ATTACHMENT TO LETTER
CHAIR – ACT PRIMARY
HEALTH-CARE SERVICES
INQUIRY

25 May 2009

SUMMARY OF PRINCIPAL CONCERNS – A.W. SKIMIN
ACT HEALTH – DENTAL – MENTAL CARE SERVICES

Background

Despite substantial change and investment in health infrastructure over the past 15-20 years the ACT Health Services continue to confront increasing demand for and difficulties in providing timely access to quality health-care services. These service delivery problems are likely to continue. Unless redressed they will detract substantially from the general health and well being of the broader ACT community.

Difficulties in achieving timely access to quality health-care services, including mental and dental health services are now being experienced on a regular daily basis. Delays in accessing treatment may extend out over 4-5 months with waiting times for access to GPs ranging from 4-5 hours to two to three days. Clearly, something needs to be done to improve responsiveness of health services.

While this local demand and access difficulties appear, in part, to be attributed to the general population growth, particularly the ageing population, other factors are influencing the situation.

We now have the rapidly expanding group in the lower socio-economic sector of the community. Historically, this group has had very little real voice in the debate on medical health or social issues. This seems unlikely to change. As a general rule the group tends to be substantially marginalised in the broader community with many at real risk.

Nationally other issues, such as the distribution of the expanding population, particularly the aged and the inherent limitations of the professional training programs for medical – dental – mental health professionals, will influence substantially the local ACT Health-care services in terms of doctor availability and levels of demand for access.

In many instances problems of achieving timely access to quality primary health-care services are exacerbated by the high level of demand and the increasing cost of these services. Other difficulties are encountered by those in the low income group in identifying medical practitioners prepared to bulk-bill services. The requirement to bulk-bill should be a mandatory obligation on all accredited GP health-care provider for those in the community holding health-care cards.

My specific comments reflect direct involvement with and observation of the ACT Health Care Services over a period of some 20 years. This involvement has been principally as a carer/parent of an adult person who has been experiencing chronic, and at times, acute, physical-mental and dental health problems.

GP Clinic Closures – Implications

Clearly, the closure of GP practices, for whatever reason, imposes unacceptable stress on the most vulnerable people in the community both young and old.

While development of large "group" medical practices may provide direct financial and other benefits to the individual GPs and related health-care providers, patients tend to be disadvantaged substantially.

Invariably, they experience difficulties in seeking timely access (at times waiting 4-5 hours) and are unable to achieve continuity in quality health-care (rarely are they able to access the same GP). This arrangement is frustrating to the client patient and detracts from the achievement of positive outcomes, often prolonging rehabilitation.

Often the complexities of diagnosis and primary treatment of either physical or mental health issues demand a seamless process to achieve positive outcomes. Without this the patient experiences high levels of anxiety and loss of self-esteem prolonging and increasing the cost of recovery.

As things stand the large group medical centres are either unable or unwilling to provide seamless health-care services. Despite their marketing strategies and disclosure statements the processes involved tend to prioritise "through-put" and profit rather than quality of care.

Clearly, the development of large group practices while providing benefits to the practising GP and other health service providers carry a distinct and increasing risk of degrading the quality of health-care through the loss of continuity in the delivery of that care.

Invariably, the situation is further complicated where the GP performing the initial diagnosis and the follow-up care is unable to obtain full and timely access to the patients' primary health records. Despite statutory obligations flowing from the *Privacy and Access Act* 1997, personal health/ medical records (both paper and electronic) do not always move easily between health-care providers.

In some cases health-care problems will be compounded where neither the GP providing the primary care nor the specialist providing higher level care is aware or able to establish accurately genetic links between the client patient and their natural parents or siblings. Gaps of this nature could be life threatening or detract from the quality of patient treatment and recovery.

Clearly, loss of continuity or quality in the delivery of either primary or specialist health-care can detract substantially from well-being and quality of life of the patient both in the short to longer terms. This is particularly the case for these patients experiencing complex mental health related problems such as anxiety-depression-insomnia etc.

Desire of Outcomes

1. Full computerisation of patient health records, including specialist medical reports and body imaging, with the patients' file being structured to provide "shared" access electronically by GPs and specialist medical practitioners including mental health and related professional health-care service providers.

2. Legislative (privacy) arrangements be developed on a national basis to provide "special access" for accredited primary health-care or specialist health care providers to determine genetic links during preliminary diagnosis and subsequent treatment of the client/patient.

