EMBARGOED TO 1AM, THURSDAY 11 DECEMBER 2014

GPs manage common conditions differently depending on location

GPs in some parts of Australia can be markedly more or less likely to prescribe drugs for some common health conditions such as depression and heart disease compared to doctors in other areas.

The National Health Performance Authority's first report on how GPs manage patients' chronic health conditions shows GPs care for these patients in different ways depending on the community.

The report, which captures data from 2005 to 2013, shows that around half of the people (44% to 56%) who visited a GP once in a year had one or more chronic conditions such as back pain, high cholesterol, arthritis, type 2 diabetes, asthma and anxiety.

People with chronic conditions are high users of the health care system, comprising around 85% of the total burden of disease in Australasia.

Depending on the community, GPs spend from 51% to 66% of their consultations providing care to people with one or more common chronic conditions, although not necessarily treating them for those conditions. However, GPs actively manage these conditions in just 34% to 50% of consultations through activities such as counselling, prescription of medicine or referral to a specialist.

The report provides insights into the geographic variation across local areas in the actions GPs take to manage some chronic conditions. The report shows from 2009 to 2013:

- The percentage of patients in big cities who were actively managed for **anxiety or depression** and received a prescription for psychotropic drugs (such as anti-depressants) ranged from 38% in **Northern Sydney** to 59% in **Sydney North Shore & Beaches**. Across regional and rural communities, this ranged from 57% in **Barwon** (Vic) to 74% in **Hume** (Vic/NSW). GP referral to other health professionals ranged from 11% in **Southern Adelaide-Fleurieu-Kangaroo Island** and **Central Adelaide & Hills** to 21% in **Eastern Sydney**.

- The percentage of patients who were actively managed for **selected cardiovascular risk conditions** and prescribed **statins** ranged from 26% in **South Eastern Melbourne** and **Sunshine Coast** (Qld) to 40% in **Eastern Sydney** and **Central Qld**. GP referral to other health professionals ranged from 4% in **Northern Melbourne**, **Bayside** (Vic) and **Central Qld** to 11% in **Nepean-Blue Mountains** (NSW).

- The percentage of patients who were actively managed for **arthritis or chronic back pain** and prescribed **medications** ranged from 52% in **Northern Sydney** to 75% in **Nepean-Blue Mountains** (NSW). Ordering of imaging by GPs ranged from 8% in **North Coast NSW**, **Macedon Ranges and North Western Melbourne** and **Northern Adelaide** to 20% in **Central Coast** (NSW).

National Health Performance Authority CEO Dr Diane Watson said the variation revealed in today's report showcases the diverse approaches GPs used to manage chronic conditions in local areas across Australia.

There are many factors that GPs consider when deciding what management for patients is appropriate, and the report makes no suggestion that higher or lower rates of prescribing medications, providing referrals or other actions is more or less appropriate.

"Today's report offers new information that can provide a starting point for health care professionals to better learn about optimal approaches to care for their community's needs," Dr Watson said.

This report is another step towards revealing different approaches to chronic care management and encourages Australia's research community to tease out the impact of these local approaches on patient outcomes to inform efforts to increase the productivity and performance of Australia's health system.

The *Healthy Communities: GP care for patients with chronic conditions in 2009–2013* report uses data sourced from the Bettering the Evaluation and Care of Health (BEACH) program, which is conducted by the Family Medicine and Research Centre based at the University of Sydney. To ensure comparisons are as fair as possible, local areas across Australia are allocated to peer groups in the report, based on similar geographic remoteness and socioeconomic status.

The new report is available on www.myhealthycommunities.gov.au, which has a new tool – MyReport – that allows users to build their own free customised report for more than 100 measures of health and care. These measures include those in today's report and others previously reported on such as obesity rates, childhood immunisation, life expectancy, avoidable hospitalisations and more.

From next week (Monday 15 December) MyReport will have enhanced capacity to build reports by Primary Health Network (PHN) boundaries which will replace Medicare Locals.

Note to media:

- The percentage of GP consultations in which one, two or three or more chronic conditions were actively managed by local area can be found in **Attachment A** below and on **page 13** of the report.

- A full list of chronic conditions used in the report can be found in **Attachment B** below and on **page 4** of the report.

