Australian Medical Association (WA)

Sustainable Health Review Submission - General Practice in Western Australia

Contents

Summary 3
Background 4
Areas where good General Practice policy will help achieve a sustainable health system 5
Integration of diagnostic results 5
Closer working relationship with Hospital and State Health services 6
Strengthening & upskilling General Practice 8
Avoid duplication of services between State and General Practice 8
Adopt policies to strengthen the Medical Home, reducing fragmentation and duplication of care 8
Engagement with WA Primary Health Alliance (WAPHA) 9
References: 10

Summary

- The majority of medical care occurs in General Practice. Last year in WA over there were 11,963,312 GP Medicare items claimed, compared to 631,000 public hospital admissions and 821,000 ED visits.
- There is not an overall lack of capacity in General Practice in WA, either in hours or after hours.
- It has been repeatedly shown that an effective primary care sector (led in Australia by GPs) results in better outcomes, lower mortality and lower hospitalization rates.
- Significant savings can be achieved by the State working productively with General Practice. Supporting rather than undermining it, and encouraging quality care, extended opening hours and integration of diagnostic results.
- Workforce policy should be to minimise reliance on IMGs and enhance training of local graduates.

Potential efficiencies:

- 5% reduction in ED presentations @$500 per visit = $ 20.8m
- 2% reduction in admissions @$10,000 per admission = $126.2m
- 10% reduction in diagnostic testing and improved efficiency =$50m
- Other efficiencies using strategies as detailed in this submission = $10m

TOTAL = $207m pa.

The total number of potentially preventable attendances and admission is higher than the above figures but 100% efficiency is not attainable and a conservative estimate has been made.

Supporting high quality General Practice is one of the key ingredients to a sustainable health system in WA

This involves:

- An Urgent Care policy based around supporting not competing with General Practice
- A closer working relationship with Hospital and State Health services
- Integration of diagnostic results, to allow clinicians to access results from any pathology or radiology provider, public or private
- Supporting General Practice with good access to specialist and allied health services
- Adopt policies to strengthen the Medical Home, reducing fragmentation and duplication of care such as immunisation in pharmacies
- Strengthening & upskilling General Practice and maximising utilisation of GPs with specialist skills
- A specific focus on Aged Care, which provides some of the most complex, long duration hospital admissions
- Workforce and training analysis including demand analysis
- Engagement with peak bodies such as AMA(WA), RACGP and WAPHA

The work currently being undertaken by the Sustainable Health Review should be seen as just the start of a long term engagement with, greater understanding of and a productive relationship with General practice by all areas of State health. The AMA (WA) Council of General Practice is ready and willing to be engaged with this process, which will result in better quality and more efficient healthcare for Western Australians.

Background

The majority of medical care occurs in General Practice. In WA over 2016-17 there were 11,963,312 GP Medicare items claimed.[1] This compares to 631,000 public hospital admissions and 821,000 Emergency department attendances.[2] A single large General Practice will see more patients per day than any Western Australian Emergency Department. 4 out of 5 Australians see a GP at least once per year.[3]

General Practice is funded exclusively by patient fees and Commonwealth Government subsidies through Medicare. It is therefore a resource not a drain on State Health funding. However, GPs do have the potential to generate large on-costs for the State Health services, via referrals. It is consequently vital that the State understand and engage productively with General Practice if the aim of a sustainable health system is to be achieved. To date this understanding and engagement has been markedly lacking at all levels.

Despite concerns expressed by the WA Department of Health, demand data show that there is not an overall lack of General Practice capacity in in Western Australia. Some areas especially rural may have local shortfalls, but overall there is adequate capacity especially in Perth and major regional centres. Data from Australia's largest on line booking service Health Engine show 38,000 appointments available over the Perth metropolitan area every weekday, of which 4,000 (11%) remain unbooked at the end of the day. In the After Hours period there are over 500 unbooked appointments every day. 27% of weekday After Hours appointments remain unbooked[4]. The real capacity is significantly greater, as Health engine only captures a small part of the total GP capacity.

