Hunter General Practitioners Association

Submission to the Senate Select Committee on Health

Public Hearing 5th February 2015

Introduction

The Hunter General Practitioners Association is an independent organisation that has been established early this year to give a voice to General Practitioners in the Hunter region. We believe that strong and sustainable primary care is critical to an efficient and equitable health system.

General Practitioners develop strong relationships with our patients, often over a long period of time, and sometimes over generations. We are privileged to share their life journeys, their hopes, their fears, their wellness and their sickness. We know them in great detail, and we want what is best for them.

One of the greatest strengths of the Australian healthcare system is the relatively equitable access to high quality healthcare. Our Medicare system has its imperfections, but few would dispute that it is vastly better than healthcare systems in many other developed nations.

We believe that the proposed co-payment and MBS indexation freeze should not be implemented. These proposals could place barriers to care between patients and their GP, and represent a disinvestment in primary care. Both of these outcomes are undesirable.

In this document, we will not dwell on those issues. The substantial and evidence-based submissions of our colleagues from the RACGP, DRS, AMA and Charlestown Square Medical Centre have already addressed these concerns.

Instead we want to concentrate on the concept that GPs do much more than just object to change. We are also looking for positive reforms to our health care system, and want to contribute our experience and expertise to the discussion.

The primary care savings and investment concepts that follow have largely been derived from less than seventy-two hours of feedback from the Hunter General Practitioners Association's email group.

There are some important concepts that underpin these proposals:[1]

1. Each proposal must fundamentally aim to simultaneously improve the patient experience of care, improve the health of populations, and stabilise the per capita cost of care

[1] Adapted from the Institute for Healthcare Improvement Triple Aim Initiative
http://www.ihi.org/Engage/Initiatives/TripleAim/pages/default.aspx

2. General practices are ideally located to be the hub which cooperates with and coordinates other specialties, hospital and community services related to health, facilitating every health professional to work at the top of their scope
3. General practitioners and other primary care providers should be given incentives for their contributions to producing better health outcomes for the population, rather than just producing more health care

Proposed Savings

1. Reduce the cost of pharmaceuticals

An enormous amount of PBS money is spent on "big ticket" pharmaceutical items which have no proven benefit over much cheaper alternatives. For example, if all patients on just two particular medications were changed to cheaper alternatives, the PBS would save $500 million *per annum*. GPs could be both educated and given incentives to make these changes via a shared-savings incentive scheme.

More broadly, substantial savings could also be realised by better supporting GPs to prescribe PBS medications in accordance with established criteria and guidelines.

The price that PBS pays to pharmaceutical companies for medications should be comparable to that paid by other countries, such as New Zealand. This should be renegotiated.

The cost of dispensing medications can be reduced by supplying patients with several months of medications at a time, at the discretion of the GP. Prescriptions for long term medications could be for a year. In this way, whilst pharmacists would contribute savings through less frequent dispensing, and GPs would also contribute through less frequent consultations.

The telephone-based Authority PBS system should be completely changed to the "streamline" system. This would save the cost of the Authority PBS call-centre, and increase the efficiency of GP workflow.

2. Reduce the cost of investigations

Certain radiological investigations are frequently ordered without following best practice guidelines (e.g. spinal X-ray for back pain, CT head for headache). Certain pathology investigations are also frequently ordered without following best practice guidelines (e.g. vitamin D, lipids, PSA). Many investigations are duplicated between general practice, private specialists and public hospitals due to the relative unavailability of previous investigations.

Education regarding the above could be combined with a system that sets certain criteria for the ordering of particular tests (e.g. similar to PBS streamline authority).

The utilisation of the PCEHR to share investigation results should be prioritised.

