Building excellence in health care in a changing environment

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(Slide 1)

- I am really delighted to be invited to address you today.
- Your theme for this conference is building excellence in primary health care.
- This is undoubtedly a very worthwhile objective and I get the strong impression that there have already been major strides in this direction in recent years through training initiatives, programs such as the Practice Incentive Program, as well as the ongoing activities of the Divisions and individual GPs.
- However many pressures on general practice have been building up in recent years and will continue to do so.
- So today I would like to describe some of the main environmental factors – both current and evolving – which make the ongoing provision of high quality care to your patients a growing challenge.
- I would then like to share with you some of my (very) preliminary observations on one perceived pressure point – that is the increase in government-imposed red tape – which is currently the subject of a study being undertaken by the Productivity Commission for the Commonwealth government.

The current environment

(Slide 2)

- In terms of the current environment, general practice is facing growing pressure from a variety of sources, some internal to the profession and others externally imposed, often by governments.

(Slide 3)

- First, a number of major changes have been taking place to the **GP workforce.**
- There has been significant decline in the numbers of GPs over the last 5 years from 132.3/100000 population in 1996-97 to 123.3/100000 in 2001-02. Allowing for the shift towards part time work, the decline has been even larger.
- It would appear that major shortages of GPs are occurring in rural and remote areas and outer urban areas. There is anecdotal evidence that inner urban practices are now also experiencing significant problems in attracting GPs to fill vacancies. If this is the case, Australia would appear to be facing an overall GP shortage, not just a maldistribution between urban and rural areas, although objective evidence is not yet available.
- A number of possible hypotheses could be advanced to explain these possible shortages. One is that there has been unexpected increase in demand for GP services. Another is an unexpected drop in the supply of GPs. Or it is possible that the Australian Medical Workforce Advisory Committee (AMWAC) got it wrong in making past recommendations on the number of GP training positions

required. Or perhaps there is a gap between what the Committee recommends and what actually happens in practice.

- A paper presented by Professor Jeff Borland at a Productivity Commission Health Policy Roundtable held in March this year noted evidence that the current system of regulating doctor numbers appears to be associated with a systematic undersupply of specialists relative to population requirements in many specialty areas. Could the same apply to general practice?

- He also noted that workforce planning is a difficult task, made more difficult by the lag between the timing of decisions to change supply and when decisions actually impact on supply (due to long training programs and unanticipated changes to government policy that can affect demand).

(Slide 2)

- Another related change is the feminisation of the workforce. The proportion of female GPs has increased from 29% in 1994-85 to 33% in 2002. While this doesn't seem like a big increase, this proportion is likely to rise given that nearly 50% of GPs under 44 years are female.

- And many female GPs, very understandably, like to work part-time (with 60% of female GPs now working 39 hours or less).

- More men, as well, are choosing this part-time option (rising from 9% to 17% over the past 7 years).

- The image of the family (male) GP working 70 hours per week and on call the rest is no longer representative – although no doubt many people in this audience still work very long hours.

- In addition GPs are now increasingly working in multidisciplinary teams. More are employing practice nurses and others are working in close association with other health professionals such as pharmacists.

- A second important change in the working environment relates to the adoption of **information technology**. A very high proportion of practices now use electronic prescribing systems (88% in May 2002, up from 78% in 2001) and a similar proportion have an internet connection or email account. However there is now an expectation that practices will use information technology in a wide range of applications, including billing. Some have readily embraced IT, while others have struggled to keep up.

- Third, the relationship between the GP and **patient** has changed significantly as patients become better informed through the Internet (and other sources). They are now less passive and more demanding consumers as they become better educated and more affluent. Patients expect easy access and a high quality service and will complain if they don't get it.

- Fourth, the **role of the GP** has changed. The general community now expects GPs to provide not just increasingly sophisticated clinical care, but a wide range of other services as well. The breadth and complexity of the GP's tasks have

increased immensely - they have to stay abreast of a complex array of new drugs and technologies, workers compensation arrangements, privacy laws, general insurance and a wide range of other areas.

