Building flexible services that work on the ground

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Our third speaker this morning is Dr Tony Hobbs, who has recently taken up the position of Principal Medical Adviser at the Therapeutic Goods Administration. Previously he was a general practitioner in rural New South Wales and former Chair of the Australian General Practice Network. Dr Hobbs has had a significant impact on Australia's health system as Chair of the External Reference Group that in 2008–09 developed Australia's first National Primary Health Care Strategy. He has extensive experience on boards, committees and advisory councils, including the National Health and Medical Research Council, university and cancer, diabetes and kidney health advisory groups: broad experience. That wealth of experience and expertise adds significantly to the contribution that he makes through the TGA, to the health system. So to tell us a little bit this morning about building flexible services that work on the ground, please welcome Dr Tony Hobbs.

Well good morning and it's a great pleasure to be here. And before I start I do want to acknowledge the traditional custodians of this land the Karuna people. I want to pay my respects to their elders, both past and present. I want to acknowledge this wonderful gift that we've received as a group here from the traditional custodians. I also want to thank Gordon and his team and my co-presenters for their generosity in allowing me time here this morning because I was a very late addition to the program, so thank you all and thank you especially to Gordon.

Many of you in the audience will be thinking: why has Tony Hobbs gone to the TGA, the dark side, to a regulatory organisation perhaps, when he has had such a long experience and hopefully a positive contribution to primary care in my local community, regionally and hopefully nationally? And that's quite a story and that's the thread that's going to tie this together so hopefully that will work. There are some people in the audience who will keep me honest because I've seen Sue McAlpine here. Sue is a current Board Director at the Murrumbidgee Medicare Local. I've seen other people here from my local community and of course there is a small contingent here from TGA, so they'll certainly keep me honest if they feel that I'm misrepresenting anything.

Basically what I want to do is talk a little bit about the community which I've just left in Cootamundra, and talk about how we worked with that local community as local service providers to build a health service that reflects their needs and meets their needs, and after I have left, maybe some would see me as a charismatic leader, that it's not going to fall over, that the structures and the processes are in place for that to move forward and to grow and develop with the community as the community needs change over time. I want to talk a little bit and reflect about the National Primary Health Care Strategy because I still think that's a fundamentally important document that sets a platform for a structured approach to primary care in this country, and then I want to segue into the TGA just at the end.

I think we've heard—and I've only been here the last day and a half, but we've heard that no one rural community is the same, and many of you in this audience, I know, have long experience working with your local communities as part of that local community.

This is the community which I've just left. A small community on the south-west slopes in New South Wales, a relatively small population. A relatively old population but a higher than state average young population, reflecting high birth rates, a higher than national average Aboriginal population and a relatively poor population. And that reflects many of your experiences, I'm sure, as well. And one of the key things last year, as our Medicare Local looked to their 21 Local Government Authorities, as we went out to first of all provide information that we had from various sources, to try and pull together a regional approach for a health plan for that population, it again reinforced to me the notion that even though all of those communities shared similar problems, each community was really different. And if you look at the Cootamundra population, yes, we have higher than state average and national average

smoking rates, overweight and obesity, but one of the things that really jumped out at me was that our community had a very significant problem with alcohol. Now that was perhaps poorly defined on hospital discharge summary, but again, that was a really important piece of information for me. Probably reflects anecdotally what I'd seen over the 20 years of working in that community, but that has already begun a conversation with that local community, with the council, orchestrated by the Medicare Local about what might be done there.

So the conversation in Cootamundra began back in about 2006, and it began with a conversation with the incumbent general practitioner workforce, all male at that time, which reflects Jane's comments. Many of us from a rural background, certainly me, but really looking at what the model of care was going to be, because at that time two of the five long time GPs, had announced a desire to retire or move on, and I also had a plan to be thinking about leaving that community within about five years. So this seemed a really good time for us as a cohort of general practitioners to think about what would the service delivery model be for the future, looking at recruitment and retention of GPs, easy entry, gracious exit and the gracious exit I'll come right to at the end.

