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Foreword

General practice has always served as the cornerstone of the Australian health care system, and contributes greatly to Australia's high international health and health service rankings. The US-based Commonwealth Fund, in an international study, has shown that when adults have a 'medical home,' their access to necessary care, receipt of effective preventive screening, and management of chronic conditions improve substantially and disparities in access and quality are reduced[1]. The medical home, as provided by general practitioners, contributes to the high approval ratings for the Australian health care system in the Commonwealth Fund survey.

Dependable statistics about process and outcome are essential when making judgements about the quality of the health care system, and this report demonstrates and summarises the substantial contribution to the statistical base in general practice made by the Bettering the Evaluation and Care of Health (BEACH) program.

Over the past decade the BEACH program has provided a unique insight into the clinical encounters between general practitioners and their patients. As the only continuous national study of general practice activity in Australia, indeed in the world, it is an extraordinarily valuable and important resource. The strength of BEACH data lies first in the sheer sample size and second, that it provides a reliable, independent and continuous measure of changes in general practice since 1998.

As this report shows, there have been substantial changes in the activities of general practice in that time, both in numbers of services delivered and the focus of these services. These changes have occurred in parallel with the progressive ageing of our population, a consequent rise in demand by patients for treatment and management of chronic illnesses, changes in the provision of bulk billing, practice and service incentive payments through Medicare, a rising awareness of the need for accountable and evidence-based practice, and a push for greater patient involvement and responsibility in their own health care.

General practice can serve as a platform for preventive care and this has attracted the interest of those determining the Medicare schedule of fees for the provision of general practice services. Likewise the coordinating role that general practitioners may play in the care of patients with chronic illnesses has been reflected in Medicare items to encourage the development of chronic care plans and the better coordination of the range of services that these patients need.

This report provides statistical evidence that general practitioners are doing more check-ups, providing more lifestyle advice and managing more chronic problems than previously. Many of the changes identified can be readily linked to policy changes that have occurred over the time of the study. However, some policies appear to have had little or no impact on general practice patterns of care, and this should raise questions in the minds of policy makers as to their value.

---

1 A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis. Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey, The Commonwealth Fund, June 2007.

Unfortunately a method for linking the measured changes in the process of care to improved health outcomes is yet to be developed and applied in Australia. In the absence of outcome measurements, the data in this report provide a means to assess the impact of past and current policies and programs in general practice, and can be used to help guide the development and implementation of new recommendations and policies.

General practice, alongside hospital care and health services more generally, is currently under review by several government-sponsored commissions and committees. These reviews are necessarily looking at how general practice might contribute to the achievement of a range of preventive and therapeutic health care goals for the future, whether in a suburban setting or as part of the effort to reduce health inequalities in Indigenous communities. Future changes in government policies affecting general practice seem certain.

Regardless of whether these imminent reports recommend revolution or evolution in the way health services are delivered, the new policies and programs that will be implemented to replace or stand alongside current policies and programs will demand evaluation of their costs and benefits, including those in general practice. The current economic environment demands that health care dollars are properly targeted and spent as effectively as possible.

The Australian Government has enunciated its support for evidence-based policy making, and the basis for this is the collection and analysis of data and the public distribution of the findings which can then be used, in a virtuous cycle, to respond to current needs and plan for the future.

This was recognised in 1994 by Canadian researchers who wrote: "*we believe that it would be useful for researchers to keep up databases … over several years so that changes over time and their consequences on quality of care and practice patterns can be quantified… Such a model could be used for projecting changes to the system and for planning for the future.*"[2]

BEACH is valuable and important work, an excellent investment that surely should continue into the future. Indeed, necessary health care reforms will make this future work imperative if we are to preserve the honourable place, well deserved, that general practice occupies in health care in Australia.

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2 P.G. Norton, E.V Dun, and L. Soberman, L. Family practice in Ontario: How physician demographics affect practice patterns. Canadian Family Physician, 2004; 40: 249–256

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Abbreviations

ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Service
ACE	angiotensin-converting enzymes
AIDS	acquired immune deficiency syndrome
AIHW	Australian Institute of Health and Welfare
ASGC	Australian Standard Geographical Classification
ATC	Anatomical Therapeutic Chemical (classification)
AUDIT	Alcohol Use Disorders Identification Test
BEACH	Bettering the Evaluation And Care of Health
BMI	body mass index
BOIMHC	Better Outcomes in Mental Health Care
CAPS	Coding Atlas for Pharmaceutical Substances
Children's survey	National Children's Nutritional and Physical Activity Survey
CI	confidence interval (in this report 95% CI is used)
COPD	chronic obstructive pulmonary (airways) disease
CT	computerised tomography
CVD	cardiovascular disease
DVA	Australian Government Department of Veterans' Affairs
ED	erectile dysfunction
encs	encounters
FRACGP	Fellowship of the Royal Australian College of General Practitioners
GORD	gastro-oesophageal reflux disease
GP	general practitioner
H2RA	H2 receptor antagonist
HbA1c	haemoglobin, type A1c
HIV	human immunodeficiency virus
HPV	Human Papillomavirus
ICPC	International Classification of Primary Care
ICPC-2	International Classification of Primary Care (Version 2)
ICPC-2 PLUS	a terminology classified according to ICPC-2
ICS	inhaled corticosteroids
IHD	ischaemic heart disease
IMG	international medical graduate

