Meeting the challenge of chronic illness in general practice

Bronwyn M Veale

ABSTRACT

- Seven of every 10 general practice encounters are for chronic conditions. Three common chronic conditions managed by GPs are depression, diabetes and asthma. Two of these are National Health Priority Areas (NHPAs), while depression is the focus of the mental health NHPA.
- General practice care for people with depression is being strengthened by the "Better outcomes in mental health care initiative", which includes a 3 Step Mental Health Process — assessment, mental health plan, and review.
- GPs have the opportunity to screen patients for diabetes and manage their condition. For those with risk factors who screen negative, GPs are well placed to encourage lifestyle interventions. Two of the four components of the National Integrated Diabetes Program focus on general practice.
- The Asthma 3+ Visit Plan, which incorporates diagnosis and assessment of asthma, development of a written asthma plan, and review of asthma management, has been shown to improve GPs' management of asthma.
- These initiatives to improve general practice interventions for chronic illness, although welcomed, put further pressure on already overstretched GPs coping with multiple changes in the primary-care sector.

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SEVEN OF EVERY TEN GENERAL PRACTICE encounters are for chronic conditions. Here I review three common, chronic conditions managed by GPs — depression, diabetes and asthma.[1]

Diabetes and asthma are National Health Priority Areas (NHPAs), and depression was chosen by all Australian health ministers as the focus for the mental health NHPA. Nomination as NHPAs reflects both their high prevalence, and the potential for significant health gains by improving outcomes for those with these conditions.[2] The other NHPAs are cancer, cardiovascular health, injury prevention, and arthritis and musculoskeletal conditions.

Depression

The current burden of illness caused by depression is alarming. Annually, depression affects over 800 000 adults, and, by the year 2020, it is projected to be the second leading cause of premature death after cardiovascular disease.[3] Heart disease, and alcohol and other substance misuse are the most frequent causes of death in people with depression.

The mental health NHPA was introduced in 1997. After the release of the NHPA report, a national action plan was developed jointly by federal, state and territory governments as well as community representatives. Key features of the depression program are the national depression initiative "beyondblue" and the "Better outcomes in mental health care initiative". In the 2001–02 Australian budget, this second initiative was allocated $120 million over 4 years to strengthen the care of people with depression in general practice.[4] The five key components of the initiative are given in Box 1.[5]

Regrettably, the current general practice care for people with mental health problems is suboptimal. Many patients who present with symptoms of anxiety and depression do not receive a psychological diagnosis or appropriate interventions.[6] This may change with the wider use of self-report tools, (eg, the Depression Anxiety Stress Scale [www.criminology.unimelb.edu.au/victims/resources/assessment/affect/dass42.html], the Edinburgh Postnatal Depression Scale [www.wellmother.com/articles/edinburgh.htm], and the Geriatric Depression Scale [www.psychologynet.org/geriatric.html]), which have been shown to be effective in case finding for depression in general practice.[7] However, even if effective treatment programs are provided for every person with depression, it is estimated that disability and premature mortality may only be reduced by 50%, because effective treatments are not always optimally delivered.[8]

While the new general practice-based initiatives for managing depression are welcomed by most in the profession, they demand that GPs spend additional time to refresh, upskill and register to deliver the 3 Step Mental Health Process to their patients. These demands are being applied to an already pressured GP workforce, who are working hard to keep abreast of multiple changes in the primary-care sector. Many wonder whether there is sufficient capacity in general practice for the additional time required for the longer consultations that comprise the 3 Step Mental Health Process. This is a particular concern in rural and urban fringe areas where GP : population ratios are unacceptably low, and where there are proportionately fewer female GPs, who tend to offer longer consultations than their male counterparts. Special incentives or assistance may be needed to bring the 3 Step Mental Health Process to areas of high need.

It will be especially important to evaluate the "Better outcomes in mental health care initiative". There is already disquiet about the paucity of general practice-based research underpinning the educational programs on the effective management of depression. An additional concern is that

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few GPs have experience working in multidisciplinary teams or with a primary healthcare approach, yet both underpin this initiative. GPs need a strong community orientation, good collaboration with other healthcare sectors, and a desire to deliver an appropriate balance between health promotion, disease prevention and treatment.

Diabetes

The number of adults with diabetes has trebled since 1981, although perhaps half of all people with this condition remain undiagnosed. In 2000, it was estimated that 7.5% of the Australian population aged 25 years or more had type 2 diabetes.[9]

Diabetes has been a National Health priority area since 1996. As a high proportion of the population visit GPs, if appropriate screening measures are used, GPs have the opportunity to identify most people with undiagnosed diabetes. Recent research supports a two-step screening strategy — fasting plasma glucose estimation for people with diabetes symptoms or risk factors, followed by full oral glucose tolerance testing for those with equivocal test results (ie, plasma glucose levels 5.5–6.9 mmol/L).[10] GPs are well placed to support lifestyle interventions (eg, regular exercise and dietary change) in people with risk factors who screen negative. It is in this group that such interventions can prevent diabetes.

In the 2001–02 Australian budget, over $43 million was allocated over 4 years for the National Integrated Diabetes Program (NIDP). Two of the four key components of the NIDP (outlined in Box 2) focus on general practice.[11]

The costs of enhanced care of people with diabetes are high and rising. Estimates derived from the Australian Coordinated Care Trials showed that the annual Medicare and Pharmaceutical Benefits Scheme costs ranged from $1900 to $3200 per patient.[12] This is likely to be money well spent.

