Hunter General Practitioners Association

Feedback regarding the RACGP draft discussion paper – "*Working towards a sustainable healthcare system – Version One – February 2015*"

10th March 2015

Introduction

On behalf of the Hunter General Practitioner's Association, we would like to thank the RACGP for both producing and inviting member comment on the "*Draft discussion paper – Working towards a sustainable healthcare system – Version One – February 2015*". Clearly a great deal of effort has gone into crafting the paper.

We would like to acknowledge that the proposed reforms have been presented as an integrated "package". This feedback document will not explore in detail the inter-relationships between the components of the "package", but does recognise that the "package" attempts to offset some of the concerns that will be raised below.

"Indexation"

We note that, as per *Figure 2* of the discussion paper, the indexation issue sits apart from the other proposed reforms, and that it is the first item of discussion in the paper.

There is broad agreement that indexation of payments is the issue of greatest immediate concern. To quote one of our members, "*It is easy to lose focus on the rebate freeze and be talked into trading it for untested reforms that may or may not work*". We would encourage the RACGP, as much as is possible, to focus on and resolve this issue before devoting too much time and energy to more contentious issues which might inadvertently serve to divide rather than unite our profession.

"Direct Billing"

There is clear support for amendment of the Health Insurance Act 1973, to allow, "…*GPs to bulk-bill (direct bill) and, when applicable, charge patients who can afford it a modest contribution*". In the words of one of our members, this would be a "game changer". It also appears that there may be some political will behind this direction at the moment. If this measure gains traction, measures will be needed to ensure that equity of access is protected, and a great deal of care will be needed with public messaging around this issue.

"Efficiency vs Quality"

The suggested tiers and times for GP attendance items have provoked a vigorous discussion. Varied views and opinions highlighted that, "*General practices vary substantially in terms of size, service provision, location, corporate structure and patient demographics*". Inherently, we tend to believe that our own individual practice style is "the best". In this context, there will be never be universal agreement on a "perfect model" for the diversity of General Practice. In addition, the point has been made that no matter what system is established, there will always be some individuals who will find a way to exploit it.

Whilst, as noted into the paper, "*detailed consideration of the content and costing for the six item descriptors is still required*", debate around this topic revolved around the topics of complexity, quality and efficiency.

The efficiency argument suggests that good/experienced GPs require less time to manage presenting problems. Under the current system, the longer the consultation within a particular tier, the less money is earned per minute. For "efficient" GPs, their reward for efficiency is managing complex cases well within the 6-10 minutes and still being able to charge the same as a consultation that takes between 11 and 20 minutes. The concern about changing this arrangement was clearly expressed by the backlash against the Government's proposed expansion of the Level A item number.

The counter argument is that some GPs are consistently not managing their patients well within 6-10 minutes.

The quality argument is that it is difficult to provide quality of service without spending more time (e.g. to discuss why you are not prescribing an antibiotic, side-effects of medication, reassurance, counselling, opportunistic interventions). On this side there is support for payment tiers of as little as five minutes, remunerated so that the higher tiers specifically do not penalise a GP for spending more time with the patient.

The counter argument is that by failing to reward efficiency, productivity may fall and some GPs may become, in the words of one of our members, "Doctor-Have-A-Chat".

Unfortunately time-based payment is not a strong indicator of the complexity of problems managed or the quality of the service provided. As previously mentioned, regardless of how the tiers are divided, careful consideration and consultation will have to go into the specific item descriptors and payment structure. This would need to be combined with further review/development of specific item numbers for chronic disease management and mental health issues (e.g. allow billing of care plans on the same day as a consultation; allow care plan billing by usual/registered practice only; add/increase remuneration for mental health consultations), as well as the proposed voluntary patient registration and "complexity loading".

Whilst not contained in the discussion paper, there was considerable discussion amongst our group about the "80:20" rule, and whether it could or should be revised to encourage quality rather than throughput. If the "80" part of the rule were to be discussed, there would need to be significant caveats such as: it should refer to patients seen, rather than services billed; patients billed with level A consultations should be exempted; exemptions would apply in areas of limited service provision; it should still trigger an audit only.

Conclusion

There is general agreement that the rebate freeze is highly damaging for general practice, and "direct billing" would be positive step, and so we would ask the RACGP to concentrate its advocacy on these issues.