- Related to this changing role, GPs have been involved in ongoing social and health systems reform agendas. They are required, for example, to act as a gateway for entry to parts of the social welfare system. **Government demands** on GPs have thus increased, leading to a perception of increased red tape. I will return to this issue a little later.

- Finally, GPs face **financial pressures.** These arise partly from a perception that the Medicare Benefits Schedule no longer adequately meets practice costs or provides an adequate return. They may also reflect the fact that under the universal fee for service system all doctors get paid the same fee for the same service no matter what their cost of supply. Meanwhile the blended payment system introduced under the PIP program has not been universally supported.

- Some GPs have also been caught up in the medical indemnity insurance 'crisis' and face future levies and premium hikes.

- Clearly you are working in a changing and challenging environment. I will now spend a few minutes considering how GPs have responded to these pressures, as well as the broader impacts on patients.

- First, recent data on **bulk billing rates** indicate a significant drop from 80.6% of attendances in 1996-97 to 74.9% in 2001-02. The rates are lower in rural and

remote areas, with some areas experiencing rates as low as 30 to 40%. Potentially this trend could lead to an adverse impact on access to basic medical care, although according to the Minister, Kay Patterson, the bulk billing rate for people over 65 years is 82.3% of attendances.

- Second, there is some anecdotal evidence that some GPs have reacted to growing workloads and professional isolation by **retiring** or walking away from their practices in smaller rural towns. Again this could have a serious adverse impact on the access of country people to adequate medical care if they are forced to travel further to visit a GP.
- Third, a study by Schattner and Conan found that even back in 1998 time pressures and financial issues were major **stress** factors for metropolitan GPs. (At that time 92% of GPs surveyed reported some feelings of stress, of which 11% labelled it as severe). The authors argued that the extent to which GPs feel stressed by various aspects of their occupation may affect the quality of patient care as well as their own health.
- It is highly likely that GP stressors have increased since 1998 and that the severity of stress would be greater in non metropolitan areas.
- Some of this rising stress could stem from GPs' increased role as gatekeepers to the social security system, through the completion of Treating Doctors Reports and others medical certificates.

- GPs are likely to experience some tension between providing an honest assessment of their patient's condition and a natural desire to support their patients and maintain their client base.

- Fourth, **patient care** could also be adversely affected if patients face reduced consultation times, increased waiting times for appointments or are denied access to GPs whose books are closed. Unfortunately, no routinely collected national data relating to patient satisfaction as an indicator of the quality of GP services are available at present. However, a recently released study by the Australian Institute of Health and Welfare reveals that, consistent with earlier studies, most consultations still last nearly 15 minutes on average, with female GPs devoting more time to their patients than males.

- Finally, the general practice **administrative arrangements** have been changing, partly reflecting a trend towards better practice management and partly in response to these pressures.

- There is a growing trend to employing practice managers and practice nurses. About 10% of practices now have a practice manager. This enhances the potential to increase the administrative efficiency of the practice and frees up GPs to care for their patients.

- There also appears to be a shift away from solo to group practice and from GP - owned to corporatised practices with a spate of buy outs by companies such as Mayne over the past few years. The latter can result in formal linkages across

the medical supply chain, between general practice and other services such as pathology, diagnostic testing and (some) specialists.

- So in summary Australian GPs are currently facing numerous pressures and challenges with significant impacts on them personally, their practices and the access of their patients to quality care.
- All these changes may explain why those working in general practice may be feeling a little shell shocked at present. But can you expect your environment to get any easier in the near future?
- The short answer is probably 'no' but being aware of what might happen will help you to prepare to meet the new challenges in the future.

The future environment

- To understand where the health system may be heading it is necessary to stand back and reflect on some current national issues and potential policy responses.
- Many policy analysts have been asking the question - does the Australian health system require major surgery or can we continue along the path of incremental reforms?
- Many of the current system-wide problems will be well known to you so I will touch on some only very briefly.
- Spending on healthcare increased gradually over the past decade, from 7.9 percent of GDP in 1990-91 to 9.0 in 2000-01, up from 8.8 percent in the

previous year. This most recent increase has been attributed to a large volume effect – that is the level of use of health goods and services increased at a greater rate than that of all goods and services in the economy.

