Submission to

the Standing Committee on Health, Community & Social Services

re

Access to Primary Health Care Services

By

Dr Chenault Doug Lee
Family physician practicing in Wanniassa since 1987
Erindale Medical Practice
1-5 Grattan Court Wanniassa ACT 2903
Ph: 62316943 Email: leedoug23@internode.on.net

29 July 2009

1. What is "PRIMARY HEALTHCARE"?

1. **"Primary Healthcare"** refers to the ongoing, preventive, and proactive medical care a GP (a family physician) provides for, and in collaboration with, her patients, using evidence based medical principles. Some examples of primary healthcare include encouraging patients to give up smoking and exercise regularly, regularly measuring and using medical intervention to optimises her patients ideal weight, blood pressure, lipid profile and cardiovascular risks, performing regular screening such as Pap Smears, prostate tests, mental state examinations etc in order to detect serious illnesses like breast and cervical cancer, prostate cancer, colon and lung cancer, depression, unplanned pregnancy, sexually transmitted diseases, influenza, and early onset of Alzheimer's disease.

2. **It is very important to emphasise that a family physician can only perform her duties if she has regular contact with the patient and is familiar with the patient's history.**

3. Australia has a proud record of training and accreditation process which produce GPs who perform these duties exceptionally well.

4. **Primary healthcare is what keeps Australia healthy and productive, but this has been the most unglamorous and under funded area of medical policies. It is not hard to see why. If a GP performs her duties well, then her patients will be happy and healthy and will not be relying on hospital system for their care. No one complains and no one knows how good a job the primary care physicians are doing.**

5. For instance I detected that a patient's blood pressure is rather high. However, because I see her regularly, I know her BP has always been normal. I saw her son a few days ago and I learned that her daughter in Melbourne had tried to commit suicide (even though she did not volunteer this information). Rather than hastily prescribing medication, I chose to console her and her BP had returned to normal by the time she left. This scenario is only possible because I am her family doctor and I know her medical history as well as her family.

6 **General practice, and primary healthcare, is as much an art as it is a science. Together with clinical acumen, the family doctor must also demonstrate compassion, commitment, and humanity. Primary healthcare isn't a high tech industry dominated by gadget and technologies. Being a GP is a job. Being a family doctor is a career. It is the career family doctors that are missing from our suburbia.**

2. "**SECONDARY HEALTHCARE**" & "**EPISODIC HEALTHCARE**"

I have coined these terms to illustrate the various roles which are performed by a GP.

1. **Secondary healthcare** are when more serious illnesses are discovered by the regular screening process or physical examination (e.g. skin cancer, depression, asthma etc). All the skill and knowledge of the family GP are then called upon to treat and manage these conditions. She knows her skill and limitations and she will refer the patient to a specialist for further treatment if needed. This term includes supportive service such as pathology, radiology, physiotherapy, occupational therapy, chiropractic & podiatry treatment etc

2. **Episodic healthcare** refers to the coughs and colds, nappy rash, minor cuts, burns and strains, minor ailments and accidents etc. In the mind of the public and policy makers, this is all that GPs do. The reality is, this is only a part of what a family doctor does. The real family doctor dedicates the bulk of her time in keeping her patients healthy by practicing preventive care

3. The superclinics and the proposed nurse clinics are ideally suited to provide episodic care.

3. "**TERTIARY HEALTHCARE**"

Tertiary healthcare is provided by the hospital system in which all the resources of specialist care and sophisticated equipment are put together to treat accidents, emergencies and difficult illnesses. Elective surgery waiting time is often quoted by politicians to illustrate the success or failure of the hospital system but it is hardly a real measure of the efficiency of the tertiary medical system. (Just as the road toll is often quoted to support or vilify road safety policies. A bus plunging into a river may increase the road toll by 30 but it does not mean the road safety policies are not working)

From the above definitions, we can see that not all GPs are family doctors.
All GPs can provide secondary and episodic care but only family doctors can provide bone fide primary medical care.

Having defined the various types of healthcare, we can now examine what sort of problem we are having.