Beyond that there are two main positions regarding the current funding arrangements. The first is concerned that current funding arrangement do not appropriately encourage quality of care. The second is concerned that any change will not appropriately reward efficiency of care.

Any further discussion will require the detail of any proposed model to be released. Whether or not individual GPs support a proposed model will depend on where they see the tipping point between efficiency and quality, as expressed by the funding balance between fee-for-service and capitation/pay-for-performance. It would also be helpful to see the evidence in support of the detail of any proposed models.

The introduction of "direct billing" may help calm the waters on what can be anticipated to be a robust debate about this "tipping point".

As a final note, whilst we applaud the RACGP for attempting to develop a funding model that "*is sustainable and better supports the delivery of quality care*", we note that the current Government has been highly focused on "cost saving". Whatever the funding model for general practice is, the Government has clearly seen it as a place to cut costs. Unless the Government acknowledges that this is *prima facie* evidence of downstream cost savings by investing in general practice, whatever funding model they agree to will be inherently destructive because it is primarily driven by the motive of short-term cost saving.

There are many other obvious ways to improve the efficiency of the health system (e.g. pharmaceutical costs, radiology/pathology costs, specialist fees) which go beyond the funding of general practice (and thus the scope of the discussion paper)[1], but which we would encourage the RACGP to pursue with the government.

The Government should focus on those areas for cost savings; and then turn to general practice as a place to invest.

The HGPA looks forward to the second draft of the RACGP discussion paper, and stands ready to contribute to the future of primary health care in Australia.

Yours sincerely,

Dr Lee Fong

Secretary, HGPA

[1] To this end, please find attached the "*HGPA supplementary submission to the Senate Select Committee on Health, Public Hearing 5th February 2015*"

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:[2]

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

[2] 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.[3] 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.

[3] 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 richard Terry rterry@internode.on.net of 0418686987 **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** • Speaker – John Olsen	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** • Speaker – Geof Tyler	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** • Speaker – Bobbie Chacko	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** • David Newby (Mater pharmacology)	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** • Chris Hayes/Mathew Pols	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** • Speaker – Dr Scott Twaddell	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** • Speaker –sham asharya	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** • Speaker – Kichu Nair	Similarly, Kitchu Nair 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** • Prof Andrew Boyle	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

[The following is a separate supplementary submission to the Senate hearing by Dr Colin Pearce, Charlestown Square Medical Centre]

Madam Chair,

Thank you for the opportunity to address this inquiry.

My name is Colin Pearce. I am proud to be an Australian General Practitioner.

I am the clinical director of Charlestown Square Medical Centre.

I am here to represent the doctors, staff and patients of our 3 medical centres based in Newcastle, at Charlestown, Redhead and Windale.

We made a submission to the senate regarding the recent proposed changes to medicare . We believe these unfairly target General practice and our patients.

These changes have stimulated much discussion about medicare , how it could be funded, what changes could be made to its model and how savings could be made in the future to ensure medicare is sustainable.

We want our health system to provide excellent health services and outcomes to all patients at affordable cost. We do not want cost barriers which will lead to excessive burdens on public hospitals and community health services, and prevent people from having affordable access to proper assessment and management of their health.

We need our practices to be viable. If there is little or no profit in owning a practice then practices will close. Then there here will not just be a shortage of General Practitioners but an extreme shortage in the infrastructure required to efficiently deliver primary health care. If this happens the government will then be required to become more and more involved in providing infrastructure to deliver primary health care at huge cost.

We believe health , but General practice in particular is currently underfunded. One approach to addressing this is budgeting to reduce costs, another is to look at increasing funding. The governments proposed “solution” is to force GPs, to increase gap payments or produce financial barriers to access health services. The aim of this is to reduce service demand (medicare expenditure). The risk is it will cause unaffordable price barriers to many patients accessing primary health care and therefore a failure of our health system. This is particularly true for middle income earners who do not qualify for a health care card. This group really struggle. Any cost cutting should be done across the whole health service in a way that does not create barriers to care and in particular does not target primary health care. Good Primary Health care is essential for the health of our nation. Hunter GPA and Dr Richard Terry Have collated some suggestions that may help reduce costs without creating price points .

