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Perspective

General practice's early response to the COVID-19 pandemic

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Abstract. The COVID-19 pandemic has resulted in multiple changes in the delivery of general practice services. In response to the threat of the pandemic and in order to keep their businesses safe and viable, general practices have rapidly moved to new models of care, embraced Medicare-funded telehealth and responded to uncertain availability of personal protective equipment with innovation. These changes have shown the adaptability of general practice, helped keep patients and practice staff safe, and undoubtedly reduced community transmission and mortality. The pandemic, and the response to it, has emphasised the potential dangers of existing fragmentation within the Australian health system, and is affecting the viability of general practice. These impacts on primary care highlight the need for improved integration of health services, should inform future pandemic planning, and guide the development of Australia's long-term national health plan.

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Introduction

Australia's early response to the COVID-19 pandemic, including low levels of community transmission and low disease mortality, has been considered successful by international standards. Although evaluation of this early response may change with evolving community transmission, the present analysis reflects on the response to date through a primary healthcare and health funding lens. International evidence has long proposed that health systems with a stronger primary care focus provide better health outcomes,[1,2] and the importance of Australian primary care in disaster management has been identified previously.[3] The strength of primary care is potentially one of the reasons for Australia's successful response to the COVID-19 pandemic to date.

The central components of Australia's primary care response have involved the rollout of whole-of-population telehealth (video and telephone consultations), establishment of general practitioner (GP)-led respiratory clinics, the provision of personal protective equipment (PPE) to general practices via their primary health network (PHN)[4] and regular communication to primary care providers.

Telehealth

Telehealth has been advocated as safe and effective, but its use in Australia has been limited because, before the pandemic, Medicare-funded telehealth was only available in rural areas.[5] The expansion of Medicare-funded telehealth (including both telephone and video conferencing) commenced in March 2020. Through multiple waves of reform, telehealth access was initially offered to vulnerable populations before expansion to 'whole-of-population' telehealth and the creation of over 100 additional Medicare Benefit Schedule (MBS) items. Currently, most health professionals can use telehealth for assessment and consultation visits until 30 September 2020.[6]

At the beginning of the pandemic there was a greater than 30% drop in GP face-to-face consultations and a corresponding rise in telehealth (predominantly telephone) consultations.[7] The rapid change to telehealth served two purposes: (1) to protect patients and clinical staff from unnecessary exposure to COVID-19; and (2) to provide access to patients who were advised to stay at home. The shift from face-to-face to telehealth has been reported internationally.[8,9]

GP-led respiratory clinics and state health COVID-19 testing clinics

Federal government funding was rapidly provided to establish new community testing and assessment services specifically for COVID-19. COVID-19-testing clinics were set up by local health districts, while over 140 GP-led respiratory clinics have been established with additional federal government funding, and supported by PHNs. These services are permitting potential COVD-19 patients to be tested, assessed and treated separately

from mainstream general practice (and hospital) settings. However, these clinics have also highlighted fragmentation in the Australian health system. National GP organisations have reported that patients have been presenting to their practice following testing and/or treatment for COVID-19 with their GP having no knowledge of the results. This has the potential to endanger the lives of other patients and practice staff. Fortunately, early community transmission, and therefore risk, was low. However, this can change rapidly, as seen in Victoria in July 2020.

PPE availability and PHNs

PPE availability has been a critical issue facing primary care (and indeed the whole health system) throughout this crisis.[10] Many general practices possessed and used little PPE before the pandemic, and commercial supplies were rapidly exhausted. In the absence of adequate PPE, many practices reduced in-person consultations, introduced telephone triage and developed innovative models to provide access safely, such as drive-through services.[11] These initiatives were potentially critical to ensuring Australia avoided additional population and health worker deaths, as seen internationally. Due to a dearth of commercial supplies, PHNs began providing PPE to Australia's more than 7000 general practices and pharmacies, and by early June 2020 had distributed over 3.4 million masks. PHNs were placed in an unenviable position between GPs expecting full PPE and government sources, which only distributed masks from the national stockpile.[12] Practices continue to report dissatisfaction with access and inflated costs to alternative sources of PPE.[13,14]