4. WHAT IS THE PROBLEM WITH OUR CURRENT HEALTHCARE SYSTEM?

Too many category 4 & 5 (the walking sick) patients are turning up in the Accident and Emergency seeking secondary and episodic healthcare, thereby clogging up a hospital system which is really meant to provide tertiary healthcare

5. WHY ARE CANBERRANS SEEKING SECONDARY AND EPISODIC HEALTHCARE FROM THE HOSPITAL'S A&E DEPARTMENT?

Canberrans need more secondary and episodic care because they are getting less good quality primary healthcare. The poorly controlled diabetic and asthmatic, the undetected breast and colon cancer which have spread, the heart attack victims who have not seen a doctor for years, teenagers with unplanned pregnancies and sexually transmitted diseases etc are turning up at superclinics and the hospital for treatment. These are secondary healthcare problems which need not have arisen if these patients have a family doctor who they see regularly.

6. WHY ARE CANBERRANS NOT GETTING ADEQUATE PRIMARY HEALTHCARE?

1. Firstly, there is a misunderstanding of the role of the family doctors by some part of the community. This section of the community doesn't understand, or are suspicious of, the coordinating, proactive, and preventive role of family doctors. They choose episodic care only when they are sick. This is most likely the same subgroup of patients who use the hospital A&E services for episodic care.

2. Secondly, there is a real shortage of dedicated family doctors who are prepared to take on the coordinating, preventive, and proactive role in providing primary healthcare.

7. WHY IS THERE A SHORTAGE OF FAMILY DOCTORS?

1. The shortage has partly been caused by the shortsighted workforce planning in the past. In the bad old days, and even now, the public expect GPs to work 65 hours a week. ("normal" working hours for doctors is defined by Medicare Australia as 8am to 8pm Monday to Friday and 8am to 1pm Saturday) and the GPs of the bygone days obliged, to the detriment of themselves and their families!
2. Workforce planning was then based on this level of work output by medical graduates.

3. New medical graduates are more aware of family commitment and life style choices (as they should be) They are not prepared to work 65 hours a week as their predecessors did. This results in a shortage of family doctors

4. The proportion of female medical graduates is increasing and female doctors need to take time off for maternity leave. Many choose to work only part time while their children are growing. Some don' return to the workforce at all.

5. Some doctors choose the regular hours of government and academic posts, again for life style reasons. This may explain why even though there are a lot of doctor names on the Medical Register, there aren't enough family doctors in the work force.

6. Many potential family doctors are lured to train in medical specialties which are more glamorous, more prestigious, and earn much more income than a family doctor.

7. Superclinics operates as successful businesses. Medical service is just a commodity they sell. They have high operative overheads. To be profitable, superclinics have to be positioned in population centres. This is why they close down suburban medical clinics to consolidate them into major population centres. It is obvious that opening more superclinics will not solve the problem of providing primary health care to Canberrans in the suburbs

8. Setting up a business as a family doctor is a long term commitment, a bit like a marriage. Few medical graduates are willing to make such commitments.

9. Many potential family doctors are lured by corporate superclinics which promise no administrative burden plus sign-on incentives ranging from $150,000 to $500,000.

10. To a new medical graduate, armed with no knowledge on how to run a small business, facing a sizeable HESC debt, possibly a new family and a mortgage, it is not hard to work out whether one should choose receiving $200,000 in the pocket and join a corporate clinic, or to go and borrow another $200,000 to set up a business as a family doctor in the suburbs. As older suburban doctors retire, there won't be new ones to take their places. This is why even with increasing number of future medical graduates, the problem of suburban medical clinic closures will not be solved.

11. Low morale amongst family doctors means medical graduates are less inclined to take up general practice as a career path. Very few children of GPs would take on general practice as a career.

8. HOW CAN WE ADDRESS THE PROBLEM OF PRIMARY WORKFORCE SHORTAGE?

8.1. IMMEDIATE SOLUTION

8.1.1. IMPROVE THE MOBILITY OF THE PATIENTS

Provide government subsidy to aged pensioners and health care card holders for taxi travel up to 10 km between home and medical appointments. They need to provide a receipt from the taxi driver as well as a signature from the doctor verifying their attendance at the clinic.
If we can't bring the doctor to the patients, at least we can try bring the patients to the doctors.
This is very similar to the taxi scheme which is currently operating and is procedurally easy to set up.

8.1.2. OFFER INCENTIVE FOR POTENTIAL FAMILY DOCTORS TO SET UP IN THE SUBURBIA.

1. My proposal is for the government to offer an **interest free loan of $100,000**, repayable over 4 years, to any doctor wishing to set up a medical practice in an "area of need".

2. An "Area of need" is defined as a location with a population of 1500 within 5 km of the proposed surgery. If a doctor, or a local community, can identify a site which will be suitable to set up a medical surgery, he/she/they can bring it to the attention of the "**Doctor Workforce Taskforce**" and the exact location is pegged for a potential $100,000 grant.

