asthma Educator. At the time of completing the final quiz a satisfaction questionnaire was included. All patients showed an increase in knowledge at the end of their asthma education sessions. All patients rated the asthma clinic as helpful, quite helpful or very helpful (**Fig. 4**).

Discussion

The aim of this paper is not to examine the effectiveness of asthma treatment in general practice. It was to examine a structural solution to delivering effective care to widely accepted guidelines. These clinics were well received and supported by both the participating practices and their patients. Evaluation of the patient data shows both support for the clinics and improvement in knowledge. The GP data recorded high levels of agreement with the patient perspective. When we analyze the business question, we still find general support, although not as marked as for the perceived impact on patients. This was particularly so for the questions (2 and 3) regarding accessing the Federal Government incentives. However, the financial data indicates that the process was cost-neutral for the division, while providing a significant profit for the practice.

These were not services that the practices had the administrative or financial capacity to develop themselves. Key to their success was the involvement of the Division in providing those services. The economies of scale of an organization with support of general practice as its mission, allowed these programs to be delivered at an overall cost-neutral, and administration-neutral basis.

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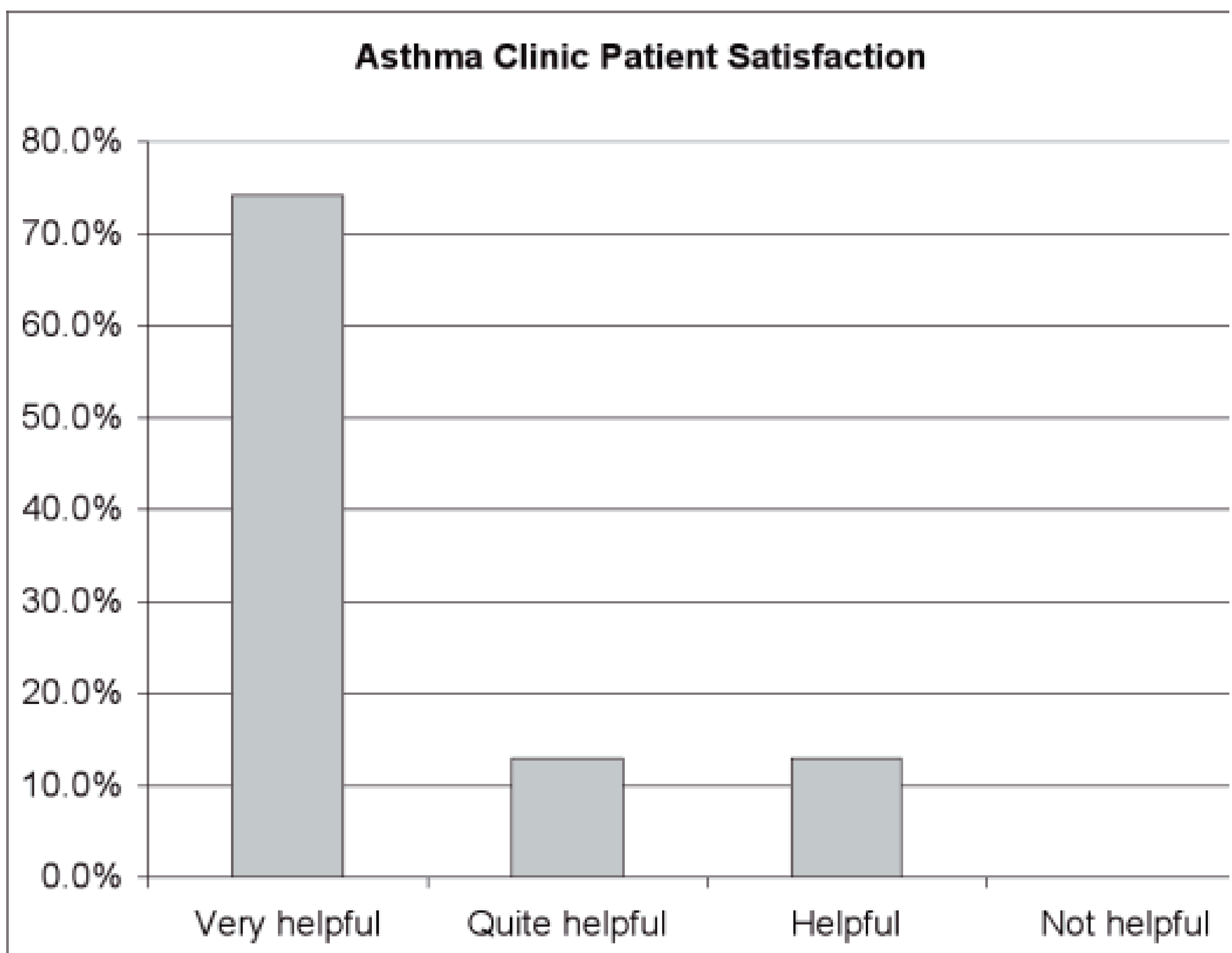

Fig. 4. Patient satisfaction survey

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