It has been clearly shown that an effective primary care sector (led in Australia by GPs) results in better outcomes, lower mortality and lower hospitalization rates.[5] The AMA (WA) supports the concept of a medical home.[6] This refers to a model of primary care that is patient-centred, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. It is not the same as the Medicare Health Care home, although Medicare has drawn on elements of the Medical Home concept. The Medical Home provides high quality care especially to those with chronic diseases and at high risk of hospitalization.

There are some specific issues associated with General Practice that we would like to bring to the attention of the Sustainable Health review where we believe General Practice has the ability to contribute to sustainability and where good policy will result in cost efficiencies. These are detailed in our submission.

Areas where good General Practice policy will help achieve a sustainable health system

Whilst a lot of focus is on acute and urgent care as a burden to our State health services, there are other areas where good health policy actively involving General Practice can help improve outcomes and reduce overall costs. Some key areas are listed below, the AMA (WA) would welcome the opportunity to explore these in more detail.

Integration of diagnostic results

All clinicians working in Australia agree that not having ready access to diagnostic (pathology and radiology) results is a great problem. This includes those working in State hospitals who cannot readily access private diagnostic results, and vice versa for private practitioners requiring access to results generated within the State system. In addition, doctors in any circumstances cannot access pathology or radiology results unless they know which company provided the service. The patient often doesn't know and request forms are interchangeable between companies, the company requested may not have provided the service.

It is estimated that 17% of pathology tests in Australia are duplicated.[8] Last financial year pathology costs to Medicare were $2.7b nationally and $254m in Western Australia.[1] This does not include State services not billed to Medicare. So there are very large amounts to be saved if clinicians were readily able to access results when required.

The AMA (WA) is aware of technology that has the potential to achieve this. This has the ability to pull results from any pathology or radiology provider in Australia and display them in various formats including reference values and collated formats. In 2016 a survey of ED consultants was undertaken and an estimate made of potential cost savings, as below:

Is accessing community pathology and radiology a daily frustration? Yes - 97%.How many minutes per shift do you waste chasing community pathology and radiology results? Av 27 mins. How many minutes per shift do the junior doctors waste chasing community pathology and radiology results? Av 40 mins each. How many patients per clinical shift does not having access to this data negatively impacts on their care? Average 4.5 per clinical shift. What are the negative impacts on patient care? Repeated unnecessary tests - 100%, Delayed discharge - 89%, Unnecessary admission - 45%, Inappropriate referral - 49%, Inappropriate antibiotics - 49%

The Costs Model - Using the above data an estimation of costs of not having access to community pathology and radiology data can be made for the Fiona Stanley Hospital (FSH) Emergency Department.

Doctor Costs Average Salary Time (cost) wasted per 24hrs Cost p.a.
9 Consultants per 24 hrs $350,000 243 mins ($4.22 per minute) $374,292
14 Registrars per 24 hrs $140,000 560 mins ($1.27 per minute) $259,588
30 Junior doctors $90,000 1200 mins ($0.78 per minute) $341,640
Total Doctor Costs $975,520
Patient costs – Average 4.5 pts per consultant impacted per 24hrs
Average cost per patient $400 Total Patient Costs $5.91m

Total FSH ED Costs p.a $6.9m

It does not take much imagination to see that the potential cost savings are huge, although further financial modelling is required, around $50m per year would not be an unreasonable estimate. The AMA (WA) is very keen to work with the State government and HDWA in ensuring the successful development and implementation of this or comparable technology.

Closer working relationship with Hospital and State Health services

It has already been established that an effective primary care sector, led by General Practice providing the patient's Medical Home has the ability to significantly reduce referrals to and therefore cost of the State funded hospital system. It therefore makes very good sense to focus on policy that improves interaction with and supports high quality General Practice. This does not require expenditure of large amounts of money - it largely involves good policy, planning and communication. The main areas are detailed below.

- Good and timely communication is essential, both from GPs referring to the State services, and by these services back to General practice in the form of adequately detailed and timely letters and discharge summaries. Electronic communication should be facilitated and encouraged in this regard as being cheaper, quicker and more secure.

- Where possible, State services should be able to accept standard referral letters generated by the GPs clinical software that states the presenting problem, with a summary of the patient past medical history, current medications, allergies and any relevant investigation results.