3. This "loan" is not granted to line the doctor's pocket. It is only available to pay for the rent for the first two months, the fit out, and initial purchase of equipment, in the setting up of the surgery.

4. This loan is interest free and must be repaid in full if the doctor leaves the area. However, for every year that the doctor remains in the location, the loan will be reduced by $25,000. If the doctor stays for 4 years, there is nothing to repay, (but by then the doctor will have been firmly established in the area). If the doctor leaves before the 4 years, he will have to repay the remaining loan on a pro-rata basis. However, if he manages to find a doctor to succeed herself, then the term of the loan continues as long as there is a doctor at the location.

5. To qualify for the loan, the doctor (or local residents) must prove that there is a population of over 1500 in a 5 km radius of the location and that there is no other medical services available. (This is easily done with figures from the Bureau of Statistics)

6. She will forward detailed invoice for the fit out, equipment purchase, and copy of the lease agreement to the Task Force, which will scrutinize, and then pay, these invoices directly, up to a limit of $100,000, upon delivery of the goods or completion of the work. If the doctor has purchased the land or building, the equivalent of two month's rent calculated on a commercial basis by a valuer, will be paid). The properties paid for by the task force remain the properties of the Task Force until four years are up.

7. If another doctor joins the practice, and the original doctor can prove that there is now a population of 3000 or more within 5km of the practice, another $100,000 will be available, again paid directly to the architect, builder, tradesmen who carry out the building extension and renovation. Two months' rent will be payable to the landlord or to the owner of the building.

8. This policy will give doctors enough incentive to go into the suburbs and country areas and open up medical practices in areas where they are needed most.

9. It removes the initial risk for the doctor to set up the service, offers significant incentive for doctors to venture out into the suburbs or country areas, and the facilities remain in the community. Even if the doctor decides to leave, there is now a ready to go surgery waiting for another doctor to step in.

10. This policy will truly address the problem of medical service shortages in the suburbs and country areas. The grant will also hopefully address the problem of sub-standard corner shop type surgeries of the bad old days, and the country will be served by well distributed, well fit out and well equipped medical surgeries to serve the population where they need it most.

11. The setup cost and infrastructure cost of this scheme is minimal. The pledged fund will not need to be spent until a doctor seriously wishes to take up the offer.

12. Advertising can even begin tomorrow. The government has the fund and the mandate to do it. If the scheme is unsuccessful and no one applies, nothing is lost. For every $100,000 the government has to spend, a doctor will be set up in the suburbs and potentially preventing 100 patients from turning up to the A&E Department of the hospital for treatment every week.

8.3. MEDIUM TERM SOLUTION

Recruit directly or provide financial assistance for existing practices to recruit graduates from overseas. A suitably qualified medical graduate from overseas can at least provide adequate episodic and secondary care. On the average, it cost around $20,000 to bring in an overseas trained medical doctor. There are many agencies which can provide this kind of arrangement. I suggest we specifically look for doctors from Canada, UK and New Zealand.

8.4 LONG TERM SOLUTION

1. Eliminate provider number restriction or streamline provider number application for area of need.

2. Government acknowledgement of the role of GP as primary health care providers and as the architect of a healthy family.

3. Simplify the paperwork involved in the blended payment system and “care plans” arrangement.

4. Reward longer consultations and family doctors who try to spend time with patients

5. Develop a fairer remuneration system for GPs which reward them for their qualification and experience.

6. This will increase the moral and status for GP and may lure future medical graduate to taking up family practice as a vocation (I have a proposed scheme but it is outside the scope of this inquiry)

8.5. COMMENTS ON SOME OF THE CURRENT PROPOSALS

8.5.1. Nurses clinics

The setup cost and infrastructure cost of the clinic is substantial. It is just reinventing the wheel, albeit a smaller one. Like Healthfirst, they are unlikely to reduce patient presentation to the hospital. A research paper actually showed that hospital presentation of category 4 & 5 patients have actually increased because the patients were told by the operators that they have to go to the hospital. Healthfirst is rumored to cost Canberra $350,000 a year.

8.5.2. ACTDGP to assist doctors in recruiting

As far as I know, not a single new doctor has started working in the ACT as a result of ACTDGP’s effort, for which it has received funding.

This level of funding could have seen 8 new doctors setting up in Canberra under my proposal, potentially diverting 60,000 patients from the hospital per year.

Dr Chenault Doug Lee
Erindale Medical Practice
25 July 2009