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Inquiry into COAG reforms relating to health and hospitals

Submission to the Senate Finance and Public
Administrative References Committee

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1. DOCTORS ACTION is an incorporated association whose members are predominantly general practitioners with many years of experience in family medicine.
2. Doctors Action was formed after a meeting in held 9 November 2009 in Penrith NSW comprising of general practitioners who have genuine concerns over the proposals announced in the primary healthcare reform section of the COAG Reforms now the subject of this inquiry.
3. Doctors Action draws the Senate's attention to the fact that Australia has more doctors and nurses per head of population than at any time in its history and that given the substantial increase in the numbers of medical graduates, this situation will continue into the foreseeable future.

Doctors per 100,000 Australians 1960-61 = 117

Doctors per 100,000 Australians 1995-96 = 241 (106% increase)

Doctors per 100,000 Australians 2005-2006 = 291(21% increase)

Nurses per 100,000 Australians 1960-61 = 605

Nurses per 100,000, Australians 1995-1996 = 983 (62% increase)

Nurses per 100,000, Australians 2005-06 = 1181 (20% increase)

(Ref: Malcolm Gillies Oration, June 2009, The Hon Dr Brendan Nelson, Appendix Health Then and Now citing ABS Yearbook Australia 1965, 1996 census data & AIHW Australia's Health 2008)

4. Doctors Action maintains that the demand pressures on general practitioners are due primarily to the confidence the Australian public has in having qualified medical practitioners who are experienced in primary care to look after their health care needs. Australians transact with general practitioners at the rate of 112 million Medicare transactions per annum (higher than any other single group of medical practitioners).

(Ref: Medicare statistics, March quarter 2010, Total GP attendances 28,016 x 4 = 112,064 million pa projected)

5. **Super Clinics**

Doctors Action believes that the Federal Government's Super Clinic program will be detrimental to general practice. This program will establish taxpayer funded primary care servicing centres in proximity to established general practices and therefore act as an incentive for general practices to close or move away from areas where the Super Clinics are located. Hence a so-called improvement in one area of primary health care will be negated by a decline in supply in another.

6. Doctors Action also maintains that once family medical practices are rendered non viable by the intervention of government subsidised medical clinics that patients will not be able to easily seek an alternative to the Super Clinics. This is often the case when patients who initially seek treatment in a Super Clinics later feel that seeing a multiple number of doctors and/or health providers is less satisfactory to their needs than establishing a relationship with one individual general practitioner in a family medical setting.

7. Doctors Action defends the right of patients to choose where they prefer to seek qualified medical treatment. Doctors Action also supports the right of doctors to work in a medical practice that best meets their professional needs. Larger medical centres cater for the needs of some doctors and patients. However a significant number of Australians still value and wish to maintain a clinical relationship with a family medical practitioner in a small practice and hence government policy which undermines this modality of primary care is contrary to the public interests and removes a critical element of general practice which is available to all patients who may at some time seek to use it.
8. Doctors Action acknowledges that there may be a case for a government primary healthcare clinic of salaried doctors in an area of chronic shortage of primary care. Nevertheless, when considering locating a government sponsored clinic in remote areas of Australia, the impact the centre will have on existing services and the ability of the town to retain and attract new GPs once the centre is established is critical in the planning and determination of the long term viability of such centres.
9. Doctors Action draws the Senate's attention to the experiences of Polyclinics (also known as Darzi Clinics) in the UK and asks the Senate to obtain information as to the viability of these clinics and their likely future success and the degree of patient satisfaction with this service.
10. Doctors Action is also concerned that the diagnostic role of medical practitioners may be bypassed in any Super Clinic arrangement. Doctors Action does not support a model whereby a patient is filtered by non-medically qualified staff who determines access to the doctor. **Doctors Action supports the right of all patients to have direct access to a doctor for their primary care needs.**
11. Doctors Action has a number of unanswered questions in relation to Super Clinics which include
 - a. How much funding will be allocated to each Super Clinic for construction and provision of all services prior to commissioning?
 - b. What is the projected revenue and expenses of each Super Clinic after commissioning expected to be? (i.e. the annual running costs)
 - c. How have these running costs been calculated?
 - d. Where will the additional Super Clinics be located?
 - e. Has any patient safety impact statement been completed for the establishment of Super Clinics?
 - f. What consultation will take place with the medical profession regarding the location of these Super Clinics?