- Where a specific referral form is required, for example endoscopy or specialized services, this must be provided as a template that can be incorporated within the clinical software. Such templates should be universal for all the relevant State services, i.e. not vary between similar services at different locations or between area health services. The number of individual referral forms required should be minimized, and specialised referral forms utilized only for good reason when genuinely required.

- Avenues to reduce referrals and waiting lists should be explored. For example, the ability to refer to a private specialist with access to a public hospital operating list is often a quicker and more efficient pathway. Also, encouraging the ability to refer to other General Practitioners with specialist skills. It would be worthwhile to look at ways of providing needed services without requiring emergency department or outpatient visits. For example specialist podiatry services for diabetics, or cardiac rehabilitation exercise programs. Also encouraging discharge back to GPs for follow up, provided clear guidance is given to the GPs. For example, many fractures do not require follow up in a fracture clinic, hospitals providing some simple instructions could allow the patient's GP to provide appropriate follow up. It is important however, that devolving

care to a GP is done within a context that provides suitable guidelines for care and a clear opportunity to send the patient back to the hospital clinic if there are any concerns about management or progress.

- Access to urgent specialist care when required. As discussed under the Urgent Care submission above, this has the potential to minimise ED attendances and costs. Examples include patients with exacerbation of COPD, chest pain, cerebrovascular symptoms and minor trauma/fractures. This could include the ability to admit direct under a specific consultant where the patients is known to the team and the additional services of an emergency department not required. An improved ability for GPs to talk directly with a consultant could also result in less referrals to ED.

- Consideration of providing public specialist care within General Practice. This would involve specialists consulting within larger General Practices. It would promote better communication, education and understanding on all sides. It would be seen by the community as providing more patient centred care, the hospital would be coming to the patient not vice versa. It would also have the potential for cost savings as such consultations could legitimately be billed to Medicare. The AMA (WA) would welcome consultation on piloting such a model within General Practice.

- Providing additional Allied Health support to General Practice. In many cases, lack of appropriate Allied health services drives referrals to hospitals. This is true of mental health as well. Enabling for example dietitians and diabetes educators to attend General Practices (their services can be billed to Medicare under Chronic Disease management items) would enable more diabetes management to be undertaken in general practice. It would also provide for better chronic disease management and prevention which will make the State health system more sustainable in the long term. Basing mental health nurses in General Practice under the Commonwealth MHNIP was shown to work well and be cost effective.[9] It saved at 2017 value $2860 per patient per year in reduced hospital admission costs. The MHNIP program has now been discontinued and funding transferred to Primary health Networks.

- Improvements or an alternative model to the Central Referral Service (CRS). This is a frequent source of complaints from GPs and delays in patients obtaining care. It is unclear to many GPs when they need to use the CRS as opposed to making a direct referral. It has resulted in a significant degree of breakdown in communication and interaction between GPs and their local hospital services. It is not clear to most GPs that the CRS is either delivering a better service or providing any cost efficiencies. It is an area that requires review regarding performance and cost-effectiveness. It must also be considered as to whether the current model represents the optimum design.

Strengthening & upskilling General Practice

As well as strengthening General Practice by increased communication with and involvement of State health services, consideration should be given to other ways in which the skills and resources available to General Practice can be enhanced. This should involve WAGPET as the training and the RACGP as the education and standards bodies for General Practice. The AMA (WA) Council of General Practice would also be pleased to be involved. There is also a potential role for the State public specialist services, as these could be utilized as a training resource. The more activity that can be undertaken in General Practice the less will be the burden on the State. In addition, there are a significant number of GPs in our State who already have specialized skills, often to a high level. These include obstetrics, anaesthetics and surgery. Such skills should be actively encouraged and maintained.

Avoid duplication of services between State and General Practice

This has already been discussed under the Urgent Care proposal, but it is vital for all sectors of State Health and especially those involved in policy and planning to recognize and understand the services provided by General Practice and to avoid duplicating or competing with them. General Practices are small business with slim profit margins and are very sensitive to market forces. They cannot compete with government subsidised services and will withdraw (usually permanently) from providing services in areas serviced or subsidised by government. This will leave the State carrying to cost for such services long term. The State should only be subsidising services that cannot be provided by General Practice. General Practice is entirely Commonwealth funded and generally it will be more cost effective to encourage and support General Practice to provide services than for the State to provide them.