As well as cost reduction, thought needs to given to raising funds to adequately pay for the health services our nation desires. The AMA and RACGP submissions both clarify health expenditure. The

medicare levy is clearly not enough. Everyone needs to contribute a little more. Some ideas may be around a fast food tax or increasing the gst .

Finally our health system may need to be redesigned to suit the changes that have occurred in the last 40 years. Much discussion has already gone into this. Achieving this it is going to require extensive discussions between government , health service providers, our peak bodies and the consumers.

With our 3 year election cycle, change in design will also require cooperation between the major parties.

Left alone GPs have been doing a great job at looking after the health of our nation. We are efficient, hard working , and are achieving great outcomes for our patients. These claims are well supported with the evidence tabled in the RACGP's submission.

The ill considered and un-modeled proposals of no indexation and a $5 co payment suggested to make medicare sustainable will not work. In the long run we believe they will increase Government costs, create barriers to care, create workforce shortages, put patients at risk and reduce infrastructure in the primary health care system.

Yours Sincerely

Dr Colin Pearce

[The following is a separate supplementary submission by Dr Richard Terry, GP, Whitebridge]

THE SOLO PRACTICE VIEW.

Personal Background

I am a GP and completed my degree in 1976, hence have had close on 40 years of experience including 32 as the practice owner of a solo general practice in suburban Newcastle NSW.

I hold a conjoint lecturer appointment with Newcastle University, regularly mentor medical students in my practice and have a special interest is organising
GP-determined needs-based weekly educational meetings spanning 10 weeks of each school term, 4 terms per year. These meetings are usually themed. For example we are currently running a block aimed at avoiding hospitalisation and iatrogenesis in the primary care setting.

In addition I have been involved in the implementation of information technology in general practice from its early days, having started the Information Technology Department in the original Hunter Urban Division of General Practice in NSW, and being involved in in-practice tuition of doctors as they transitioned to using computers on their desktop.

I continue to write software and contribute to Open Source Medical Software in the Linux environment and moderate the HunterGP general practice email list-serv.

Solo General Practice – Actual Practice Numbers vs % of Total Doctors

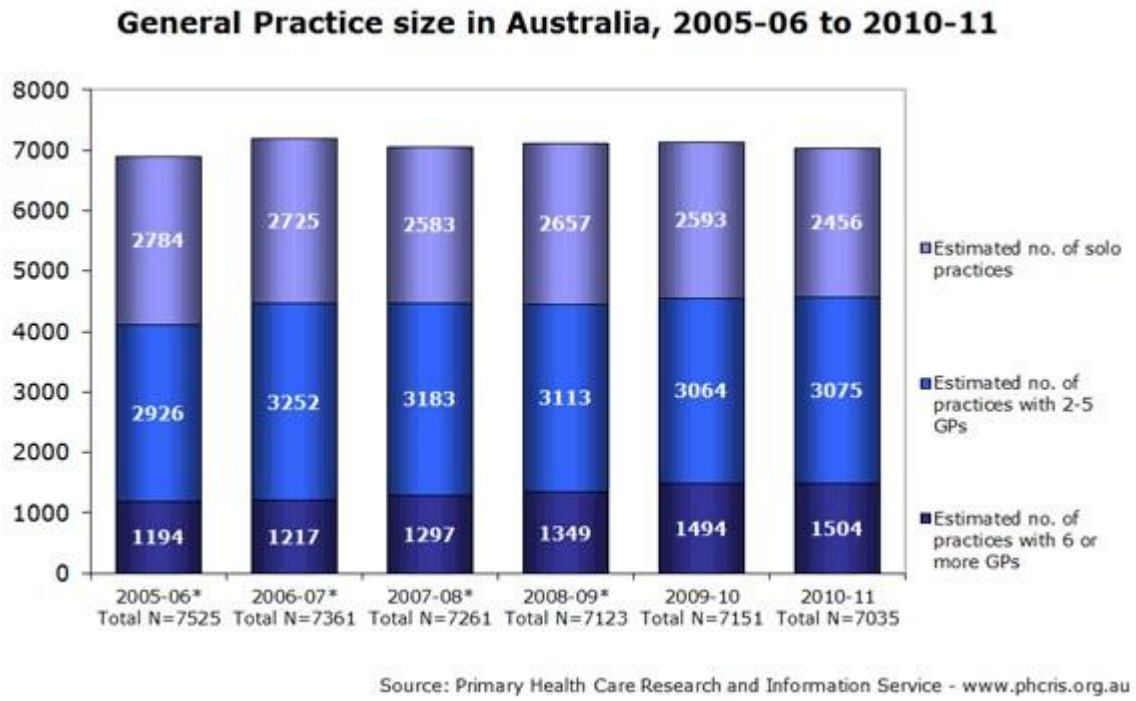
Figures on the proportion of solo practitioners and numbers of general practices are hard to come by but the numbers are dropping.