- A summary of how GP activity is measured in the report can be found from **page 6** of the report.
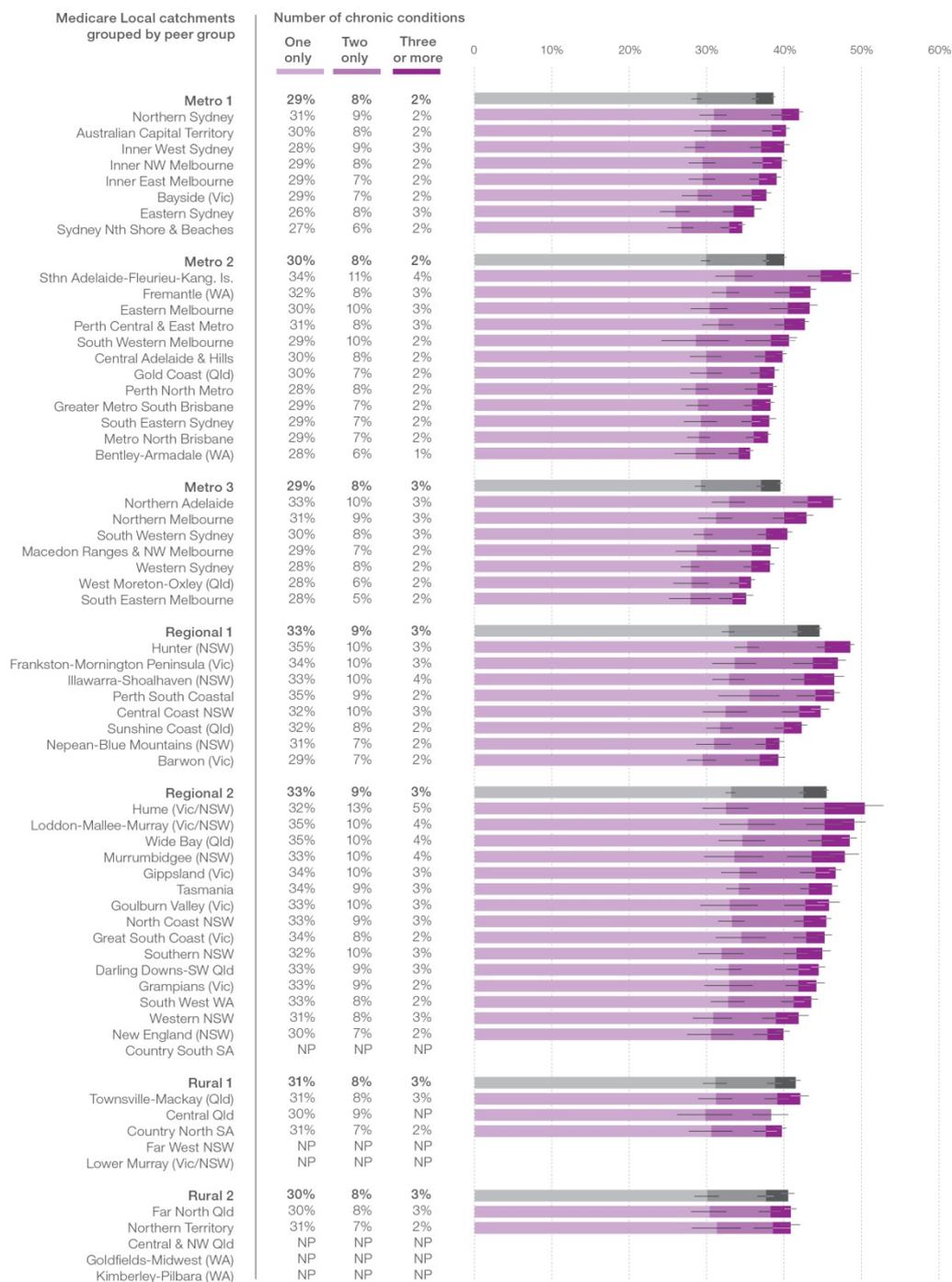
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Figure 3b: Percentage of GP consultations in which one, two or three or more chronic conditions‡ were managed, by *Medicare Local catchment*, 2009–2013