Communication through primary care

One successful feature of the response has been regular and comprehensive communication between government sources and peak primary care organisations (e.g. Royal Australian College of General Practitioners (RACGP), the Australian Medical Association and the Australian Primary Health Care Nurses Association). After some initial issues, including a lack of consistent messaging on triage, testing and PPE, two-way communication has been prominent and led by strong involvement from experienced GPs within the federal health department. National organisations have been able to help coordinate timely and accurate information to state-based bodies, local hospitals, PHNs and practicing primary care providers. Importantly, there has been a mechanism to feed 'frontline' experiences of COVID back up these communication channels and the potential to influence policy at local, state and national levels. These regular communication channels have allowed for clear consistent messages and for 'trusted sources of truth' to develop.

What has been learned so far?

Primary care has performed well

Despite the challenges identified, primary care providers have continued to provide safe and high-quality care. Practices adapted quickly to remote working, reduced the risk of infection in waiting rooms, embraced telehealth and clearly notified patients of the need to call the surgery before attending. This shift in care delivery demonstrates the flexibility of primary care, highlights the role of primary care in curbing the initial wave of COVID-19 and can be considered a public policy success. The roles of PHNs in supplying general practices with PPE, in supporting the establishment of GP-led respiratory clinics and in identifying integration issues for allied health, pharmacies, nursing homes and general practices have shown the potential of these organisations in improving linkages throughout our fragmented health system, both during the pandemic and beyond.

Telehealth appears likely to stay

Telehealth has been welcomed by patients and health professionals.[15] Peak GP bodies, like the RACGP and Australian College of Rural and Remote Medicine (ACRRM), have been quick to develop tools and guidelines to support the quality use of telehealth, including when it is appropriate and when it is not.[16] Government support for telehealth suggests continuation beyond the pandemic.[17] This is despite concerns about potential for misuse, including the appearance of opportunistic providers offering telehealth without any routine care and without links to a patient's regular GP,[18] and the current predominance of telephone over video care.[7]

Many practices are adopting a 'teleconsult-first' approach to triage patients to determine whether health needs can be met remotely rather than needing physical attendance. Research is needed to assess the effect of the shift to telehealth on the quality of patient care. Evaluation is also needed to ensure that telehealth delivers the care that patients need,[19] and that limited health resources are not wasted on low-value care.[20]

In July, access to Medicare-funded telehealth was restricted to patients who had attended general practices in the previous year. Although this restriction will encourage continuity of care, the effects on patient access, particularly for vulnerable patients (who may not have established a relationship with one practice), and practices need monitoring. Potentially, the availability of telehealth needs to be further modified to particular consultations, patient groups or provider types. Such restrictions would need to ensure that Australia's public policy success is not undermined, be clear and support access to a patient's usual general practice, and be evaluated to make sure they are strengthening the provision of quality primary care. Telehealth could be expanded to improve communication between health providers (e.g. GPs and hospital doctors), and therefore improve discharge processes, improve coordination and reduce unnecessary hospital readmission.[19,21]

Longer-term health effects are emerging

Long-term effects of COVID infection are likely to include chronic physical and mental health issues for a subgroup of patients, which will be managed in primary care. Beyond the direct result of infection, other long-term health impacts are emerging for both patients[21,22] and healthcare providers.[13] Uncertainty created by changing COVID-19 transmission and changing regulations related to testing, quarantine and public health advice, such as mask utilisation, is increasing stress and the prevalence of mental health conditions in both the community[21] and health professionals.[13] As patients obtain less face-to-face care (by shifting to telehealth or by postponing routine care), control of chronic health conditions is anticipated to worsen.[22] Delays in accessing care will be exacerbated by

cancellation of non-urgent elective surgery in the pandemic response. The delayed burden of chronic disease will also be predominantly managed in primary care, but it is uncertain how practices will manage this increased workload, and how they will manage to provide pre-pandemic chronic disease care in a COVID-19-safe manner.