A 2009 report by the University of Sydney and the Australian Institute of Health and Welfare stated that the proportion of doctors working in solo practice halved between 1999–00 and 2006–07.

Elizabeth Sturgiss et al in a 2013 AFP article 'To own or not to own' states that about 10.7% of doctors worked in solo practice – which at a casual glance does not sound much.

The PHCRIS[4] Fast Fact website gives actual figures from 2005-06 to 2010-11 in terms of practice numbers supplied by the Division of General Practices from around Australia which paints an interesting picture.

[4] The Primary Health Care Research & Information Service (**PHCRIS**) is a national primary health care organisation based in the Discipline of General Practice at Flinders University in South Australia



2010-11 2456/7035 = *35% total practices are solo.*

Though the data is now 3 years old, even if the numbers have dropped considerably to say 20-25% that is still a large percentage of the total number of practices in Australia.

Financial Vulnerability of Solo Practice

The low Medicare rebates, lack of proper indexation, the lack of appropriate reimbursement for the time spent doing longer consultations, the increasing burden of administrative costs and the costs of proportionally high staff ratios has led to an exodus from solo practice over the last 10 or so years. Hence this type of practice is already severely financially stressed.[5]

Running a 2-4 doctor practice costs little more than a 1 doctor practice. The price the solo GP pays for their independence is usually a considerably lower wage. Anecdotally many solo practices continue because the doctor owns the premises, which removes pressures of commercial rent.

Though impossible to obtain figures, it is probable that many solo practices are owned and run by older general practitioners close or above the retirement age.

Adoption of the co-payment and lack of indexation is likely to lead to closures of financially vulnerable solo general practices who predominately bulk bill and have not yet turned away from bulk billing and converted to fee for service.

[5] Rural Doctors Association supplementary submission Sub 87a discusses these costs, and the authors personal and anecdotal experience during discussions with fellow solo GPs confrim this.

Summary

Despite the low and falling total percentage of the total workforce, solo general practitioners probably represent between 20-30% of actual physical general practices.

Mandatory co-payments should not be implemented. Co-payments already exist and are quite high for private patients (for example, up to $30-$40 for private patients who can afford it), and should continue to be determined between GPs and their patients.[6]

Given the probable aging demographic of the solo practice owners and/or the fact the many of these practices are probably in small country towns, a disturbingly high percentage of actual practices could succumb to financial pressures and close as they lose financial viability.

If, as is likely especially in country areas, those practices have already reduced or abandoned bulk billing, the co-payment as well as indexed CPI rises will undoubtedly be passed on to patients as those practices attempt to stay viable.

Whereas this move towards closure of solo practices has been the intention of government policy for a decade or more, it could leave many hundreds of thousands of already disadvantaged Australians struggling to find medical care.

As the move to co-ordinated team-care based general practice continues, which of course is a good thing, I believe that the slow decline of these practices will continue in the coming decade but would urge this process to be a managed one, rather than a catastrophic dislocating event caused by poor government policy.

Finally a comment from a doctor on a national GP mailing list this week:

"The senate need to know that if the current trend to freeze the Medicare rebates and remove item numbers continues, there will be a point reached where there will be mass exodus from bulk-billing patients. GPs are now close to this point. "[7]

This is not a point that we want to reach, and not a position we want to be forced into.

[6] See RACGP submission to the Select Committee on Health Oct 2014 Summary of recommendations point 2

[7] The nat-div list as a closed email list-serv and is run by a group of dynamic and vocal General Practitioners.