INR international normalised ratio

LABA long-acting beta-agonist

MBS Medicare Benefits Schedule

NHPA National Health Priority Area

NHS National Health Survey

NSAID non-steroidal anti-inflammatory drug

OTC over-the-counter (that is, medications advised for over-the-counter purchase)

OTD overseas trained doctor

PBS Pharmaceutical Benefits Scheme

RACGP Royal Australian College of General Practitioners

RFE reason for encounter

SAND Supplementary Analysis of Nominated Data

SAS Statistical Analysis System

SPANS New South Wales Schools Physical Activity and Nutrition Survey

STI sexually transmitted infection

URTI upper respiratory tract infection

UTI urinary tract infection

WHO World Health Organization

Wonca World Organization of Family Doctors

Symbols

↑/**↓** indicates a statistically significant linear change

↑/↓ indicates a marginally significant linear change

§ indicates a non-linear significant or marginal change

– indicates no change

< less than

> more than

N/A not applicable

NAv not available

NEC not elsewhere classified

no. number

NOS not otherwise specified

Executive summary

This report looks at changes in the clinical activities of general practice in Australia over the decade 1998 to 2008, in the context of numerous government initiatives, changes in the general practitioner (GP) workforce and changes in the population.

General practice activities are measured by the Bettering the Evaluation and Care of Health (BEACH) program, a continuous national study based on data collected from new samples each year of about 1,000 GPs. Each GP provides details for 100 consecutive GP–patient encounters. BEACH began in April 1998 and this report uses data collected from then to March 2008, covering about 9,900 GP participants and 990,000 GP–patient encounters.

The report focuses on general practice activities for eight health conditions declared as National Health Priority Areas in recent times by the Australian and state and territory governments and two emerging health areas—sexual health and gastro-oesophageal reflux disease. It also summarises care provided to the Aboriginal and Torres Strait Islander population by GPs.

Australians and their GPs

- Both the Australian population and its GPs are ageing.
- GPs are spending an increasing proportion of their time with older patients and less with children.
- An increasing proportion of GPs are female (almost 4 in 10).
- Most GPs are in group practices; the average GP is working fewer hours.
- Based on the number of doctors and the hours they work, there has been an apparent GP shortage, and recognised geographic maldistribution.
- Over the period of 1998–2008, visits to GPs fell from a peak of 5.5 visits per head of population at the start to a low of 4.9 in 2003–04, then rose towards the earlier level to 5.2 in 2007–08.

General government measures

- To improve equity of access to GPs, the Australian Government took steps in 2004 and 2005 to increase certain GP payments and reduce patient costs.
- Government also encouraged GP management of chronic diseases, and increased preventive health checks among at-risk groups, by creating payment incentives through the Medicare scheme.
- Responding to the GP shortage, governments have created more training places, encouraged employment of doctors from overseas, and supported use of nurses to help GPs in their clinical work, by providing Medicare rebates for some nurse activities.

Why patients visit GPs and what GPs are doing

- The number of reasons patients give for seeing the GP have increased over time and changed, with a move towards more requests for services (such as check-ups and prescriptions) and away from descriptions of symptoms.

- GPs are more often doing check-ups and detecting and managing chronic diseases, such as diabetes, hypertension (high blood pressure) and other cardiovascular problems, cholesterol disorders and depression.
- They are increasingly likely to order pathology tests at a visit and to order more tests when they have decided to test.

Where has disease management improved?

There have been numerous special government initiatives over the decade, and some new clinical guidelines, aiming to help GPs improve their management of a range of priority health problems. The initiatives have mainly been to ensure that GPs are appropriately reimbursed when they adopt what are considered to be best practice methods of clinical care. This is done by devising new items for services that can be claimed under the Medicare scheme. The causal effect of policies is often difficult to assess because of the complexity and breadth of general practice, and because some policies have been in existence longer than others, having less time to have had an effect. However, this report has shown that GP clinical activity generally correlates strongly with health policy initiatives

Positive developments include increased:

- detection and management of Type 2 diabetes
- involvement in detecting and managing cancers of the breast, cervix, skin and prostate, suggesting greater sharing of responsibility with specialists for the care of these problems
- referrals of psychological problems to psychologists but no decrease in GP involvement in management, again suggesting more sharing of care between these professions
- use of asthma maintenance therapy for adults, in line with recent policies and guidelines
- prescribing of the cholesterol-lowering statin drugs and monitoring of patients' cholesterol levels, particularly those at risk through Type 2 diabetes, in line with guidelines for reducing the risk of heart disease and stroke.

So far there has been ***no measurable impact of policies*** on:

- multidisciplinary team management with, and use of, allied health professionals by GPs in the management of priority health areas, except for psychological problems and Type 2 diabetes
- management of arthritis and other musculoskeletal conditions, except osteoporosis
- management of heart disease and stroke, except for cholesterol-lowering activities, though the lack of an increase in the incidence of stroke in an ageing population suggests better preventive care
- how health problems among Aboriginal and Torres Strait Islander patients are managed.

And the study raises ***concerns*** about:

- the cost of the continued rapid growth in the ordering of pathology testing
- an increase in the management rate of adverse medical events in older patients and younger women
- the increasing number of patients who will be diagnosed with complex health needs, the time that will be needed to care for them and the effect this will have on the future GP workforce.