The ordering of investigations can sometimes be used as a mechanism to conclude a consultation, in the context of the current MBS system rewarding shorter consultations. The MBS system could be reviewed to encourage longer consultations that involve the use of

clinical skills, rather than the over-ordering of investigations. *Please note that this should be done in a way that is cost-neutral – that is, such a review should not be done with the primary objective of saving money (as appears to have been the case with the last Level A/B proposal).*

Few GPs would be aware of the cost to the taxpayer of the investigations (or pharmaceuticals) that they are ordering. A calculator could be developed which automatically adds up the cost of each of the investigations and pharmacy items that we order, so that we can see a real-time running total down the side of our computer screens as the consultation progresses. There would be no direct commentary on the total cost, but it would serve to remind us that everything we request has a cost associated with it. The same program could also display information about equivalently efficacious but reduced cost alternatives (e.g. you have ordered/prescribed ABC at the cost of $XXX. Ordering/prescribing DEF would cost $YYY).

Where it can be demonstrated that there has been money saved by a reduction in unnecessary investigations, a proportion of these savings should be directly reinvested back into the general practices involved through a shared savings incentive scheme. This could be done on a regional basis (e.g. by Primary Health Network).

3. **Stabilise the cost of specialist care**

Review and amend the means by which specialists charge a higher MBS fee every 12 months by requiring a "new" referral.

Encourage specialists to generate clear management plans for stable patients, enabling effective hand-over to or shared-care with the patient's GP.

Have private specialists publish their "gap" fees so that both GPs and patients are aware of the out-of-pocket cost of care. This information could be held and published online as part of a health services directory administered by the Primary Health Networks.

4. **Review Chronic Disease Management Medicare items**

These could be reviewed and restructured to reduce both the bureaucratic burden to GPs and the cost to government.

Proposed Investments

1. **Review, reinstate or create MBS items**

Examples include:

a. Aged care facility/home visits for the elderly – greater supports and/or higher incentives should be made available to GPs to encourage the provision of medical care for the frail elderly. The alternative is more unstable elderly patients being transferred and admitted to acute care hospitals.
b. Greater financial support for employing practice nurses - The GP practice nurse is ideally placed to contribute to both the efficiency and efficacy of general practice.

This could include telephone triage, vaccinations, wound management and chronic disease management. They would be helping GPs to operate at the top of their scope by working at the top of *their* scope; practicing within a safe and supervised environment; and avoiding the fragmentation of care that would come from, for example, doing routine childhood vaccinations in a pharmacy.

c. Joint injections - In 2009, MBS items 50124 and 50125 for intra-articular joint injections were removed from the MBS. What could have been a relatively inexpensive procedure done by the GP is now frequently referred to be done by a specialist radiologist at substantially greater cost to the MBS.
d. Intra-uterine device (IUD) insertion - The MBS item number for IUD insertion could be increased to encourage GPs to do this procedure, rather than referring patients to a specialist gynaecologist for the same procedure at a significantly higher cost.
e. After-hours home visits - the use by some home-visit services which (a) do not utilise effective triage, (b) routinely bill "urgent" MBS item numbers 597 and 599, and (c) largely utilise a workforce of less experienced non-VR practitioners, not only puts pressure on the MBS, but may also be "training" the public to seek care for non-urgent issues in the after-hours period.

2. Education

Education for GPs should be targeted and co-ordinated to address local needs, particularly as they pertain to hospital-avoidance.[2] GPs could receive incentives to encourage attendance at these targeted sessions, through direct payments and/or outcomes-based reimbursement.

Alternative funding models

1. There has been significant discussion around capitation and pay-for-performance systems as an alternative to the current largely fee-for-service Medicare system. Australian patients are already enrolled in practices in a voluntary but currently unacknowledged way. We would suggest that if there is a possibility of such a system having the support of Australian GPs, it would need to be based on a voluntary "mixed capitation" system, as has been implemented with Ontario's Family Health Teams.

Conclusion

General Practitioners know first-hand the problems and inefficiencies of existing primary care systems. In addition, whatever changes are required to the primary care landscape will inevitably require the support of General Practice.

It follows that General Practitioners should be intimately involved in developing the changes our health care system will require to meet these needs.