Evidence from the UK Prospective Diabetes Study suggests that intensive control of a patient's blood glucose and blood pressure levels results in improved clinical outcomes and fewer diabetes-related complications.[13]

The CARDIAB database is an important Australian resource for the management of diabetes and cardiovascular disease in general practice.[14] It is used by over 43 Divisions of General Practice nationally. CARDIAB provides a centralised register–recall system, enables identification of high-risk cardiovascular patients and all diabetes patients, and incorporates the National Diabetes Outcomes Quality Review Initiative (NDOQRIN) minimum data set (which reports the majority of the clinical indicators for the National Divisions Diabetes Program) and CVData (the cardiovascular minimum data set).

Pekarsky and other commentators have queried the capacity of the Australian healthcare system to cope with the pressure of more intensive management of diabetes.[12] Furthermore, unexpected and unintended consequences may result from providing allied and specialist services to people with diabetes. Examples include expansion of waiting lists for elective surgery and inequitable access to services. Disadvantaged patients obtain allied health services from public hospitals and make up the vast majority of patients on waiting lists for surgery. Under this scenario, these patients, who cannot afford the high copayments required for treatment in the private sector, are more likely to miss out on needed services. It was also somewhat discouraging that the Australian Coordinated Care Trials were unable to show a cost saving from intensive management of patients with diabetes over two consecutive years. Clearly, health benefits that should accrue from good management of this chronic condition require longer timeframes and a long-term investment strategy.

1: Major components of the "Better outcomes in mental health care initiative"

1. Education and training for general practitioners to familiarise them with the initiative and to increase their mental healthcare skills and knowledge.
2. The 3 Step Mental Health Process — effective and holistic patient assessment, mental health planning and a review —provides a framework for the management of mental health disorders in primary care. Eligible GPs who are registered with the Health Insurance Commission for the initiative will receive a Service Incentive Payment for providing the 3 Step Mental Health Process.
3. Focussed Psychological Strategies are specific, evidence-based mental healthcare treatment strategies. Provision of Medicare Benefits Schedule (MBS) rebates encourages appropriately trained GPs to provide these strategies.
4. Access to allied health services to enable GPs registered with the initiative to access Focussed Psychological Strategies from specified allied health professionals (eg, psychologists). In 2002–03, this is available as a pilot program through 16 Divisions of General Practice.
5. Access to psychiatrist support in case conferencing under the Enhanced Primary Care MBS items for consultant physicians; the development of new MBS items for psychiatrist involvement in discharge planning and case conferencing in the community; and the development of a mechanism for GPs to access psychiatric advice in emergency situations.

2: Key components of the National Integrated Diabetes Program

1. Incentives to general practice
Since 1 November 2001, funding has been available through the Practice Incentives Program to improve the prevention, earlier diagnosis and management of people with diabetes.
2. Infrastructure and support for Divisions of General Practice
Funds are available for establishing and maintaining diabetes registers, providing best practice management, and addressing inadequacies in access to community services and multidisciplinary care.
3. Engagement of consumers
Nationally consistent information, education resources and tools will be developed for those people living with or at risk of diabetes.
4. Supporting changes in health professionals
Funds are available for diabetes services or organisations to change their current systems, so that early identification of people with diabetes, better prevention and improved health outcomes are realised.

Asthma

Moderate to severe asthma affects at least one in 10 adults and is another recognised cause of preventable premature mortality and morbidity in Australia.[15] Optimal management of asthma can reduce asthma-associated mortality and hospitalisations.[16]

In August 1999, asthma was added as a NHPA. In the 2001–02 Australian budget, almost $49 million was allocated over 4 years to improve asthma management in general practice.[15] Box 3 gives the twin components of this asthma initiative.

Australian research focused in general practice has resulted in improved asthma management. Population-based surveys suggest that, without tailored interventions, asthma management plans were provided to about 33% of patients with asthma in 1996, and this proportion had declined from the previous year.[17] There is evidence from a randomised controlled trial based in South Australia that either attending an asthma clinic run by a nurse educator and a GP, or regular review by a patient's usual GP, increased the likelihood that people with asthma had a written action plan and were taking inhaled preventer medication.[18]

Thus, the proactive Asthma 3+ Visit Plan is underpinned by the most robust Australian research evidence of any of the three conditions covered in this article. Surprisingly, the initiative does not specifically encourage GPs to identify and support smokers with asthma to quit the habit.

3: Twin components of the GP Asthma Initiative

1. The pro-active Asthma 3+ Visit Plan which incorporates diagnosis and assessment of asthma, development of a written asthma plan and review of asthma management. Incentives are available to GPs through the Practice Incentives Program to adopt and complete the plan for people with moderate to severe asthma.
2. Funding for community awareness about asthma and support for health professionals and consumers.

Conclusions

The 21st century will likely see the rapid expansion of the evidence base for general practice interventions aimed at ameliorating the effects of chronic diseases. However, the more taxing matter of chronic illness prevention may attract less funding, as research bodies are pressed for adequate monies, become impatient for results, and are tempted to impose unrealistic timeframes on research programs.

For people with depression, a critical factor is whether they are referred to a psychologist directly or the GP has shared-care arrangements with psychologists, who are often important in the effective management of this condition.

Many people with asthma deny that they have a chronic condition, and this has an adverse impact on their compliance with referral and review visits. Patient and community education need to be linked more strongly, if general practice interventions are to reduce the burden of these NHPA diseases.

Another uncertainty is whether the GP workforce will widely adopt the incentives to enhance the care of patients with chronic diseases through the NHPAs. Undoubtedly, the current GP workforce is insufficient for the additional activity that will be required to deliver these services to the whole population in an equitable manner. Will primary care teams develop to counter the present workforce dilemma, or will a comprehensive primary healthcare approach be adopted? The success of federal initiatives, such as support for practice nurses and more allied health service programs in rural (but not urban) areas point to a way forward.

Competing interests

None identified.

Acknowledgement

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