- The upward trend in health expenditures is expected to continue over the next 30 to 40 years, with estimates (by the Commonwealth Treasury) of health expenditure as a proportion of GDP as high as 19 percent by 2041.

- Governments tend to worry about these sorts of predictions to the extent that they may have major budgetary implications.

- In this context it is interesting to note that the Commonwealth government's expenditure on medical services (provided by GPs) accelerated in the latter half of the 1990s.

- Spending is also rising in per person terms – by 50 percent between 1990-98, driven partly by increases in the number of medical services provided per person (rising from 8.5 to 10.6 over the decade to 1999) and a significant increase in pharmaceutical spending.

- To these financial trends can be added major concerns about the health status of Indigenous Australians, as well as people in rural and remote areas who also have significantly higher illness and mortality levels than the general population.

- Yet while as a community we are spending more on health, piecemeal performance indicators and anecdotal evidence suggest that quality and safety in our health system could be improved. The Australian Council for Safety and

Quality in Healthcare estimates that errors in the treatment of patients cost Australia up to $4 billion each year.

(Slide 4)

– In addition, the health economist Dr Richard Scotton has described a number of structural features of our health system that inhibit the efficient use of health resources including :-

  - program multiplicity and fragmentation;
  - funding and service overlaps between the Commonwealth and State governments;
  - dysfunction between public and private sector funding and service provision; and
  - remuneration arrangements largely unrelated to outputs and outcomes.

- He points to the desirability of incorporating efficiency– promoting structures and incentives into the health system, but within the universal framework of Medicare.

- All these issues would suggest that health system reform will be ongoing. Whether it is big bang or incremental is yet to be seen.

- Scotton has proposed a radically different model for the health system which he calls **managed competition**.

- It is a fairly complex model so I don't intend to go into detail about it today.

- In August, the Productivity Commission ran a one day workshop to discuss this proposal. Many participants expressed a degree of nervousness about implementing such a big bang reform in the near future.
- A number of alternative, less ambitious reforms were suggested.
- One of most direct relevance to GPs was proposed by Professor Stephen Duckett of Latrobe University.

(Slide 5)

GPs as purchasers?

- He suggested that GPs, through general practice divisions, be given broad budget responsibilities as purchasers of medical services and pharmaceuticals, with the pooling of all MBS and PBS funds. His model, which has some similarities to the UK model (based on Primary Care Trusts), would make GPs as purchasers responsible for the financial risk associated with these programs.
- Associated with this approach would be a further shift away from fee for service to capitation payments. That is, the Government would pay doctors a fixed annual amount for each patient on their books. GPs would then have a financial incentive to allocate this budget efficiently between patients.
- Also this arrangement would provide inbuilt incentives for GPs to focus further on prevention, health promotion and disease management. The

healthier your patients, the less you would need to spend on medical services and pharmaceuticals and so the better off your practice would be.

- Less ambitious, but nevertheless still a major change, is another suggestion to give GPs budget responsibilities just for new high costs drugs. GPs could be given a fixed budget to purchase these drugs for their patients, based on the assumption that they are the best judge of who would benefit most. In this way expensive PBS leakages (to non cost effective indications) such as that which occurred for Celebrex, could be avoided.
- Under both approaches there would need to be some sort of monitoring of quality of service provision to ensure it is not jeopardized.
- Implementation would not be simple – but growing budgetary pressures may well create a climate in which alternatives such as these are considered seriously.

New technologies

- Even if GPs don't become purchasers in the immediate future, they will soon face a world in which increasingly efficacious but costly drugs and technologies will become available.
- Professor Tom Rice, UCLA, who also spoke at the Productivity Commission Health Policy Roundtable, noted that "the most prominent of these concern genetic therapies, which offer the prospect of catching (the) disease even before symptoms appear, as well as for providing cures for ailments that

currently cannot be treated". This means being able to do more to more people.

