

2 Introduction

2.1 Scope of Evaluation

This evaluation was undertaken for the GP Super Clinics established between 2007 and 2008. It focused on three aspects of the GP Super Clinics Program:

- Implementation: the administration of the Program by the Department of Health and Ageing
- Establishment: the planning and construction of the 36 GP Super Clinics across 37 localities established in the 2007-2008 tranche
- Operations: service delivery in the seven GP Super Clinics which were operational for a minimum of six months prior to the commencement of the evaluation

The evaluation is focused on the GP Super Clinics Program 2007-2008 as implemented by the Department of Health and Ageing and the establishment and operations of the GP Super Clinics from the perspectives of Clinic Directors, clinicians and importantly patients. It is not an evaluation or an assessment of the policy which guided the GP Super Clinics Program.

2.2 Background

In the lead-up to the 2007 Australian Federal Government election, the Australian Labor Party, then in Opposition, announced primary health care reforms which included the establishment of GP Super Clinics.¹ Their policy document, *New Directions for Australia's Health: Delivering GP Super Clinics to Local Communities*, articulated the increased investment in primary care through the delivery of GP Super Clinics.

The establishment of the GP Super Clinics aimed to encourage general practitioners (GPs) to practise in localities of identified GP shortages and to deliver more services focused on patients with chronic disease and the associated disease burden on the community. This included the provision of allied health services and a stronger focus on preventative health care and chronic disease management.¹

With the election of the Labor Government in November 2007, changes in primary health care were included as part of the new government's overall approach to health care reform. The criteria for selection of localities for the GP Super Clinics were areas where:

- Access to health services was poor
- Health infrastructure was underperforming
- The provision of a GP Super Clinic could take pressure off emergency departments
- Levels of chronic disease were high and/or there were populations with high needs such as large numbers of children, or a higher proportion of older people who have higher health needs than the general population

- Areas currently experiencing or anticipated to experience rapid population growth¹

The 31 localities for GP Super Clinics which were initially announced are identified in Table 1. In 2009 a further five localities were identified for inclusion in the GP Super Clinics Program for the 2007-2008 tranche:

- Cockburn (Western Australia)
- Gunnedah (New South Wales)
- Portland (Victoria)
- South Morang (Victoria)
- Wodonga (Victoria)

Table 1: Localities Identified as GP Super Clinics in 2007

NSW	Queensland	Tasmania
Blue Mountains ¹	Brisbane Southside ¹	Burnie ¹
Grafton ¹	Bundaberg ¹	Devonport ¹
North Central Coast ¹	Cairns ¹	Hobart Eastern shores – Clarence (Site A) ¹
Port Stephens ¹	Gladstone ¹	Hobart Eastern shores – Sorrell (Site B) ²
Queanbeyan ¹	Ipswich ¹	Victoria
Riverina ¹	Redcliffe ¹	Ballan ³
Shellharbour ¹	Strathpine ¹	Bendigo ³
Southern Lake Macquarie ¹	Townsville ¹	Berwick ¹
Northern Territory	Mt Isa ³	Geelong ³
Palmerston ²	South Australia	Wallan ¹
	Modbury ²	Western Australia
	Noarlunga ²	Midland ²
	Playford North ²	Wanneroo ²

¹ Localities administered by Commonwealth-led invitation to apply process

² Localities progressed jointly by the Commonwealth and the relevant state or territory government

³ Localities where funding process was conducted with an identified recipient

The Australian Government committed \$181.7 million to establish GP Super Clinics as part of the overall investment in primary health care services.² This funding involved three separate processes for allocation, which were determined by the Australian Government and were outlined in the *GP Super Clinics National Program Guide 2008*:²

- Funding through a Commonwealth-led Invitation to Apply process
- Funding progressed jointly with states and territories
- Funding process with identified recipients at the nominated localities

The level of investment for each site was determined by the Australian Government and was detailed in the *GP Super Clinics National Program Guide 2008* for each locality.² In some instances matched contributions from state and territory governments were also available.²

Following the Federal election and the change of government in November 2007, the Department of Health and Ageing was tasked with the implementation, establishment and ultimately the operational components of the GP Super Clinics Program. These three aspects were developed and managed initially by Primary Care and Chronic Disease Branch and then

by the GP Super Clinics Branch established within the Primary and Ambulatory Care Division of the Department of Health and Ageing.

2.3 Program Objectives

The ten objectives of the GP Super Clinics Program described as characteristics of the service delivery model are contained in Appendix 1. A key focus of the service delivery model was the delivery of multi-disciplinary care by different disciplines and service providers through physical or virtual co-location, working as teams.² The nature and range of services provided under the GP Super Clinics were to be tailored to the needs of local communities. While these services were not prescriptive, it was expected that the funded GP Super Clinics would demonstrate the following core characteristics in their service delivery model represented in the GP Super Clinics Program objectives:²

- Well-integrated multi-disciplinary patient centred care
- Responsiveness to local community needs and priorities including those of Aboriginal and Torres Strait Islander peoples
- Accessible, culturally appropriate and affordable care
- Support for preventative care
- Efficient and effective use of technology
- An environment conducive to recruitment and retention of workforce
- High quality best practice care
- Viable, sustainable and efficient business models
- Support for the future primary care workforce
- Integration with local programs and initiatives.