Very early on in those discussions it became really apparent to me that there were great opportunities to work much more inclusively and collaboratively with a group of other stakeholders including our community, our local council, orchestrated by the then Division of General Practice and the Medicare Local, our local hospital, Allied Health both private and public, our Community Health Centre. And right at the very start we broadened the conversation, we set up a working group, which worked for 18 months in the development and planning of the health centre, to find something that was going to be workable and sustainable for our local community. And I think that's the thing that holds us together, and one of the things that I'm really impressed about this Conference, is the strength of relationship with community that the National Rural Health Alliance has. It's great to see.

And we were really keen to look at more integrated models of care and I'll talk about that in a moment. Why? Because the thing that really drives me and I know drives many of the people in this room, and again Jane referred to it, as did Bob in his presentation, is that it's about access and equity for me, for rural communities and how we respond as a local community to that, how our health service can respond within the framework, the funding framework and the structural framework that we find at a policy level. And clearly to me it wasn't about the GP, I have to say right up, GPs are very important. It was more about the team that surrounded the GPs and right at the very top of that list we decided, in our local community setting, that it was to enhance the role of the practice nurse and when we looked at the design of the centre and the workings of the centre, right at the very heart was a team of practice nurses, three full time equivalents each with their own independent rooms and really the heart of the practice. And as you'll see in a moment when I show you some of the data, which we've been able to actually improve access to care in a timely manner. With a view to exploring other models of care as well and particularly interesting for me was the role of the nurse practitioner working together with a team of other people in the general practice setting. That's something that needs to be worked out, and our team leader at the time, our senior nurse, is now looking at doing her Masters to accomplish that.

But of course there are other people on the team as well and we've heard strongly over the last day about the important role of Allied Health. When we're talking about a response to people with multiple complex comorbidities, it needs a very coordinated integrated approach and certainly working with a team of Allied Health both public, private, within, without the practice, with the division, without the division, coordinating all that in a way that worked for our local community again was a great opportunity for us.

As I said at the outset it was really important for us also to identify those people within our community who self-identified as Aboriginal, and right from the get-up our figures, when we reflected on that, showed we had done that really poorly. I think in the first year of operation, we had 12 people out of about 300 on our census data in our local community that we had identified in the practice as Aboriginal. As I left towards the end of the last year, that had expanded to well over 200.

Why is this important? Because clearly within the structure within we work, we can offer them Aboriginal-specific health checks and we can certainly work with them through a variety of projects and funding arrangements to make sure that their access to care, both within their community and in our regional community, visiting specialists, was enhanced, so that's a really important opportunity.

And the other thing we were able to do around access was looking at our hours of operation, and again right from the get-up, it was clear that our community was really interested in accessing care out of hours. And so we established an after-hours set-up in our town with the same cohort of GPs, in a sustainable way, and that's been very important in improving access. Again that was ably supported by our Division of General Practice and clearly this is one of the key tasks, the challenge, the opportunity for Medicare Locals this year.

There are some of the team members, and not surprisingly, and many of you in rural Australia know that the workforce has changed, so when I first went to Cootamundra 20 years ago there was one overseas-trained medical graduate. As I left there were no local medical graduates in my community at all. That's not to say there isn't a strong team of GPs, mostly South African doctors, all of whom have done their local fellowship through the college, with a team of excellent young doctors coming through, so PG, PPPs, registrars and also very importantly our medical students. So a very vertically-integrated teaching and mentoring system, which is a key, but again that fundamental shift in the health professionals who are providing services in the local community, and that's important for the community because they need to adapt to that as well.

As I said right from the start, we worked with the community in the planning and development of the centre, but clearly to me there was an opportunity to continue that close engagement with our community in a formal way, and here I reflect on the work of Michael Grecko done in Devon, now about 12 years ago in fact. And it's a very simple idea about a Critical Friends Group, inviting members of your community into your practice, supporting them to give you structured feedback on the way you provide your service and that's a good talisman, a good measure about how you're responding to your community's needs.

