A tale of two systems: primary care for depression in London and Melbourne

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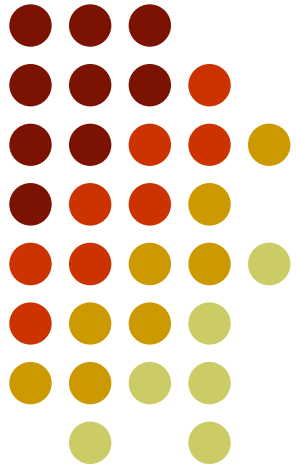


Presentation

- What we did and how we did it
- Why we did it
- What we found – emphasising findings of interest in Australian context
- Connections to current health care reform in Australia

What we did

- Sought the views of GPs and patients ‘on the ground’ about system features which help or hinder the best care for depression
- Drew a distinction between features being present in policy and/or reality
- London and Melbourne ‘exemplars’ of urban England and Australia – we assumed GP and patient experiences would be “typical”
- 2-round Delphi Technique questionnaire using ‘expert’ panel of GPs and patients in London and Melbourne – 77 participants in total
- Questionnaire: 45 statements, starting with Starfield’s ‘strength of primary care’ framework

What we did (2)

- *Purposive* sampling
- Statistical significance: 78% or more panel scores were within three-point range containing median
- Delphi: “derives quantitative estimates through qualitative approaches”
- Data collection took place 2004-2006
- Collaboration between the Institute of Psychiatry (King’s College London) and Departments of General Practice at Monash and University of Melbourne

Questionnaire: example

Statement	1. Does this statement reflect primary care system policy in the UK? 1=Strongly disagree 9=Strongly agree Please circle number	2. Does this statement reflect the reality of the primary care system in the UK? 1=Strongly disagree 9 =Strongly agree Please circle number	3. Is this important for the best delivery of care for mild to moderate depression in primary care? 1=Strongly disagree 9=Strongly agree Please circle number
GPs can obtain timely advice from specialists by telephone	1..2..3..4..5..6..7..8..9 or Don't know □	1..2..3..4..5..6..7..8..9 or Don't know □	1..2..3..4..5..6..7..8..9 or Don't know □
Please comment on statement above if you wish:			

Why we did it

- Unmet mental health need
- Depression: significant – and growing - burden of disease in both countries
- Evidence that organisational factors hinder primary care for depression
- Two very different systems
- Opportunity to see which system features ‘worked’ and which didn’t

What we found

1. Key differences in systems
2. Differences in perceptions of policy and reality
3. Views from specific panels about what's in place and what isn't but should be
4. System features all panels agreed were of value for management of depression

1. The two PC systems

Australia

- ‘Light touch’ govt policy
- Fee-for-service oriented
- Co-payments/bulk billing
- Health care responsibilities fragmented
- Multiple funding streams
- Small but expanding PC teams
- Emphasises choice of doctor and practice
- Private psychiatry plays major role
- Strong consumer movement

UK

- Central government policy driven
- Capitation oriented
- Free at point of contact for all
- Clarity about health care responsibilities and funding streamlined
- Large, multidisciplinary PC teams
- Registration with one practice
- Public psychiatry dominates
- Patient/public involvement enshrined

1. The two PC systems (cont'd)

- *But* role of GP as first point of contact, generalist and gatekeeper to secondary care – very similar

2. Differences in perceptions of policy and reality

- Individuals and panels did differentiate
- Melbourne patients saw a gap between policy and reality on

  1. Patient-centred care
  2. Being seen within one working day where the patient believes they need urgent attention
  3. Professional interpreting/translation services being available

"The hardest thing to do in a depressed state is communicate effectively. I can't imagine the difficulties non-English speaking patients may have"

2. Differences in perceptions of policy and reality – cont'd

- Melbourne GPs saw a gap between policy and reality on

1. GP/patient relationship extending over time (continuity)
2. Patients being able to see a GP within 2 days of making an appointment
3. Being able to provide consultations of different lengths

"It may be 'policy' but I find it <u>not</u> an incentive"

3. Views from Melbourne patient panel

Our Melbourne patient panel believed that:

- Patients can see GPs at any practice

  "Lousy idea, you would not receive the quality of care"

- Patients should have one set of general practice notes

  "Practices don't share information between each other"

- Practices do not make contact with patients if they do not re-attend but they should
- Patients are not involved in service planning

3. Views from Melbourne patient panel – cont'd

- Patients do make co-payments, and GPs should be paid every time they see a patient

"This is a very odd statement – if a GP was not paid, would a GP work?"

