

# What GPs want: time and time again

*Our unsustainable health care system needs reforms that capitalise on GPs' passion for patient care*

*"... it takes all the running you can do, to keep in the same place. If you want to get somewhere else, you must run at least twice as fast as that!"* LEWIS CARROLL

July 1999 saw the first *MJA* general practice issue emerge, by dint of some careful gathering of relevant articles for Family Doctor Week. Over time, this special issue has become an annual fixture, and this year we had the luxury of being able to choose from a bumper crop of articles submitted especially for the issue. Our dilemma now is not, "How do we fill the issue?" but "How do we pick from the crop?"

We particularly wanted to reflect the priorities of general practitioners and did what any self-respecting journal does — waved a magic wand towards the GPs in our current reviewer database, and asked what they most wished for to help them in their clinical practice. Their greatest desire turned out to be more time to spend with their patients. And they are not alone. In 2000, generalist and specialist physicians in five countries — Australia, Canada, New Zealand, the United Kingdom and the United States — wanted health care reforms that gave them more time with patients.<sup>1</sup>

What GPs want is indisputably linked with more satisfied patients and better outcomes.<sup>2</sup> Yet, it seems that Australian GPs are, to some extent, already having their wish fulfilled and are spending more time with their patients, as are their UK and US counterparts.<sup>3</sup> In the 10 years to June 2004, claims to the Health Insurance Commission for "brief office consultations" dropped by 42% to 5774 services per 100000 population, and for "standard consultations" (up to 20 minutes) by 12% to 348946 per 100000.<sup>4</sup> Meanwhile, claims for "long consultations" (over 20 minutes) rose by 52% to 49399, as did "prolonged consultations" (over 40 minutes) by 59% to 4824.

So, why do we still feel pressed for time? Our patients' needs are greater — we battle with chronic disease, complex comorbidities and the frailties of age. Expectations are higher on all fronts —

from society, government and the profession itself. Greater patient participation in consultations, an agenda extended to include health promotion, access difficulties and lack of continuity of care also add to time pressures.<sup>2,3</sup> To fathom how consultation length is affected by a GP's age, sex, training and other characteristics, as well as the type of patients and problems managed, turn to the analysis by Britt et al of over 70 000 general practice consultations on page 68.

Of course it's not just GPs who want more time — everyone else in our society does too. But few other professionals attempt to undertake complex tasks in 20- or even 40-minute spurts. Our health care juggernaut creaks with infrastructure and payment systems inherited from an age when acute care was paramount. Remedial patches, such as financial incentives and Medicare items to promote quality care, are applied with reels of red tape.<sup>5</sup> On page 64, Zwar and colleagues show that it is mainly paperwork that stops GPs using the government's Asthma 3+ Visit Plan for organised asthma care.

The phrase "hamster health care" has been coined for a system that depends on everyone running faster on a treadmill.<sup>6</sup> It is not sustainable and "the answer must be to redesign health care". But many GPs prefer instead to spend less time as hamsters. According to Schofield and Beard (page 80), employment and retirement patterns of Australian doctors and nurses show that "generation X" GPs are working shorter hours than "baby boomers" did at the same age. But some hamsters just can't break the habit; our workforce is ageing, with older GPs working beyond the traditional retirement age of 65 years. Others, however, are branching out into special interest areas, and Wilkinson et al (page 84) canvass the pros and cons of this solution.

## The path to reform

*"There's no use trying," [Alice] said: "one can't believe impossible things." "I daresay you haven't had much practice," said the Queen. "... Why, sometimes I've believed as many as six impossible things before breakfast."* LEWIS CARROLL

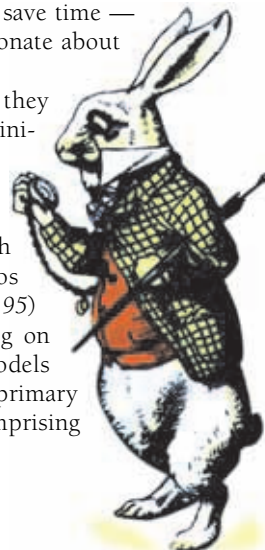
In this issue, we only ask you to believe two things:

- 1) that health care reform is possible and will save time — eventually; and 2) that GPs are still passionate about what they do.

We asked a small sample of GPs how they would grant the wish for more time for clinical practice. They conjured up remuneration that rewards time spent with patients, less paperwork, better IT support and more efficient collaboration with allied health professionals. Pegram (page 94), Aloizos (page 96) and Wenck and Lutton (page 95) give concrete suggestions for these, drawing on some real-life local examples. Similar models being tested elsewhere include cohesive primary care teams in the UK and the US, comprising



Recognise this waiting room?