3. Large group medical centres be obliged to:
   - develop and demonstrate "best practice" processes to reduce patient waiting time and improve continuity in health-care;
   - establish bulk-billing arrangements for **all** patients eligible for Health Care Cards;
   - "Best practice" processes to be identified to form part of a mandatory audit arrangement in the accreditation of large group medical centre or other centres employing four or more GPs.

Linkages – government and non-government health-care providers

With the growing demand and increasing costs of providing quality health services, there is an urgent need to improve existing or develop new innovative best practice arrangements. These changes are required to offset new levels of demand and provide improved linkages and responsive communications across **all** health-care service providers both regionally and nationally.

In some instances this may mean establishing legislative obligations to protect both the health-care consumers and those responsible for providing the services government and non-government.

Improved linkages will be dependent on the use of new communications and computer technologies including broadband networks. There will be a pre-requisite in the systems design, both nationally and regionally, for operational compatibility and configurative control across **all** users government and non-government. Unless this control is established from the outset, systems design will be fragmented and without inter-operability across users.

Cross discipline linkages require review and clearer definition. The division of responsibilities in some cases is unclear. Some primary care GPs appear reluctant to become involved in the initial diagnosis or treatment of patients with complex mental health problems. Despite being closer to the client patient and with better knowledge of the individual patient's health they will seek to refer the patient to other medical or related service providers. Often the referral lacks detail or background. Simply a vague request without scope or definition.

From experience the GP may either prescribe medication in some form or other to suppress anxiety/panic symptoms without seeking to explore the real cause or determining the suitability of the medication for the individual patient. In other cases the patient will be simply referred to psychiatrists or psychologists for opinion with little or no patient health history being provided for background.

Often the primary care GP will have little or no real professional knowledge of the ability or experience of the specialist psychiatrist or psychologist to which the patient is being referred. A decision process a little like the old TV series "Pick A Box".

This form of professional linkage will rarely provide quality outcomes and could well prejudice the patient's health and wellbeing. Invariably these circumstances will undermine the patient's confidence and serve to erode trust in the medical profession.

In cases where the psychiatrists/psychologists provide an opinion/diagnosis to the referring primary care GP, there is no guarantee that the GP will act on or consult the patient/carer concerning the professional opinion. In what must be a worst case situation the patient did not become aware of the content of the professional opinion until the medical records were transferred to another practice nominated by the patient.

Invariably, the "carer" of the patient subject of referral and receiving the health-care is left entirely out of the consultation/treatment "loop". This disconnection detracts substantially from the quality/completeness of the initial diagnosis and follow-up treatment/rehabilitation. The disconnection is a particularly sensitive issue where the client/patient is either frail, aged or a person experiencing chronic health or mental problems.

Desired outcomes

1. Improve/extend the professional post-graduate development of GPs in the areas of mental health diagnosis and treatment processes.

2. Establish mental health post-graduate development as a mandatory element of the GP practice accreditation process.

3. General Practice accreditation to embrace some form of continuing (mandatory) mental health competencies assessment.

4. Develop legislative changes to make provision for the recognition and involvement of "nominated carers" in both the primary care (GP) and specialist health-care levels including initial patient consultation/diagnosis, treatment and related review/rehabilitation processes.

5. Primary and specialist health-care providers responsible for diagnosis and treatment of chronic or complex acute health, including mental health problems which may reasonably be expected to involve genetic links, to have reasonable levels of 'special' access to primary health records of natural parent(s) and/or siblings.

6. Encourage best practice by improving linkages across **all** health-care service providers.

7. Provide incentives to adopt and access new communications and computer technologies that are operationally compatible across the broader health-care network.

Other Related Issues

In seeking to establish 'best practice' outcomes and control growing costs in the delivery of quality patient care, the management practices involving prescription medication and drugs need to be improved to provide better outcomes, especially in the primary treatment phases.

Unless improvements can be achieved in this area effective treatment outcomes and containment of costs are unlikely to be achieved.

Looking at the effects of prescribed medication on the patient (in my case an adult son) treatment in balance with the 'consumer information' provided with that medication, confused messages are often delivered to both patient and carer. This raises broader concerns in terms of the risks and effectiveness (or appropriateness) of the medication in treatment of the symptoms.

Patients obliged to draw on the health-care services of the larger group practices, simply to achieve access to bulk billing arrangements are at greater risk with less likelihood of achieving positive outcomes in their treatment. With repeatedly changing GPs and loss of continuity in the knowledge of the individual patient there are often changes in the prescribed medication to simply suit the change in GP. These changes can be detrimental to the patient and the health-care will invariably fall well short of 'best practice'.