- GPs should be able to provide consultations of different lengths
- Patients cannot consult other primary care staff but should be able to
- Referral to a choice of psychiatrist should be available in the public system

3. Views from Melbourne GP panel

Our Melbourne GP panel believed that:

- Relationship between patient and practice should extend over time – but they weren't sure it did

  "No incentives in current Australian policy for patients to maintain continuity in one practice: a MAJOR inefficiency"

- Patients can see GPs at any practice

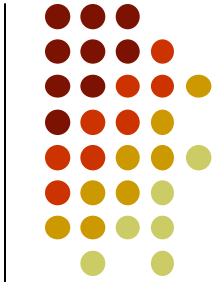
  "A positive quality if your usual GP is great at all other things but not depression"

3. Views from Melbourne GP panel – cont'd

- The general practice team does not include clinical psychologists or counsellors, but should include clinical psychologists
- Referral to a choice of psychiatrist should be but is not available in the public system

"Not much choice! There aren't many psychiatrists in the public system"

4. System features all panels said helped the best care

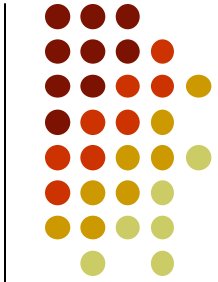


A. Patient-centred care and decisions about the need for specialist care being jointly made by GP and patient
B. Continuity of care
C. Availability of translation and interpreting services
D. Having sufficient time within a routine consultation
E. Formal arrangements for transfer of information between GPs and specialists

4A Patient-centred care

- Balint (1964)
- It may take time to deliver this approach
- Tension between polyclinics/super clinics?
- Policy makers may want to ensure education/training emphasises patient centred care and quality of relationships is monitored and

4B. Continuity of care

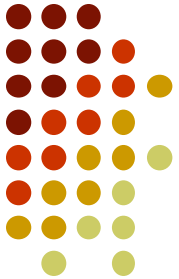


- Patients in both systems valued ongoing relationship with single GP
- UK ensures this to a degree - Melb. patients said they take steps to ensure continuity of care when important
- Australian patients can and do attend >1 practice – pros and cons:
  - Shop around for right person/Doctor shopping
  - Go somewhere different – stigma
  - Info continuity/adverse events/telling story again
  - ‘Responsibility’

4B. Continuity of care (cont'd)

- May affect notions of GP/practice 'responsibility' for patients: UK GPs have a defined practice population of patients – responded more favourably to some Q's
- Literature on continuity in Australia

4C. Availability of translation and interpreting services



- Australia has TIS – telephone based
- ?not consistently used
- Reform docs: cultural appropriateness

4D. Having sufficient time within a routine consultation

- Need time to unravel mental health issues – evidence for longer consults
- Concern that there was often insufficient time
- Less remuneration per hour for longer consults than for shorter – also noted by Britt (2002)
- Barrier also in scheduling appointments
- Reforms present opportunity to address this?

4E. Formal arrangements for transfer of information between GPs and specialists

- Problem in fragmented system
- Proposed electronic patient record will help

Surprisingly…

- The same fundamental problems were reported about not having enough time to manage mental health issues, about a lack of referral options, and about the loss of an interpersonal relationship between GP and patient.

What does it all mean in the current policy debate?