**Just another day at the practice . . .**

A young woman D confronts her new GP, Dr T, with gangrenous, bone-exposed toes, a complication of previous meningococcaemia. Her other leg looked similar, she says, until the below-knee amputation. The specialists advise amputating this one too, an option she refuses to consider. Dr T seeks opinions from other specialists, who advise the same. But both GP and patient refuse to give up hope. Dr T contacts a surgeon with extensive overseas experience in reconstructive surgery for patients with leprosy. This surgeon intervenes and the leg is saved (minus a few toes).

The story doesn't end there. D wants to lead as normal a life as possible, and next Dr T and the prosthesis team scout for a waterproof prosthesis so that she can waterski. Now, she not only waterskis, but mountain climbs, visits building sites as part of her job, and has had a child after a complicated pregnancy, all with the support of her GP and other health professionals.

health professionals from different disciplines, which have been shown to benefit patients and doctors.<sup>7</sup>

There has been slow headway in the paperwork battle. In June, in response to the 2003 Red Tape Taskforce review,<sup>8</sup> new Medicare Enhanced Primary Care items were announced. It is hoped that these will reduce the administrative complexity of care planning and improve allied health access for GPs managing patients with chronic disease.<sup>9</sup>

While most general practices are computerised, our ability to save time by harnessing the digital revolution for communication and information management is still in its formative stages.<sup>10</sup> Beilby et al (page 99) confront what is required to achieve systems that allow effortless communication across health sectors, and seamless movement between patient records, decision support tools, and practice audits. A groundbreaking analysis of pharmaceutical advertisements in prescribing software (Harvey et al, page 75) illustrates some of the pitfalls of new technologies; and a linked editorial by a former pharmaceutical industry insider Ruff, and colleague Haikal-Mukhtar (page 73), sheds light on how relationships between stakeholders in modern health care might evolve.

Difficulty getting timely appointments introduces another time pressure. An innovative appointment scheduling system applied in the UK and the US provides patients with same-day appointments with their doctor of choice. This model is set to roll into 300 Australian general practices at a cost of \$15 million, and the initial experience of two Australian practices (Knight et al, page 101) shows it is feasible and can boost staff morale and working conditions.

Clearly, sensible health policy reform should come from quality primary care research (Glasgow et al, page 97), but McAvoy (page 110) draws attention to the huge discrepancy between funding for primary care research and that for hospital- and laboratory-based research not only in Australia, but also in New Zealand, the Netherlands and the UK. Despite this, Kamien (page 91), Weller (page 92) and Jackson (page 93) attest to the achievements and map the future tasks of academic general practice. They want fairer funding, and a redoubling of efforts, firstly, to engage non-academic GPs (and general practice registrars) in a research culture and, secondly, to make general practice integral to shaping our health care future. We have included in this issue several reports of useful research embedded in the general practice setting, including a randomised trial of different injection techniques for vaccinating babies and toddlers (Cook and Mur-

tagh, page 60), and evaluations of two different psychiatric services (Simpson et al, page 87; Bradstock et al, page 90).

**The passion of GPs**

Martin and Sturmberg (page 106) argue that reforms focused solely on structure and behaviour change will fail without an understanding of the GP's role in complex, living, relationship-based systems. And our general practice issue would be incomplete without stories of such relationships: a tale of patient persistence and GP passion (see Box) and Cowap's *Personal Perspective* on page 72. These are the real reasons we want reform. However, we should take care that the individual discourse of general practice is not overshadowed by reform incentives leading to a purely biomedical or population health model (Russell, page 104). Don Berwick, a leading proponent of health care reform in the US, is wary of financial incentives to individuals: "I think people respond to joy and work and love and achievement and learning and appreciation and gratitude — and a sense of a job well done."<sup>11</sup> Incentives without passion are meaningless.

As this issue goes to print, it is disappointing to hear that discussions have stalled between the Council of Australian Governments (COAG) and an unprecedented coalition of over 40 health professional and consumer groups (the Australian Health Care Reform Alliance, AHCRA) (Professor John Dwyer, Chairman, AHCRA, personal communication). It appears that, rather than capitalise on the passion at the frontline with a broader collaborative approach, the task of developing strategies for reform is now in the hands of government officials, who will report in December 2005.<sup>12</sup> We hope that they will engage frontline clinicians and consumers. Without this engagement, any plans for reform are doomed to failure and the time-poor will remain with us.

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