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‘If this..., then...’

Resource allocation in a finite world

Background

Tasks in general practice can be divided into three areas: acute care, planned secondary and tertiary prevention, and primary prevention. There is some evidence that the demands placed on practitioners by the second and third areas can decrease the time available for the first.

Objective

To assess the work load of general practitioners and the evidence around benefit for effort, and suggest some strategies for making the most of available time.

Discussion

Time wasting in general practice can be doctor-generated, role-generated or Medicare/government-generated. Doctor-generated time wasting includes doing things for which there is evidence of futility and may comprise investigations, screening and specific treatments. Appropriate workforce deployment can reduce role-generated time wasting. Medicare/government-generated waste occurs when there are financial incentives for health care providers to persist in activities with little evidence of benefit, or even evidence of no benefit. GPs need to actively plan to achieve a balance in providing care in the three areas of general practice.

Keywords

health services delivery; general practice; preventive medicine



Time is a valuable commodity for general practitioners (GPs). We have many competing demands and therefore need to spend our time wisely. Amongst physicians, time pressure contributes to stress¹ but time spent well influences outcomes in five areas. These are patient satisfaction, chronic disease outcomes, prescribing practices, physician satisfaction and risk of malpractice.² General practice can be divided into three areas:³

1. traditional acute care: treating ‘ill health’ reactively, including the roles as ‘gate keeper’ of referral to second-tier care, coordinator when patients return, and non-patient contact organisational time for management of ill health
2. planned secondary and tertiary prevention: chronic disease management (CDM) for cardiovascular disease, diabetes, asthma, etc.
3. primary prevention: adult and childhood immunisation, Pap smears, screening mammograms and age-appropriate health checks.

In this article we look at the workload of GPs and the evidence of benefit for effort in various areas of general practice. We then discuss strategies for improvement.

Time demands of prevention and CDM

Recently, the time that GPs are expected to spend on the second and third areas listed above has increased dramatically. A 2003 study looked at the time required for a primary care physician to provide all services recommended by the US Preventive Services Task Force (USPSTF). A patient panel of 2500, with an age and sex distribution similar to that of the US population, provided with the preventive services at the recommended frequency, took 1773 hours of a physician’s time annually, or 7.4 hours per working day.⁴

Using similar methods, Østbye et al⁵ applied guideline recommendations for ten common chronic diseases to a panel of 2500 primary care patients (with an age and sex distribution and chronic disease prevalence similar to those of the general population). They found that 823 hours per year, or 3.5 hours a day, were required to care for the 10 most common chronic diseases, provided the diseases were stable and in good control. When recalculated for uncontrolled disease, the estimated time requirement tripled. Thus, time demands could be 2484 hours per year or 10.6 hours a day. When we combine



the results of these two studies, it is apparent that the average American family physician following guidelines is expected to spend 10.9–18 hours per day delivering preventive and chronic illness care.⁶ It is unlikely that the Australian experience is much different.

Is acute care suffering?

So where do we find time for the pursuit of reactive acute care? Could it be that we are sacrificing our traditional role of seeing sick people and making them better in order to attempt effective chronic disease management and preventive medicine? It is useful to look at overseas trends. In the US over the last two decades, urgent care centres (UCCs) have proliferated, growing to 9000 facilities. UCCs commonly treat acute conditions requiring reactive care, such as ear infections, strep throat and influenza, as well some minor injuries, such as lacerations and simple fractures.⁷ In Australia, care of these conditions is regarded as the province of general practice.

There is some evidence of movement away from reactive acute care in Australia. *Table 1* contains three Medicare Benefits Schedule (MBS) item numbers for management of common simple trauma: simple fracture radius (no reduction required); superficial lacerations face; and superficial lacerations other area. Between 2007 and 2012, claims for these three items have decreased by 3.7–11.3%.⁸ In addition, the fourth report on the National Healthcare Agreement from the COAG Reform Council, which was released in 2013, confirms pressure on acute care. It reported that 24% of people had to wait more than 24 hours for an urgent GP appointment in 2011–12, an increase of 14% from one year earlier.⁹

Wasted time

Time wasting in general practice can be:

- doctor-generated – doing things for which there is evidence of futility. The doctor is either unaware of or chooses not to cease activities of proven futility. This includes radiology and pathology ordering, specific treatments and screening activities.
- Role-generated – doctors not delegating to nurses, nurses not delegating to administrative staff, the practice team not using appropriate IT software maximally to improve efficiency. Appropriate workforce deployment is emphasised in point 3 of the National Primary Health Care Strategy (NPHCS): ‘building a flexible and well-trained workforce through effective training and teamwork’.¹⁰

- Medicare/government-generated – some MBS item numbers create incentives for practices to perform tasks with no evidence of benefit. This is alluded to in NPHCS point 5: ‘a focus on financing and system performance to drive practice and system outcomes’.¹⁰ A recent article in the *Medical Journal of Australia*¹¹ identified over 150 low-value, non-pharmaceutical health care practices listed in the MBS, many of which were relevant to the primary care setting. These included testing for C-reactive protein, chlamydia screening, imaging in cases of low back pain and liver function tests. A recent article in *Australian Family Physician*¹² identified five low-value activities common in general practice. Well women checks at the time of a Pap smear may still be recommended to include pelvic and breast examinations¹³ despite evidence of harmful consequences.^{14,15} This exemplifies doctor-generated waste of time and money.