- Policy recommendations
- Connecting to Australia's Draft National Primary Care Policy

Policy recommendations

1. Reforms in both systems should recognise the possible tension between patient-centred care and larger primary care organisations and take steps to ensure this approach is embedded in new organisations through training and development, and monitoring the patient experience
2. Primary care reforms in both systems should recognise the importance to patients of being able to see the same GP for some conditions, including depression, and take steps to ensure that this is a choice that is available.

Policy recommendations2

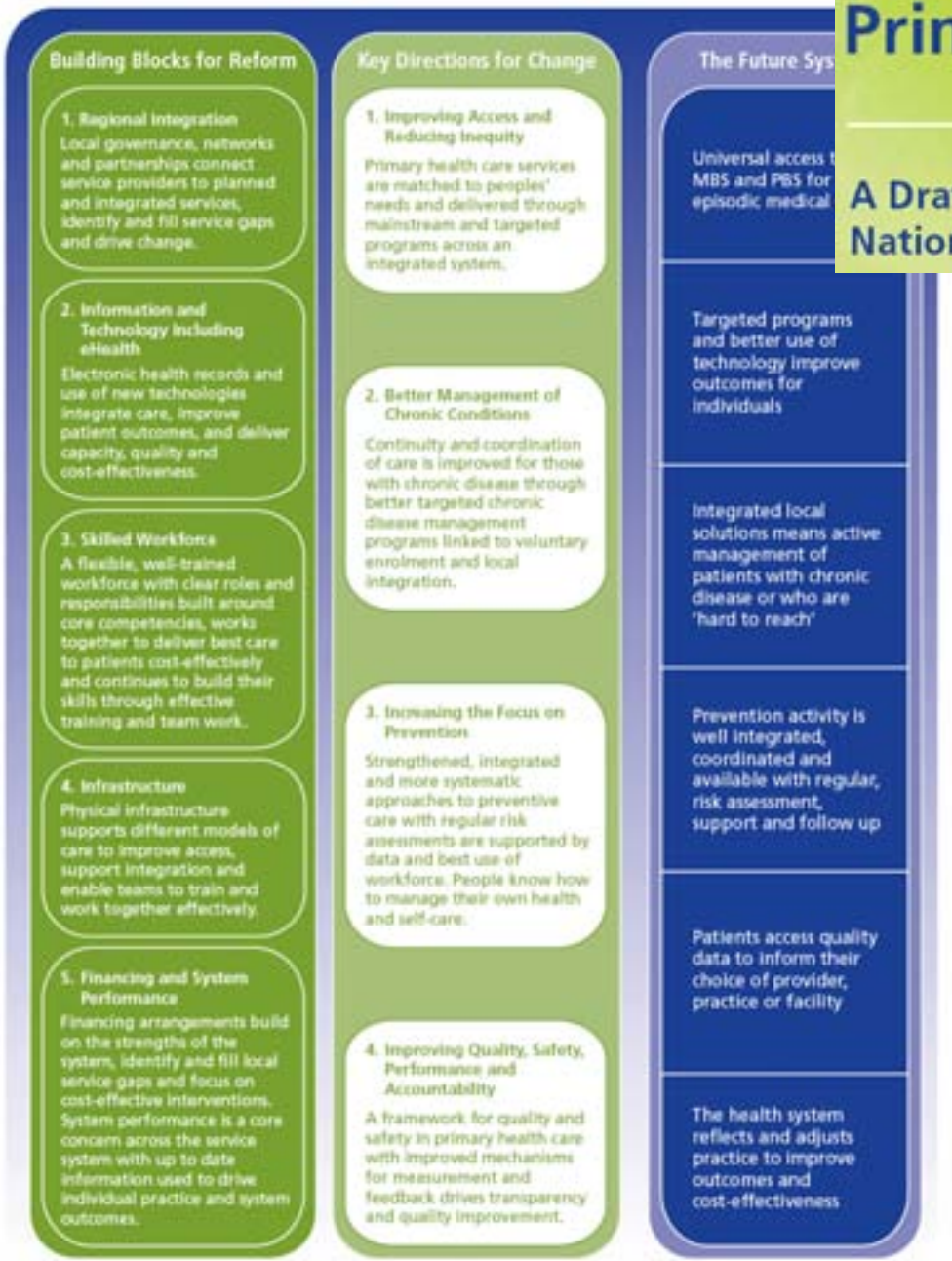
3. Both systems should pay close attention to the need for high quality interpreting and translating to be readily available to general practices.
4. Primary care reforms should recognise that GPs respond to a variety of patient conditions during the day, and that some require more time to be spent than others. Good practice in scheduling appointments should be identified and shared.