[2] See Appendix 1 for an example of a Newcastle GP education meeting schedule with the theme of hospital avoidance

In this document, the objective was not to present definitive solutions. What we hope to have demonstrated is that General Practitioners are more than willing to contribute to the process of finding solutions. They have good ideas. *They just need to be asked.*

To develop the detail of any proposal, broad consultation and feedback from experienced grassroots General Practitioners should be combined with the input of organisations such as the Australian Primary Health Care Research Institute. The result would be a valuable resource that would inform important and necessary changes to our primary health care system.

The Hunter General Practitioners Association in particular stands willing and able to help develop proposals that have the ability to change systems, where appropriate trial these proposals locally, and help scale up successful solutions for wider implementation.

The challenges that face primary health care are great. We look forward to facing them together in a collaborative partnership.

Dr Lee Fong

Secretary

Hunter General Practitioners Association

Appendix 1 – Example of a GP education program with a theme of hospital avoidance

CHARLESTOWN NETWORK EDUCATIONAL MEETINGS TERM 1 2015

Venue: Charlestown Library Meeting Room Cnr Smith/Ridley Streets, Parking council car park next door
Time : 12:45 lunch, 1:10pm start 2pm finish (sharp)
Points: Via HPMI/RACGP 1/meeting = 10/term = 40 per year!
RSVP: To **IF YOU DO NOT USUALLY ATTEND**

The theme of this term is Iatrogenesis – the consequence of medical treatment or advice to a patient. With the increasing burdon on ED patient admissions can often be prevented by us simply e.g patient education in the elderly to get them to stop some types of medicaiton when they become sick/unwell, or to present to us earlier.

DATE	TOPIC	DESCRIPTION OF MEETING
28/01/2015	**The Local Hospital System – How it Works** •	It seems that because of some internal changes in recent years, GP's may not be conversant with the best way of using/referring to the hospital system. John will give an overview
04/02/2015	**Iatrogenic Hospital Presentations** •	Geof tells met that on one of his recent on-call periods, 7 our of 8 admissions were related to drugs that seem to be used in a problematic way in general practice
11/02/2015	**Understanding CKD** •	The renal world feel that there is a bit of a way to go with GP's understanding of chronic kidney disease.
18/02/2015	**Avoiding Bad Drug Interactions** •	If you really want to stuff up a patient, David will present which drug combinations you should use to achieve this end. Note: this is the inverse of which drug interaction that MDW and Best Practice throw up that you can ignore (we will have this talk next term)
25/02/2015	**Resisting & Managing Demands for Benzo's & Narcotics** •	These two drugs are the root of many problems both in primary care and in hospital presentations. Chris will discuss indications for their use and Mathew (a psychiatrist for those who don't know him) will look at how we can identify manipulative behaviour and resist prescribing these drug entitities
04/03/2015	**Pitfalls in Anti-Coagulation** • Speaker – Brad Willsmore	A general anti-coagulation update to help avoid bleeding disasters
11/03/2015	**Severe Emphysema + COPD – Preventing Hospital Admissions** •	This update will both include a look at some of the newer durgs available for treating COPD and how to manage the deteriorating COPD patient to prevent their hospitalisation
18/03/2015	**The Sick Diabetic – Preventing Hospitalisation** •	Sham will look at measures we can take to improve our management of the sick diabetic, to ensure they don't end up in ED
25/03/2015	**Sick Elderly Patients – Preventing Hospitalisation** •	Similarly, will look at managing medications in the elderly patient, specifically in regard to an acute illness – which ones to add/stop. Additionally hopefully we will discuss which drugs to permananantly stop in the elderly – a topic we have tried to do in the past but failed to to lack of co-operation of the female geriatritian involved.
01/04/2015	**Identifying Acute Chest Pain Syndromes** •	Andrew will look at algorithms to assist you in teasing out the dangerous from the non dangerous acute chest pain presentation, which of course we see a lot