- Demand could be immense for genetic therapies that could eliminate the prospect of contracting say Alzheimers Disease.
- Potentially such therapies could have substantial benefits, in contrast to the recent past where we have seen only marginal gains from many new health technologies.
- This clearly raises some wonderful prospects. But it will also raise some difficult issues.
- For instance, take the drug to prevent Alzheimers that I mentioned a minute ago. Early prescription would have enormous budgetary costs in the short-term though in the long term it would help the budget by reducing the need for medical and nursing home care.
- Nevertheless the demand for such drugs could be so large that Governments, for budgetary reasons, may find it difficult to list them on the PBS.
- You could well get caught in the middle of a community debate as to who gets what. How do you tell your patients that they will miss out on a potentially beneficial drug because they cannot afford to pay for it? No doubt many of you have confronted this question already – but it may become even more pronounced in the future.

Demographic change

- Another trend that needs to be factored in is the changing health needs of the population as it ages and chronic diseases, social isolation and mental disorders become more prevalent.
- This shift away from communicable disease will affect the types of treatment provided and skills required by GPs.
- Aligned with this is the need to deal with what Robert Fitzgerald has called the “impatient patient”- that is that group of ageing baby boomers who are generally both demanding and informed consumers of most goods and services.
- The shift in the ‘balance of power’ which you have probably already noticed will become more pronounced in future.

Ongoing shortages

- Finally, it is likely that any shortages will continue to be experienced in general practice, at least in the medium term.

- Even though AMWAC is now surveying GPs as part of its new review of GP numbers, this will not be completed until mid 2003.

- Supposing AMWAC concedes a shortage of GPs as a result of this survey, lags can be expected while the results are being considered and decisions made about implementing the recommendations.

- If it is decided that more doctors should be trained, significant lags of up to 10 years can be expected while students move through the training system

- Alternatively, more overseas trained doctors could be enticed to work here. But the recent review of the AMWAC (Tomorrow's Doctors) reflects on the moral and ethical implications of being a net importer of doctors from developing countries.

- So I ask the rhetorical question – Will you sink or swim? This will be partly determined by how you as a professional group respond and partly by the Government's policy responses to these challenges.

GP Compliance Cost Study

- I would now like to spend just a few minutes bringing you up to date on the current Productivity Commission study on GP compliance costs.

(Slide 6)

- As you can see red tape is just a small part of the total picture. It represents only one of a number of pressures on GPs.

- GPs' complaints about red tape are symptomatic of concerns about a much wider range of factors influencing their environment.

- I don't intend to go into much detail about the study today but I would like to make just a few very general points about it and the Commission's role.

(Slide 7)

- The Commission has been asked to report to the Government by early next year on the costs that GPs face in complying with Commonwealth Government policies and programs and to suggest ways to reduce the compliance burden.

(Slide 8)

- It is important to remember that the scope of our study is fairly narrow. Under our terms of reference we will *not* be:

    - considering the merits of Government programs and policies;
    - assessing the costs of complying with government programs that impact on businesses generally, such as superannuation or taxation; or
    - exploring the costs of complying with state or local government programs or private requirements.

– Notwithstanding these exclusions, the study has the potential to throw a great deal of light onto the costs that GPs face in complying with major government programs.

(Slides 9 & 10)

– The Commission is well placed to undertake this study. We always take an economy-wide, independent approach to the issues that we analyse. We guard our independence jealously – in part because it is that independence which helps to give our work its credibility. We recognise of course that independence is not enough. Our work in the end will only be credible if it is of demonstrable high quality.

(Slide 11)

– Another reason why the Commission is well placed to do this study is that we are used to consulting widely, in order to gather and assess all relevant perspectives. We have recognised that this approach is essential for this study and have already visited many doctors and their organisations, health officials and other health experts.

– We released an issues paper in late July and so far have received 25 submissions from GPs, their organisations, divisions of general practice and government agencies.

– We have also set up an advisory committee, with which we have met once, and have arranged focus group discussions with groups of GPs.

- We will continue to consult widely for the duration of our study. We will be holding a second workshop with our advisory committee as our results start to take shape. We are currently conducting more focus group discussions and some in depth case studies of the compliance costs faced by particular GPs.