And according to Michael, and certainly in my experience over the last five years, the three key roles of these Critical Friends are about exchange of information and perspective from them to us, and us to them, that two-way communication to allow them to review our quality improvement systems, what we're actually doing and trying to achieve in our integrated care models, and they had a great input into our integrated maternity shared care model, into our integrated diabetes care model, into our working towards a more integrated mental health model to respond to the needs of our community. And also very importantly, to spread the word about how the local health—the primary care centre, was actually trying to work to meet the needs of our local community.

So when we look at the people who were on this Critical Friends Group, we had the editor of the local paper, a very important person and also able to disseminate information. We had an Aboriginal elder from the Wiradjuri Tribe. We had people with physical disability. We had people with mental health issues, young mothers, old people. A very broad representation to give us good quality feedback from a broad range of our community. And I know that's ongoing. I know there's a real commitment from that organisation, as I leave to continue that good work.

And so what I'm going to show you is a little bit of data. Now I could have put up a whole lot of data, and I know Chris is sitting here, and many of you look at your data on a regular basis, and we've certainly done that in Cootamundra, so we have regular management meetings, so we have practice managers, doctors, nurses, looking at our data and feeding back, whether it's around diabetic care, whether it's around how we look after patients with COPD. And clearly I'm going to have a conversation with Jane about some of the incentives that she's reflected on, because I think there's some very good reasons about why some of those curves go up and some of them flat-line, and that's in the way the incentives are driven and how they're reflected in our business of doing our day-to-day work in

general practice, and sometimes it's a bit of a disjunction between policy setting and what's actually happening on the ground, and I think that's where organisations like the NRHA come in.

One of the key things that our community were interested in is how easy it was to make a timely appointment with the doctor or nurse of their choice. It's nice. And you can see this is now getting towards 12 months old but the data is still accurate. I rang the centre recently. So it's nice to be able to reflect back and say well here you are, here's the data. Why is that important? Because it's important to them. It's also important because you do get criticism. No one appointment system, like no one funding system, is going to be the panacea for every individual or every particular circumstance and so we will get criticism. It's really nice to be able to provide feedback and say we're doing our best, here is the data. We can hear your individual problem, can we sort it out? Do you have a better way of us working our appointment system, for instance? Another thing that the Critical Friends Group said to us is that we're keen not to waste a lot of our time sitting in your practice waiting for our appointment once we're actually in your building. And one of the things that you can look at with our technology is to look at the practice time from the time that people register to the time they actually see the health practitioner of their choice, and as you can see mostly that's well under 15 minutes. When we feed this information back to the Critical Friends Groups, they're quite happy with that, and see that there's a good response to their concern.

The other extraordinary thing that's happening in our community over the five years is this very significant decrease in presentations to the local hospital. Now some of the cynics might say it doesn't really matter in a small rural community because it's the same GPs who are providing the care within primary care, who also provide the care at the hospital. But the minute that someone takes that step across the threshold of a hospital setting, because of the infrastructure cost sitting behind that, the cost of care is significantly different. So that's one thing. The other thing is that our patients said that they wanted to be seen in their primary care setting with a group of people who have their usual ongoing care as well. That's the response. Obviously the current financial year is not fully accounted for, and I think that will probably flat-line but you can see there's been about a 50 per cent reduction. We haven't costed that. It'd be interesting to have a chat with Jane or someone else about that, but I would think that's a clear savings to the system over all.

So that's a small vignette of our health system and just hearing Lucy's acceptance speech yesterday, I know this isn't in any way unique, but it reflects what we've done in our local community and I think there's a whole body of this good work going on. It needs to be captured and shared so that other communities can take the bits out that will fit their community and build whatever's going to work for them.

I want to quickly just reflect now back on the Primary Health Care Strategy, and it's interesting that I think that this strategy has been informed by a group of people from the bottom up, so 13 primary health care people sitting around a table for 12 months influencing policy, and this is what we've ended up with. Not surprisingly, number one priority was around access, improving access and reducing inequity, better management of chronic conditions, increasing the focus on prevention, and Jane's talked about that. Quality, safety, performance, and accountability for all of us. We have to be accountable for the sort of care we provide, both to our local communities, and at a national level. And not surprising those sort of things turn up in the TGA as well. Based on regional integration, and there was a presentation about Medicare Locals yesterday, and you heard both Jane and Bob speak about the importance of regional organisations to respond to that regional need.