2.4 What is a GP Super Clinic?

The GP Super Clinics were established within local communities as new or refurbished facilities. It was expected they would be sites of excellence in primary care service delivery and would provide opportunities for health professional education and training with a multi-disciplinary focus.² They were to provide a broad range of services that targeted the health needs of local communities by bringing together a range of clinicians, including general practitioners, practice nurses, visiting medical specialists and allied health professionals.² Models of care were expected to reflect best practice multi-disciplinary and integrated care focusing on chronic disease and preventative health care.

2.5 The Need for Reform

Governments in many developed nations have recognised the need for health system reform, to address increasing demand related to ageing and chronic disease, system fragmentation, equitable access, efficiency, costs, safety and quality.³⁻⁷ These challenges have contributed to the World Health Organisation (WHO) articulating the need for refocusing on a strong primary health care sector globally.⁸

In Australia, a number of key reasons have been identified for the need for reform with an emphasis on primary care. The first relates to the burden of disease and increasing rates of chronic disease and ageing, resulting in increased demand for a range of health services.⁹ The second relates to the need to reduce admissions and length of stay in hospitals by providing clinically appropriate care in the community. Aligned to the focus of WHO, the third reason relates to the need for greater geographical, financial and health condition equity in access to primary health care services.^{9,10} Further, an ageing and inequitably distributed health workforce continues to place pressure on the current primary health care system, requiring a focus on workforce capacity building as part of primary health care reform.⁹

2.6 Primary Care Critical to Health Outcomes and Equity

Primary care addresses the most common health problems in the community, integrates care where there are multiple health problems and addresses the context in which illness occurs.⁹ The WHO identifies primary care as the linchpin of health equity and achieving health outcomes for all, supported by robust theoretical and empirical evidence, with strong national primary care systems associated with improved equity and health indicators.^{8,11,12}

In both developed and developing nations, evidence exists for the link between a strong primary health care system and equity.¹³ Generally, primary health care is perceived as more equitable than other forms of health care, in part because it requires fewer resources.¹³ Numerous studies have identified the link between strong primary health care and improved health outcomes related to mortality, morbidity, patient experiences and self-reported health status.^{13,14} These outcomes are commonly associated with lower expenditure on individual and system costs.

2.7 Models for Primary Care and General Practice

Internationally, models of primary care have evolved over the last decade with some common elements. Evidence suggests that organisational structures such as joint ventures and alliances can support achievement of health outcomes while ensuring sustainability of business models.¹⁵

While the nature of the models differs, most developed nations have attempted to implement organisational structures to support development and coordination of local primary care services.¹⁶ Evidence does not exist to support a particular organisational model, with variations in type of organisation, governance, legitimacy and capability.¹⁶ Commonly, co-location of multiple services under one organisational clinic structure has developed in various forms to deliver more integrated care, particularly for people with chronic diseases.⁴ Regardless of the model, it has been identified that new organisations in primary care need time and stability to build capability, trust, culture and systems in sustainable ways.¹⁶

Trends in models of primary health care have also seen an increase in organisations that provide comprehensive services to particular populations.⁷ These services are provided by multi-disciplinary teams, with enhanced roles for nurses, pharmacists and other providers.⁷ There has also been an increased emphasis on health promotion, disease and injury prevention, and management of chronic illnesses.⁷ Workforce and organisational model trends in general practice have seen shifts from single to multiple GP practices, from single to multi-disciplinary practices, and from practitioner autonomy to greater accountability.^{4,16}

Funding of general practice and primary care has seen a shift towards payment structures which reflect broader system requirements and a move from general practitioner focused fee-for-service payments to blended payments incorporating elements of capitation, patient co-payment and incentive payments.⁹ Payments for specific activities have also been used to increase provider activity in certain areas.¹⁶

In Australia there have been many initiatives designed to address some of the pressures in general practice and in primary care. However, many of these have been localised and not sustained.¹⁶ Organisational models reflected in Divisions of General Practice or Networks have limited capacity to improve integration and coordination of care and to improve health outcomes for the local population in the absence of health system reform.¹⁶

Recent emphasis in models in the United Kingdom have been driven by the need for greater flexibility and shifting the balance of power to primary health care, to the practice level and to consumers.¹⁶ There have been three key changes in the way primary care is delivered in the United Kingdom: patients are now registered with a practice not an individual GP; out-of-hours care is not provided by the GP but rather is provided by primary care organisations, some of which may sub-contract to GP practices; and 25% of GP income now relates to the quality targets of the United Kingdom's Quality and Outcomes Framework which provides additional financial rewards to those practices that deliver agreed levels of patient care, based on a points system.¹⁶

Evidence for the effectiveness of primary care provided under service models such as those provided through GP Super Clinics suggests various impacts.¹⁷ Outcomes related to patient experiences of communication and coordination, and health outcomes for chronic disease and for quality and efficiency have been demonstrated under health services which are structurally integrated and provide a continuum of services.¹⁷ Higher quality of care in group general practices is reported compared with single or small practices, and in those accredited as training practices.¹⁸