Viability of general practice

There is increasing concern about the effects of the pandemic and the government response on general practice viability. Many practices have reported decreased activity and income, and marked decreased in profitability as practices have adapted to the provision of remote consultations while maintaining their physical presence for face-to-face appointments[13,23,24] and requiring increased administrative support to coordinate telehealth. One restriction on telehealth has been a regulation requiring GPs to bulk-bill patients with healthcare cards, children, patients with chronic diseases, all people aged >70 years and Indigenous Australians over 50 years of age.[25] The legality of this regulation has been questioned[26] and has particularly affected practices that do not routinely bulk-bill all their services and have had to adapt their business model, as well as their service delivery, during the crisis. Another concern has been about the financial impact of opportunistic telehealth providers. If these providers lead to a budgetary blowout, they may damage ongoing funder support for telehealth. If these providers divert funding from usual care providers, they may further reduce the viability of comprehensive general practice.

Prior to the pandemic, Australia was entering a period of primary care reform, with the Federal Health Minister announcing a primary care taskforce as part of Australia's long-term national health plan and the introduction of voluntary practice enrolment and additional funding for general practice beyond current fee-for-service payments.[27] These reforms have been delayed due to COVID-19, but will resume and should be designed and informed by primary care's pandemic experience. Practices are likely to need additional support (beyond Medicare-funded telehealth services) to detect and evaluate the impact of the pandemic on their practice population and to manage increased morbidity.

Policy makers have long advocated for better coordination and integration between the hospital setting and primary care[28,29] in order to reduce fragmentation, improve clinical outcomes and reduce system inefficiencies and costs. The pandemic has highlighted the potential dangers of poor coordination. Sharing of necessary health information between state and federally funded health systems must be consistent and standard care for all patients. Plans to introduce patient enrolment with a GP will assist by creating a default patient–GP link, a link that all health services should recognise and support by sharing results. The ongoing development of a Primary Health Care Data Asset by the Australian Institute of Health and Welfare[30] has potential to better connect and use primary healthcare data throughout the health system and should remain a priority.

Final reflections

The COVID pandemic has highlighted the agility of our complex health system, as well as its fragmentation. The ability of health professionals to rapidly shift from face-to-face consultations to telehealth has been astounding and effective in rapidly protecting our patients and ourselves from this infection. Private GP surgeries have been driven by need for viability, and the sudden acceptance by funders of the usefulness of telehealth has been very welcome. Integrating telehealth into previous models of care will take time and investment, as well as research to evaluate its utility. Ongoing fragmentation of care and failure to share health information has the potential to worsen the spread and impact of the pandemic, and should be rectified. Primary care will manage an increasing burden of COVID-19-related disease related to long-term effects of infection, delayed chronic disease management and increasing mental health prevalence, and will need support to increase capacity and maintain viability.

We recognise that strong primary care alone is not enough in this pandemic response and Australia's early successful response has been multifactorial. The UK has been regarded as having a strong primary care system, but delays in social distancing and testing have meant UK primary care has been unable to limit the spread of COVID-19. Potentially the balance of public and private providers in Australia has enabled our health system to adapt with greater speed and agility than systems that are completely publicly funded.

Conclusion

As Australia emerges from the pandemic, these learnings about fragmentation and primary care viability should be incorporated in the resumed development of Australia's primary care plan,[27] and formally included within future pandemic planning. With better collaboration between health providers and improved sharing of patient data, there is potential to greatly consolidate existing workforce and resources, and create a single health system that maximises the benefits of mixed funding and patient choice, rather than being characterised with fragmentation as a fatal flaw.

Competing interests

Michael Wright is Chair of the RACGP Reference Expert Committee on Funding and Health System Reform, Deputy Chair of the RACGP New South Wales/Australian Capital Territory Faculty, Chair of the Central and Eastern Sydney Primary Health Network and a general practitioner in Woollahra, New South Wales. Roald Versteeg is RACGP General Manager for Policy, Practice and Innovation. Jane Hall has no competing interests to declare.

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