Information and communication technology really important, day-to-day business in primary care in 2013 really is informed and enabled by information communication technology. We can look at our practice population data and change the way we do business and see what the outcomes are. We need to reflect that back to our local populations, and obviously health planners are very interested in that and clearly we're all waiting to see the final iteration and expression of the personally controlled electronic health record, and I can see Dr Chris Mitchell here from NETA who's going to be speaking.

Having a skilled appropriate workforce and again Health Workforce Australia has the national responsibility of setting those policy levers, but what happens in your local community is important and again it needs to reflect the needs of that local community. Infrastructure is important. I didn't really speak about that but there's a whole complex model of investment in the setting in Cootamundra and I'll be happy to talk to you about that later.

And again, financing insistence performance. That's about being accountable, being cost effective, building the evidence case for why there needs to be continuing strong investment in primary health care. I think that's crucial. And that really tries to capture within that document what a 21st century primary health care system might look at. And I think the other thing is that we're doing pretty well in Australia, the system is not broke. There are very significant challenges. As you can see that line, the trend line, the GDP spend going up. We're doing better than a lot of other countries. It's really about Australians driving the system that's going to meet our needs best.

So how then have I ended up in the TGA? It's a really interesting discussion. Having been 20 years in my previous current town of Cootamundra, having been in the Northern Territory, Southern Africa, so almost 30 years of my working life has been spent in primary care. I'd been offered an opportunity to work for our national regulator. Three principles that drive the TGA are quality, safety and efficacy. For me, that's a natural fit with what I've tried to express in my primary care life.

So—what does it do? Within those focused areas, it regulates therapeutic goods coming into this country or indeed produced in the country and being exported elsewhere, including our medicines of all varieties, medical devices, blood and blood products. This is a risk-based approach. Now that's a difficult concept. We can't reduce all risk completely. It's about risk mitigation within the confines of the regulatory framework, which we work enabling people to access our medicines and therapeutic devices, but there is always some risk and that's something that we need to clearly try and articulate throughout the community.

What we don't do: we don't focus on professional practice, although clearly a lot of what we regulate has an impact on what health professionals do. We don't evaluate cost-effectiveness either. And interestingly, if we just look at prescription medicines for a moment, so we will regulate on a safety and efficacy and quality point of view. The PBAC will then look at this from a cost-effectiveness point of view and then the government will make a decision. To try and improve that process, there is now what we call a parallel process where industry can simultaneously put a product forward for regulatory approval, but also have the PBAC begin to consider its cost-effectiveness. But we also do a whole range of other things.

So, for instance, just to digress slightly, so at the moment the things that are exercising my mind apart from businesses used from the regulatory framework, it's Australia's response to antimicrobial resistance. It's Australia's response to the N7N9 Bird Flu situation that's evolving out of China and changing every day and could well, of course, end up as something that's going to affect us in Australia, so it's within our framework how we respond to that, working very closely with the department. It's how immunisations are listed in this country, how they're given in this country and how adverse events are reported, and how that influences the knowledge base we have about immunisations, so it's not just about the regulatory framework, it's about a whole range of other things as well. And as well as that, we have a very significant reform process going on. It's about making the TGA more open, more transparent, more accountable, if you like, to the community and to other parts of the health sector. So there's a whole range of work going on there.

What I suggest you do is that: we have a booth, so we have Alex, and Alex and Bronwyn and I will be there for a while. Come and ask us questions. I'm very happy to give advice, where we can, about regulation, about what's happening in Cootamundra. Any questions you have. So I'm open for questions and discussions. And I thank you for the opportunity again. I wish you well. I've been really impressed by how the organisation has been responding to your comments and every day we've seen

that list and I think that's going to be really important, again, in influencing policy in this country. So thank you very much.