A 'production line' culture and mentality is developing where the focus is increasingly on time and through-put rather than the quality of the service being provided to the individual patient. Clearly, this practice, while it may be profitable to the health service group, is detrimental to the patient's well being and long term recovery.

From experience there is a growing body of evidence, based on the content of patient records, suggesting that some GPs will prescribe medication, including controlled Schedule 8 medication, to treat chronic pain and/ or depression symptoms without fully considering either the individual patients medical or mental health needs at the time or past medical history. While this development may save time in terms of the GPs increased daily patient through-put, the trend is disturbing. Apart from being costly (even with bulk billing) and frustrating to the patient, it is dangerous and can detract substantially from the quality of care in terms of patient well-being in the short term and full and effective recovery in the longer term.

Decisions being made by some GPs to prescribe new or change existing medication without full consideration of the patients' needs seem to be fundamentally flawed or at best 'hit or miss'. This is especially the case where there is no follow-up or monitoring by the GP responsible for authorising the script of the effect of the drug/ medication on the patient. Without effective monitoring the prescribed medication/ drug can simply aggravate existing symptoms or give rise to adverse side effects which will prolong recovery.

Clearly more care needs to be exercised by GPs in prescribing new or changing existing medications, especially in cases where the patient involved may have a long history of chronic and recurring health issues for which multiple medications have been prescribed over time with little or no positive outcome.

To achieve positive health outcomes for the patient (the most vulnerable), the GP responsible for prescribing medications should be obliged to regularly monitor the effects on the patient. It is not good enough to have this element of health-care transferred solely to the patient or carer. The risks are simply too high and can compound the patient's health issues and well-being.

Patients experiencing complex health issues or depression related symptoms over a prolonged period will often become confused and frustrated. Some will have difficulty in making rational decisions while others will resist using prescribed medication or use it incorrectly. Some may resort to self-medication with over the counter or natural medicines or medicines which are beyond their 'use-by-date'. Against this background many simply lose confidence both in themselves and the professional ability of the GP or specialist health-care provider. In this situation the patient is at their most vulnerable, they simply give up.

Clearly there is more to 'best practice' quality health-care than simply authorising a script and charging either the patient or the government for the privilege of that service.

Physical and mental health consultation/diagnosis are often completed in isolation to related specialist and/or dental health providers or "carers". **All** four elements of health-care need to be considered in balance if "quality" holistic treatment or rehabilitation plans are to be achieved.

Carers providing regular patient support need to be acknowledged and recognised by primary and specialist health-care providers in both the initial diagnostic and subsequent treatment/rehabilitation phases. "Medical privacy" tends to be used to limit involvement of other than the GP or the medical specialist. This culture needs to be reversed to acknowledge the functions and roles of carers.

Invariably, those without family or carer support are marginalised. Many will often find themselves either at risk or experiencing severe mental health issues (anxiety – insomnia) which snowball and detract substantially from either their quality of life or ability to rehabilitate back into the broader society.

To ensure best practice quality outcomes, processes controlling management of patient health-care records need to be redeveloped and maintained as a computer based electronic file. These changes are required to improve information flow/transfer in compatible E-formats and provide more efficient access for **all** health-care service providers.

Increasing costs and specialisation of medical services tend to marginalise the most vulnerable in the community, especially the low income earners or the unemployed. Many are unable to access quality health-care services without financial support or ability to access bulk-billing or "on-line" Medicare rebate arrangements.

Unfortunately, medical health providers seem to resist involvement in direct on-line Medicare rebate services on the basis that the processes are onerous and costly. This claim is not supported by the dental (Hicap) and physiotherapist professions who have embraced the on-line rebate arrangements.

Based on the available evidence and success of e-commerce there is justification for governments to seek to educate and change the culture of GPs/ specialist health-care providers along with their professional associations on the benefits of on-line medical rebates.

Desired Outcomes

1. Holistic health diagnosis and treatment/rehabilitation plans should be developed as an element of “best practice” to embrace physical-mental-dental health and medication managements.

2. GPs and specialist medical practitioners responsible for prescribing medication/ drugs should be obliged to consult the patient (and/ or carer) on the need for and purpose of the medication **and** monitor the effect of that medication.

3. Carers providing support to patients need to be acknowledged as being an integral part of both the ACT and Commonwealth health-care processes.

4. Potential for natural health treatments be accepted for on-going research and where appropriate accreditation.

5. GP and specialist health providers be obliged to provide:
   - bulk-billing facilities for low-income or unemployed persons;
   - access to on-line Medicare rebate along similar lines to the Dental and Physiotherapist professions.