- We recognise that our report will only be as good as the data that goes into it. But we have found ourselves in a rather ironic situation. To collect information about compliance costs we need to know, for example, how much time doctors take to fill out particular forms. But only doctors can give us this information, and our initial intention was to survey doctors to get it.

(Slide 12)

- Our pilot survey, however, revealed that doctors are not willing to fill in yet another survey, even one that might ultimately contribute to lessening the paperwork burden. So we will instead be collecting the information through focus groups – and I would urge you to agree to participate in one of these if you are approached to do so.

- One consequence is that our results, while they will be indicative, will lack the statistical robustness that would have come from a survey.

(Slide 13)

- In spite of these limitations, we hope to be able to report on:

    - the total costs to GPs of complying with Commonwealth government policies and programs;

- which policies and programs impose the largest compliance costs;
- how the costs varied between doctors in different regions – inner and outer capital city, rural and remote areas; and, if the data permit
- how the costs differed between privately owned and corporate practices.

We also intend to put forward practical suggestions for reducing compliance costs.

Some preliminary observations

(Slide 14)

- From our consultations to date it is possible to make a number of general (but very preliminary) observations.
- The first is that despite GPs being largely in the private sector, they are increasingly being used by government as a gatekeeper to government programs to control costs and to deliver quality improvements.
- GPs have an important role to play in a wide range of government social welfare, health and other programs through form filling and other activities.

(Slide 15)

- And the demand on GPs' time through some of these programs seems to have increased considerably. For example, there has been a very large 65% increase in the numbers on disability support pensions in the past decade

which translates into a significant increase in Treating Doctor Reports to be completed by GPs.

(Slide 14)

- Many new health programs have come on stream in a relatively short time. These include the Practice Incentives Program and Enhanced Primary Care Program, both with complex requirements. And the breadth of these programs is expanding.
- The reality has now struck that GPs must actively manage fairly sophisticated processes – those practices with practice managers and computerised record keeping seem to be managing better.
- It can often be difficult to comply with the requirements of the EPC program (and undertake health assessments, develop multidisciplinary care plans and conduct case conferences) when the practice is under pressure to meet the growing demand from patients coming through the door.
- Nor do GPs have enough time to do the expected background reading contained in the explanatory documentation for these programs.
- GPs are often unable to distinguish between the paperwork tasks of Commonwealth/State and other programs.

(Slide 16)

- Many dislike forms that require judgements they feel ill-equipped to make (e.g. ability of patient to work in a normal job). The old Centrelink forms seem to have caused the greatest frustration.

- There is a general acceptance that this work is now part of the job of being a GP. One focus group participant said “it is part of running a practice and offering a service to the patient”.

- Some GPs don’t appear to delegate many paper work tasks to others in their practice.

- We are also seeing some differences in opinion arising in a number of areas, for example regarding the appropriateness of blended payments and the time taken to perform certain tasks.

- We are seeing a wide range of estimates about how much time paperwork and related tasks take, ranging from 5 hours per week to 2 hours per day to half the working week.

- There is also some confusion about the remuneration arrangements for some programs.

– There appears to be no general agreement about the most burdensome tasks so we may find that it is not any individual programs that are causing concern but the compounding effects of a wide range of demands on GPs time.

- So far we have received very little evidence of unnecessary forms, inappropriate information being collected, duplication or overlap.
- That said we would welcome any information you can provide us about your own experience with red tape and any ideas you may have about how to reduce the compliance burden.

Our capacity to produce a useful report will be greatly enhanced by your active participation.

(Slide 17)

Conclusion

- In conclusion, GPs are working in a challenging environment, in which they will confront many challenges as well as opportunities. They perform multiple roles and there can be tensions between these roles.
- These tensions are unlikely to diminish.
- In this environment doctors' frustration with paperwork is understandable, even though I'm sure that most recognise that a certain amount is inevitable.
- It should be of great interest to the profession to find out how much time doctors as a group are spending on compliance and whether there are ways to reduce the compliance burden.
- We need your help to address these issues and I and my colleagues at the Commission looks forward to working with you over the coming months.