Medicare Local catchments grouped by peer group	One only	Two only	Three or more
Metro 1	**29%**	**8%**	**2%**
Northern Sydney	31%	9%	2%
Australian Capital Territory	30%	8%	2%
Inner West Sydney	28%	9%	3%
Inner NW Melbourne	29%	8%	2%
Inner East Melbourne	29%	7%	2%
Bayside (Vic)	29%	7%	2%
Eastern Sydney	26%	8%	3%
Sydney Nth Shore & Beaches	27%	6%	2%
Metro 2	**30%**	**8%**	**2%**
Sthn Adelaide-Fleurieu-Kang. Is.	34%	11%	4%
Fremantle (WA)	32%	8%	3%
Eastern Melbourne	30%	10%	3%
Perth Central & East Metro	31%	8%	3%
South Western Melbourne	29%	10%	2%
Central Adelaide & Hills	30%	8%	2%
Gold Coast (Qld)	30%	7%	2%
Perth North Metro	28%	8%	2%
Greater Metro South Brisbane	29%	7%	2%
South Eastern Sydney	29%	7%	2%
Metro North Brisbane	29%	7%	2%
Bentley-Armadale (WA)	28%	6%	1%
Metro 3	**29%**	**8%**	**3%**
Northern Adelaide	33%	10%	3%
Northern Melbourne	31%	9%	3%
South Western Sydney	30%	8%	3%
Macedon Ranges & NW Melbourne	29%	7%	2%
Western Sydney	28%	8%	2%
West Moreton-Oxley (Qld)	28%	6%	2%
South Eastern Melbourne	28%	5%	2%
Regional 1	**33%**	**9%**	**3%**
Hunter (NSW)	35%	10%	3%
Frankston-Mornington Peninsula (Vic)	34%	10%	3%
Illawarra-Shoalhaven (NSW)	33%	10%	4%
Perth South Coastal	35%	9%	2%
Central Coast NSW	32%	10%	3%
Sunshine Coast (Qld)	32%	8%	2%
Nepean-Blue Mountains (NSW)	31%	7%	2%
Barwon (Vic)	29%	7%	2%
Regional 2	**33%**	**9%**	**3%**
Hume (Vic/NSW)	32%	13%	5%
Loddon-Mallee-Murray (Vic/NSW)	35%	10%	4%
Wide Bay (Qld)	35%	10%	4%
Murrumbidgee (NSW)	33%	10%	4%
Gippsland (Vic)	34%	10%	3%
Tasmania	34%	9%	3%
Goulburn Valley (Vic)	33%	10%	3%
North Coast NSW	33%	9%	3%
Great South Coast (Vic)	34%	8%	2%
Southern NSW	32%	10%	3%
Darling Downs-SW Qld	33%	9%	3%
Grampians (Vic)	33%	9%	2%
South West WA	33%	8%	2%
Western NSW	31%	8%	3%
New England (NSW)	30%	7%	2%
Country South SA	NP	NP	NP
Rural 1	**31%**	**8%**	**3%**
Townsville-Mackay (Qld)	31%	8%	3%
Central Qld	30%	9%	NP
Country North SA	31%	7%	2%
Far West NSW	NP	NP	NP
Lower Murray (Vic/NSW)	NP	NP	NP
Rural 2	**30%**	**8%**	**3%**
Far North Qld	30%	8%	3%
Northern Territory	31%	7%	2%
Central & NW Qld	NP	NP	NP
Goldfields-Midwest (WA)	NP	NP	NP
Kimberley-Pilbara (WA)	NP	NP	NP

About the patients

Patients identified as having **one or more selected chronic conditions** include those patients, of any age, diagnosed with one or more of the following 18 commonly managed conditions, in order based on prevalence at GP consultation:

- Hypertension
- Osteoarthritis
- Hyperlipidaemia
- Depression
- Gastro-oesophageal reflux disease
- Anxiety
- Asthma
- Chronic back pain
- Ischaemic heart disease
- Type 2 diabetes
- Cancer (malignant neoplasm)
- Sleep disorder
- Chronic obstructive pulmonary disease
- Cerebrovascular disease/cerebrovascular accident
- Congestive heart failure
- Peripheral vascular disease
- Rheumatoid arthritis
- Type 1 diabetes.

The BEACH data were used to identify patients, of any age, with **selected cardiovascular risk conditions** based on clinical guidelines[10] to support the management of:

- Ischaemic heart disease – including acute myocardial infarction (AMI)
- Cerebrovascular disease and stroke
- Heart failure
- Type 2 diabetes among people 60 years of age and older
- Hyperlipidaemia.

Patients identified as having **depression, anxiety or both of these conditions** include patients, of any age, who have diagnosed depression, anxiety or both conditions, which is considered by the GP to be chronic.

Patients identified as having **arthritis or chronic back pain** include those patients, of any age, who have diagnosed osteoarthritis, rheumatoid arthritis and/or chronic back pain. Osteoarthritis and rheumatoid arthritis account for 86% of all arthritis problems managed in BEACH data.