Adopt policies to strengthen the Medical Home, reducing fragmentation and duplication of care

The greatest strength of General Practice is that it provides holistic, long term coordinated care that involves a deep knowledge of the patient, including their medical, social and psychological background. It does this in an environment that is protected, confidential and over a long term relationship. As well as providing the highest level of skills and training of any profession. The doctor-patient relationship provides the opportunity to achieve results and change behaviour that cannot be reproduced in any other setting. It also allows for opportunistic care, for example the routine prescription repeat that involves support for quitting smoking, or the routine childhood vaccination that involves assessing child development and screening for postnatal depression.

So although various practitioners can replicate small parts of what occurs in General Practice they cannot reproduce the therapeutic environment. It has been repeatedly shown that an effective primary care sector (led in Australia by GPs) results in better outcomes, lower mortality and lower hospitalization rates[5]. In the increasingly complex Australian health environment it is more important than ever before that fragmentation of care does not occur. It is easy for this to happen if policy planning looks at facets of care in isolation. For example,

it is easy to suggest that we might improve on our already high vaccination rates by allowing vaccinations at the local pharmacy. However, this approach ignores the damage that is done to long term health care and long term outcomes by fragmenting care, disrupting the doctor-patient relationship and missing the more important aspects of the consultation that occur in General practice when a patient presents for a vaccine. Most of what occurs during a consultation about a travel vaccination is not about giving a needle, even though the patient initially thinks that is all they need. Interestingly, it has also been shown that it does not increase vaccination rates, as lack of access is not the key driver. Since pharmacists began delivering influenza vaccinations in Western Australia, the vaccination rate has not increased, although the cost to consumers has.[10]

Engagement with WA Primary Health Alliance (WAPHA)

The WAPHA represents the Primary Health Networks in Western Australia. These are Commonwealth funded bodies with the aim of improving efficiency, effectiveness and coordination of care. There are 31 nationally with a total budget of around $1b.[12] They hold significant funds to provide services, assist and enhance in many areas that have the potential to improve care and reduce costs to the State. Although there has been some criticism of lack of results to date and some degree of interaction with the State health service, we believe that there is potential for more efficiency and better results with greater engagement with the State. Given the WAPHA budget and aims, working productive with them and associated GP stakeholders should be a focus of State Health in the future.

References:

1. Annual Medicare Statistics – Financial Year 1984-85 to 2016-17 – Australian Government, Australian Institute of Health and Welfare
2. Primary Health Care in Australia https://www.aihw.gov.au/reports/primary-health-care/primary-health-care-in-australia/contents/about-primary-health-care - Australian Government, Australian Institute of Health and Welfare
3. Australia's hospitals 2015-16 at a glance – Australian Government, Australian Institute of Health and Welfare ISSN: 2205-5096 (PDF) 1036-613X (Print) ISBN: 978-1-76054-146-0 https://www.aihw.gov.au/reports/hospitals/australias-hospitals-at-a-glance-2015-16
4. Dr Marcus Tan, Health Engine, unpublished data – personal communication
5. Starfield B, Shi L, Macinko J. Contribution of Primary Care to Health Systems and Health. *The Milbank Quarterly*. 2005;83(3):457-502. doi:10.1111/j.1468-0009.2005.00409.x.
6. AMA Position Statement on the Medical Home – 2015. https://ama.com.au/position-statement/ama-position-statement-medical-home
7. Patient-Centred Primary Care Collaboratives. Defining the medical home: A patient-centred philosophy that drives primary care excellence. https://www.pcpcc.org/about/medical-home
8. Prof. M Georgeff. How Digital Technology will affect your health. Presentation for Monash University U3A Seminar 19.8.16. http://u3amornington.com.au/data/documents/Dialogue-2-2016-Digital-technology.pdf
9. Evaluation of the mental health nurse incentive program. Australian Government Department of Health. http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-e-evalnurs-toc
10. Dr R Capolingua, 2017. Personal communication.
11. Adj. Prof. J Bell, WAGPET WA 2017 Report
12. Booth M, Hill G, Moore MJ, Dalla D, Moore MG, Messenger A. The new Australian Primary Health Networks: how will they integrate public health and primary care? Public Health Res Pract. 2016;26(1):e2611603.