Incomplete delegation to practice nurses may be a significant cause of the increase in short (Level A) consultations.¹⁶ In order to charge for a consultation, the doctor spends time with the patient, rather than delegating tasks completely to an appropriately qualified nurse. Qualified Nurse Immunisers¹⁷ and certified Pap smear providers¹⁸ working in a general practice are capable of providing services without a doctor consultation.

Nurses’ roles also need critical appraisal. An Australian study described six roles of nurses in general practice, including not only patient carer, but organiser and quality controller.¹⁹ The organisational activities included morbidity disease registers maintenance and recall in chronic disease management. These are clerical administrative tasks in the US and UK. Quality control includes some delegable tasks such as stocking and sterilising.

Medicare/government-generated waste occurs when there are financial incentives for health care providers to persist in activities with little evidence of benefit, or even evidence of no benefit. Significant system-wide savings can be made by changes to item numbers. A good example to consider is the health assessment for Australians aged over 75 years (75+ HA), an initiative that was expected to be useful, is popular and cost \$87,067,265 in 2012 (*Table 2*). There is, however, little evidence of this intervention improving health outcomes. Preventive care for the elderly originated with a study in the UK in 1964,²⁰ which reported many unmet health needs in the elderly and advocated early intervention. Subsequent randomised controlled trials (RCT) inconsistently demonstrated improved outcomes for the elderly. Two systematic

Table 1. MBS statistics: whole of Australia and calendar year 2007 and 2012

MBS item number	Description	2007 claims	2012 claims	% change
47378	Fracture radius or ulna (no reduction required)	1782	1580	–11.3
30029	Superficial laceration other area	98289	94562	–3.7
30032	Superficial laceration face	38997	36524	–6.3



literature reviews published in 2000 reported no sound evidence in favour of health assessments.²¹ In a small Australian RCT of 100 patients, primary outcome measures did not demonstrate a statistically significant reduction in problems or mortality in the intervention (75+ HA) group, compared with the control group.²¹

One commonly held belief is that by doing the 75+ HA we will keep people functioning in the community for longer, but the evidence does not support this notion. A large Australian RCT assessed the effect of health assessments over 3 years for 1569 community-living veterans and war widows aged 70 years or older. During the study period there was no significant difference in the probability of hospital admission or death between the intervention and control groups. However, significantly more participants in the intervention group were admitted to nursing homes.²² This is not only contrary to the desire of most elderly people, but raises the risk of longer waiting times for beds in nursing homes for frail elderly people.

Time saving and supporting acute care in general practice

Abandoning the 75+ HA would seem a rational response to this evidence. Any patient over 75 years with a significant condition qualifies for a general practice management plan (GPMP) and team care arrangements (TCA). There seems to be little extra value in adding a 75+ HA to a properly performed GPMP.

Abolition of nurse item numbers has been accompanied by an increase in item 3 consultations, suggesting a decline in solo role substitution and more doctor-generated time wasting.¹⁶ Reinstatement of the practice nurse item numbers would help to reduce this.

Authority script requests made over the telephone are very time wasting according to GP surveys;²³ online requests could be a viable alternative. This leaves us with the very important question of what we can do to support our reactive acute care role. Here are some suggestions:

- use booking systems that preserve a percentage of appointments per day for acute problems, or a 'doctor of the day' who starts the day with no booked appointments and is available for 'walk-ins'; or a template with designated 'acute' bookings.
- 'quick clinics' twice daily for brief acute problems, no appointment needed, often reserved for children, and a duration of 30–45 minutes.

- walk-in and wait 'paperwork or script' clinic once daily reserved for things of administrative urgency, not medical urgency, such as script renewal, routine referral renewal or travel forms.
- education of patients in differentiating between acute illness management and chronic disease monitoring, which should not be tacked on to the acute problem. For example, the diabetic hypertensive being treated for a tennis elbow does not need to have his blood pressure taken but should be recruited to a follow-up planned CDM consultation.

Summary

It is our view that GPs need to actively plan to achieve a balance in providing care in the three areas of general practice. If we do not, then consequences may well follow, such as the advent of US-style acute care clinics, to further fragment primary care. Is this where Australian general practice should go?

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Table 2. Health assessments in 2012

MBS item number	Description	Dollar value 2012 calendar year	Dollar value for 75+ HA	% due to 75+ HA
Item 707	HA – prolonged	62,784,361	53,910,885	86
Item 705	HA – long	29,958,681	19,888,195	66
Item 703	HA – standard	27,838,355	12,544,110	45
Item 701	HA – brief	3,897,059	724,075	19
Total		124,478,456	87,067,265	70
HA = health assessment				



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