- g. What services will be provided by each Super Clinic and will all services in each Super Clinic be available?
- h. How will the treatment risk and potential liability in each clinic be underwritten and paid for?
- i. What cost benefit analysis has been undertaken on each Super Clinic and will that information if available, be made publicly available and accessible?
- j. Will patients be guaranteed access to a licensed medical practitioner if they visit a Super Clinic?
- k. What restrictions will be placed on patients accessing a licensed medical practitioner should they visit a Super Clinic?
- l. Will all Super Clinics provide 24/7 care?
- m. If not, what are the minimum number of hours and days on which they will be open?
- n. What are the advantages of a patient going to a Super Clinic and being referred to a dietician as opposed to going to their family doctor and being given a referral?
- o. By what advertising, either inside or outside the clinic do the public know they are attending a Government funded Super Clinic?
- p. Since many of the Super Clinics are not in under-doctored areas, what are the contractual arrangements for the Super Clinics if they are not financially successful in, say 2, 3, 4 years or longer, will the government provide further taxpayer funds?
- q. If they have to close is the Government reimbursed the initial grant with interest?
- r. What restrictions, if any, are there on advertising the clinic in order to encourage patients to change from care in their previous practice?
- s. Should a Super Clinic have to close for any reason, what will be the established method of its disposal and what compensation if any would be available for those who have made the decision to relocate to work in the Super Clinic?

12. Diabetes Healthcare plan

Doctors Action believes that this program needs clarification in a number of areas including,

- a) Will patients who are being currently treated by existing general practitioners, and their preferred specialists, be able to continue with this modality of care should their GP choose not to participate in the registration scheme?
- b) Should a patient be enrolled with GP x, will they be penalised if they choose to visit GP y, i.e. they are unable to see GP x, or they no longer prefer to see GP x.
- c) Given that one of the aims of the scheme is to prevent so-called “unnecessary hospitalisation”, will a patient who presents at a public hospital with complications from diabetes be referred back to their registered GP? i.e. refused admission on the grounds they are enrolled in an existing program with their GP?
- d) If it is the case that admission will not be refused, how does the program intend to prevent so-called unnecessary admissions to public hospitals by patients with diabetes who agreed to voluntary enrolment?
- e) Will the incentive payments be directed to the treating GP or the treating general practice?
- f) What action, if any will be taken against GPs who accept the incentive payments but choose to sub-contract the treatment of the patient to allied or healthcare assistants with minimal supervision?
- g) What level of supervision of allied healthcare workers attending to diabetes patients in this program has been recommended and by whom?
- h) What clinical guidelines have been developed for the running of this program?
- i) Has a patient safety impact statement been undertaken for this program?
- j) What disincentives will there be for a general practice, which accepts payment for the treatment of a patient under the diabetes enrolment scheme, but then refer the patient for indefinite specialist care?
- k) What disincentives will there be to prevent general practices from enrolling only patients with less demanding symptoms whilst avoiding the enrolment of patients whose disease is more chronically advanced? i.e. cherry picking
- l) Will the grant be paid to the practice or the doctor?
- m) What practices administration costs are factored into the grants?
- n) What would happen if a diabetic patient died (or ceased care for any reason) one day after being registered with a practice – is the grant returned to the Government?
- o) If a locum GPs see a diabetic patient, are they paid for their consultations?
- p) GP registrars usually work for less than 6 months in a practice, how are they paid to see diabetic patients
- q) Does Medicare define a patients “regular doctor” as one who has seen a patient for at least 6 months?
- r) Will the new Super clinics be able to register patients even though they have not been open for at least 6 months? How will this be monitored?

- s) Will the option of registration be open only to patients of Accredited practices?
- t) If so, what will happen to patients of non-accredited practices?
- u) If not, why then are the grants for nurses limited only to accredited practices?

13. PHCOs and Medicare Locals

Doctors Action cannot see why existing divisions of general practice should be supplanted by what Doctors Action believes will be a new health bureaucracy which will put unnecessary demands on existing general practitioners whilst contributing little to patient care.

- 14. The likely impact on general practice from such a structure will be demands for survey completion, patient information, report writing, email answering and meeting attendance. GPs cannot afford to be micro-managed nor have demands placed on them over and above their current commitments.
- 15. Doctors Action is also concerned that such organisations will be involved in the rationing of healthcare funding and contractual relationships which may be imposed on general practitioners altering the existing referral rights of general practice i.e. that PHCO/Medicare Locals will suffer from chronic mission creep to their initially publicly stated objectives.

In summary, working GPs have had little input into the planning and discussion re the necessity for many of the proposals described as 'primary healthcare reforms'. DOCTORS ACTION draws the Senate's attention to the fact that Australian general practice has been an extremely successful model over many years, delivery high rates of productivity on a fee for service basis. Its popularity and the importance the patients place on the doctor/patient relationship is all the evidence required for the existing model to be strongly supported and that any attempts to re-engineer the medical workforce should be treated with the highest degree of scepticism and scrutiny.