SOD
163

Notes for Senate Select Committee on Medicare

23rd July 2003

Dr Ross Kerridge

Submitting as a private citizen.

Who am I?

I am a Specialist Anaesthetist with a long history of coal-face involvement in innovative developments in health service delivery, including reorganising elective surgical services (the Perioperative System); introducing the Medical Emergency Team; and changing attitudes to management of dying patients in Intensive Care. I have been a system redesign consultant for a number of hospitals in Australia and New Zealand. I have published, and spoken widely in Australia and overseas on these topics.

Selected references:-

1. Daffurn KD, Kerridge RK, Hillman KM. Active management of the dying patient Medical Journal of Australia 1992;157:701-704.
2. Kerridge RK, Lee AL, Latchford EM, Beehan SM, Hillman KM. The Perioperative System; A new system for managing elective surgery patients. Anaesthesia & Intensive Care 1995;23:591-596
3. Kerridge RK. The Medical Emergency Team:- No evidence to justify not introducing change Med J Aust 2000;173:228-229
4. Kerridge RK, Crittenden MB, Vutukuri VLSP. A Multiple-Hospital Anaesthetic Problem Register: Establishment of a regionally organized system for facilitated reporting of potentially recurring anaesthetic-related problems. Anaesthesia & Intensive Care 2001;29:106-112
5. Kerridge RK Updates:- Anaesthesia Med J Aust 2002; 173:6

I am also a state office-bearer in the Australian and New Zealand College of Anaesthetists.

Why am I submitting?

I am disappointed by the narrow focus of the public discussion that is occurring on Medicare. This discussion appears to be failing to recognise some of the problems currently developing in the health care system. There appears to be little appreciation of the need for fundamental system redesign if a major health service crisis, leading to economic or political instability, is to be avoided.

In Summary

- The current GP system, in particular the remuneration system, has inherent flaws that work against the provision of efficient and effective general medical care.
- The system is currently heavily dependent on the commitment, goodwill and traditions of GPs who are becoming older, more frustrated, and increasingly demoralised.
- The frustration and demoralisation of General Practitioners is reflected in their behaviour – to leave the system, discourage those following them, to resent (and cease) the financially unrewarded tasks of goodwill; and to seek greater financial compensation for their frustrations (e.g. by co-payments, cherry-picking etc).
- There is a 5-10 year window for change. If this is not achieved there will be economic, social and political instability that could seriously distort the national agenda. The economic cost of rebuilding the health system will be much greater if the virtues of the current system are lost.
- The major future challenge in health care is to maintain the commitment of the nursing and medical workforce. This requires redesign of the health care system to facilitate the efficient delivery of effective health care to the entire population.

Possible Solutions

There are some fundamental components in an effective redesign of the General Practice section of the Health Care system. These include:-

1. **Information systems**
   Designing systems to allow and to foster the efficient transfer of patient and other information around the system, so that effective patient care is facilitated and enhanced, and the enormous frustrations and inefficiencies of the current system are avoided. At present, information transfer from GPs is unremunerated and based on ethics and traditions. Technological solutions to improve communication will fail without a remuneration system to support it.

2. **Reinforcing the GP system**
   A generation of Doctors is rising who are not developing a traditional, comprehensive medical care style of practice. Medical services are delivered as a commodity rather than as part of an ongoing relationship. This behaviour is reinforced by the remuneration system. The strength of the GP system lies in value of the GP providing the comprehensive overview – including picking up the pieces when the system falls down, or guiding the patient through the system when things get complicated. The structure of the system (organisational, remunerative, and non-financial rewards) should reinforce this strength.

3. **Capitation-based funding**
   The backbone of the current health care system is based on GP remuneration using a Fee-for-Service system. It has been recognised since the time of Hippocrates that there is an inherent contradiction in paying your Doctor when you are sick. The current legalities of the Australian system reinforce these contradictions, forcing GPs to provide unnecessary services, or provide them inefficiently (e.g. not using nurses, or insisting on face-to-face follow-up consultations) rather than using their skills to organise patient care in the most efficient and effective way.

   By contrast, the only alternative remuneration system for Doctors is some variation of salaried practice (e.g. sessional rates etc). This system is inherently subject to all the well-recognised problems of removing incentive from remuneration.

   In other countries, including the US and UK, (and historically in Australia) Doctors have been remunerated using a capitation-based system. In essence, a patient registers with a doctor (or practice). The practice then receives regular payments (adjusted for patient age and comorbidities) for providing the patients general medical care for as long as the patient remains registered with the practice. The system emphasises long-term patient care and satisfaction, and allows the practice to develop systems to provide this in the most effective and efficient manner.

   The above description is a major simplification. In implementing such a system, it would become apparent that adjustments would be needed. Each GP would continue receiving remuneration for some services using a fee-for-service system (e.g. for immunisations, pap smears etc). Some salary-type payments would also be included. Nevertheless, the core values of a patient-focussed health system would be reinforced by the remuneration system. This is an inherently more efficient system. It needs to be brought into the discussion of possible options for the Australian Health System.

Conclusion

The General Practice section of the Australian Health Care System is on the cusp of decompensating and collapsing. Fundamental redesign using a global perspective, is required. A change to a capitation-based remuneration system needs to be strongly considered as part of that redesign.
