Health
4 March 1999

Mrs PENFOLD (Flinders): World Health Day is coming up at the beginning of June. Therefore this is an appropriate time to look at one of the many good things that the Government is doing in health. I refer to an innovative program being undertaken by South Australian Health Plus in conjunction with doctors, almost all of whom are general practitioners, and care givers. The coordinated care trial is operating in four divisions of general practitioners in South Australia—three in the city and one rural—and deal with specified chronic illnesses. The trial aims to demonstrate that coordinated care and greater involvement by patients and their families or carers in their own health care reduces the incidence of crisis and complications.

One of the projected outcomes was to improve the health of those with chronic illness and to lessen the demands on existing health resources, in particular hospitals. I am delighted that Eyre Peninsula is actively involved in the trial and I am further delighted that the preliminary results show that the aim and the outcomes are being met. The Eyre Peninsula section of the trial is managed by the Eyre Regional Demonstration Unit under the chairmanship of Dr Peter Morton, with Peter Harvey as regional manager and Jim Collins in charge of service coordinators. To begin the trial, the unit established a care model, gained support from most general practitioners in the region and established a service coordination process. The patients enrolled in the trial suffer from diabetes, cardiac, respiratory or back pain conditions.

The project was developed initially from the nationally recognised diabetes project developed by Dr David Mills. A defined population of patients with the specified illnesses mentioned were enrolled in Port Lincoln and Whyalla. Service coordinators were recruited and trained. By early 1998 enrolments ended and full-time care planning and data monitoring of 1 350 patients on Eyre Peninsula began. In addition, 510 control patients were located on Yorke Peninsula.

A care plan encompassing best practice protocols for each participant's physical condition was implemented with the intention of reducing the need for medical and hospital services and enhancing daily life. The care plan detailed clinical services needed by the patient and allowed the patient to set themselves achievable goals over a specific period of time. Patients also completed a preliminary questionnaire that allowed them to rate the impact of their illness on their life and work. Service coordinators have contacted patients at a determined frequency depending on the severity of their problem. The care coordinators have ensured that care plans were adhered to and that patients were supported in their efforts to meet their specified goals and targets.

After less than one year of intervention, patients were reporting that they felt much more in control of their condition and that they felt more confident in their dealings with their doctor, who is the care coordinator. The control group, when scaled to match the intervention profile, was found to be hospitalised at a higher rate and to use medical benefits scheme services at a much higher rate when compared with the intervention group. The trial set out to establish an integrated data network through which service use, medical and pharmaceutical information, and community health service provision would be linked to enable total coordination of services according to need. That was designed to reduce service duplication and to ensure that best practice protocols were followed in caring for patients. State and Commonwealth funding was pooled to purchase relevant services as defined by patients' care plans.

The South Australian Health Plus central office developed a data repository to house comprehensive patient data to involve all providers, carers and coordinators to view care plans on-line and to make appropriate decisions about patient care. Service provision was principally the same as it was prior to patient enrolment, so the only new factors in the patient care program were the involvement of patients in a formal goal setting and care planning process and the extended involvement of the general practitioner through regular contact with service coordinators.

In place of the routine, general practitioner visits, patients received ongoing contact, support and encouragement from their service coordinators who worked in teams based in Port Lincoln and Whyalla. The team approach was adopted because of the need for collaborative and group support. An additional benefit of the program is that service coordinators have supported patients to make the best of the community health services in Eyre Peninsula. That is, service coordinators, in addition to their defined role, became de facto service providers as a way of compensating for limited service available in rural centres.

Initial trial outcomes suggest that social intervention and support for patients with chronic and complex illnesses reduces the incidence of health crisis leading to hospitalisation and visits by general practitioners. The reason for this may be that, since the majority of patients are elderly, retired and living reasonably confined lives, the regular visits from service coordinators and the interest shown in patients through this process has triggered a more positive approach to self-management amongst trial patients.

Currently the Eyre Peninsula trial is showing significant savings against hospitalisation and this saving, if it were capitalised upon, would provide the majority of funds needed to fund service coordination for the trial group. It is expected that the current trend of savings, against hospital admissions from which preventive activity is at least theoretically funded, will continue as the trial progresses.

The introduction of other major elements such as the general practitioners' IT network, the advent of education programs and the establishment of new purchasing arrangements for services should mean that the Eyre Peninsula component of the trial could achieve even greater efficiencies in the longer term. This would enable the region to provide an even more comprehensive primary health support program for patients with chronic illnesses and to permanently shift resource allocation from the acute section to the primary health sector.

These tentative and early indications of a successful outcome of the coordinated care trial in regional South Australia suggest that significant outcomes can be achieved for patients as a result of well planned and coordinated service provision, but this does not necessarily require more medical services. Quite the contrary! The implication is that consistent and caring social support and encouragement of patients to learn about and manage their own illness will lead to even better outcomes than are currently achieved through a more medical approach to illness management.

These early findings are significant for rural South Australia. In a community where informal networks exist but where traditional extended family structures are breaking down people feel better and more confident and positive about their health if they have the reassurance of regular human contact and support.

It is clear from those involved in the trial that many patients with chronic conditions are living in less than satisfactory social situations and, as a result of these conditions, may tend to neglect their health. When the basic human networks fail, patients suffer a loss of direction and motivation. They allow their health to deteriorate and, ultimately, rely on medical intervention to help them once their potentially manageable condition progresses beyond their control.

The South Australian Health Plus service coordinators appear to have compensated for a lack of social support for patients with chronic illness, giving people back their dignity and their will to help themselves rather than relying on external intervention once essentially preventable crises have occurred. Trial outcomes are positive. They include:

- Full participation of the intervention target group.
- Demonstrated improved participation rates and improved patient motivation to manage their condition through care planning and positive self-help.
- Demonstrated reduced hospitalisation for intervention patients against the control group.

- § Demonstrated savings in the use of medical benefits services.
- § Significant general practitioner involvement in the trail and in he potential of coordinated care to provide an ongoing solution to improving service and health outcomes for patients with chronic illness.
- § Established and tested new service delivery purchasing and delivering processes.
- § Modelled and tested new organisational structures.
- § Collected valuable data on patient utilisation trends.
- § Influential in modelling change management within health.
- § Established the potential for coordinated care processes to work across all Department of Human Services divisions, and not only in health.
- § Introduction of general practitioners to information management, which has an enormous potential benefit for quality of practice beyond the trial.

Other States are observing the South Australian trial with a view to implementing similar programs in their health services.

The DEPUTY SPEAKER: Order! The honourable member's time has expired.