Policy recommendations3

5. Primary care reforms should pay close attention to the need for timely, accurate and secure transfer of information. This will become more challenging and important as primary care teams develop in Australia, and as both countries increase referral to psychological therapies.
6. The emerging Australian national primary care strategy should take steps to improve informational continuity so that there is consistent information about a patient available to each practice that patient attends.

Policy recommendations4

7. Policy-makers working on health service reform should recognise that people often cannot see beyond what they know, and this may lead to wanting to preserve what they know to the detriment of innovation.



Building a 21st Century Primary Health Care System

A Draft of Australia's First National Primary Health Care Strategy

First comprehensive policy statement for primary health care in Australia's history

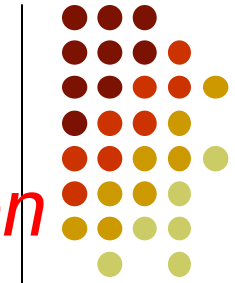
Not a detailed implementation plan

Further discussion required

Changes will take time

Presents opportunity…

Building blocks for reform



- Regional integration *transfer of information*
- Information and technology including eHealth *informational continuity* and *transfer of information*
- Skilled workforce [Super Clinics?] *patient centred care*
- Infrastructure [Super Clinics?] *patient centred care*
- Financing and system performance *transfer of information, scheduling appointments*

Key directions for change

- Improving access and reducing inequity *translation/interpreting, scheduling appointments*
- Better management of chronic conditions [includes vol enrolment] *patient centred care, personal continuity, informational continuity*
- Increasing the focus on prevention
- Improving quality, safety, performance and accountability *patient centred care, personal continuity, informational continuity, translation/interpreting, scheduling appointments*

Limitations

- Same approach for GPs and patients - may not be appropriate? Patients may not know about policy.
- People tend not to be able to see beyond their own systems

Finally

- Timely findings for health care reforms
- Learn a lot from system comparisons
- "...*exposure to the rest of the world helps us to make better judgements, to think more creatively, to see around corners, to distinguish the superficial from the profound*..." Mulgan

References

- *Balint M (1964) The doctor, his patient and the illness. Pitman Books, London, UK*
- *Britt H., Valenti L., & Miller G. (2002) Time for care. Length of general practice consultations in Australia. Aust.Fam.Physician 31, 876-880*
- *Cronin E, Campbell S, Ashworth M, Hann M, Blashki G, Murray J & Tylee A (2009) A tale of two systems: perceptions of primary care for depression in London and Melbourne. Family Practice 26(3) June*
- *Mulgan G. (2002) International comparisons in Policy Making. The View from the Centre. Sydney, Institute of Public Administration Australia*
- *Starfield B. & Shi L. (2002) Policy relevant determinants of health: an international perspective. Health Policy **60,** 201-218*

Thanks

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	Practice registration	No practice registration	Voluntary registration – eligible patients w CD
Advantages	GPs feel responsible Encourage personal/practice cont'y Informational continuity Manage chronic disease Manage prescribing PH data	Patients choose when they want personal continuity – and info continuity Keeps practices at top of game Go elsewhere for stigmatised illness	Manage chronic disease (for these patients) Enhance personal continuity (for these patients) Info continuity (for these patients) GP responsibility (for these patients)
Disadvantages	Patients 'stuck with practice' Patients avoid disclosure of stigmatised illnesses Paternalistic – continuity	Doctor shopping (prescriptions) Lack of info continuity – adverse events	Inconsistent for different patients Data incomplete