Restoring the Balance - The Importance of General Medicine in the New Zealand Health System

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Dr Phillippa Poole
Associate Professor in Medicine, University of Auckland
General Physician, ACH
President Internal Medicine Society of Australia and New Zealand (IMSANZ)

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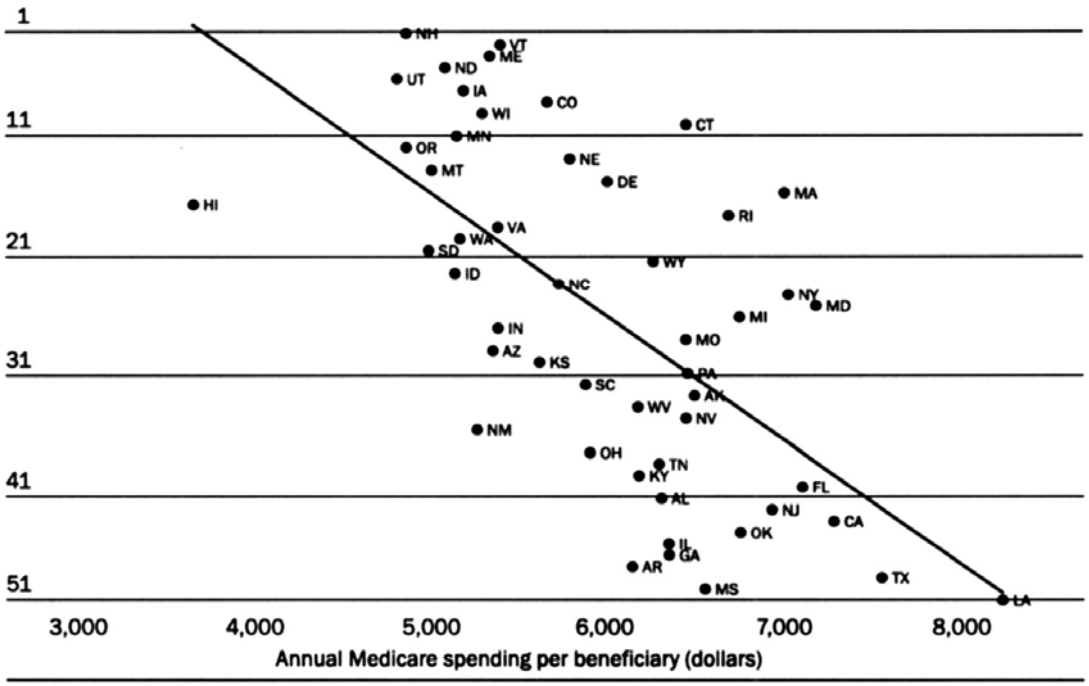
  General Physician CMDHB

Quality and spending in health care systems

EXHIBIT 1
Relationship Between Quality And Medicare Spending, As Expressed By Overall Quality Ranking, 2000–2001



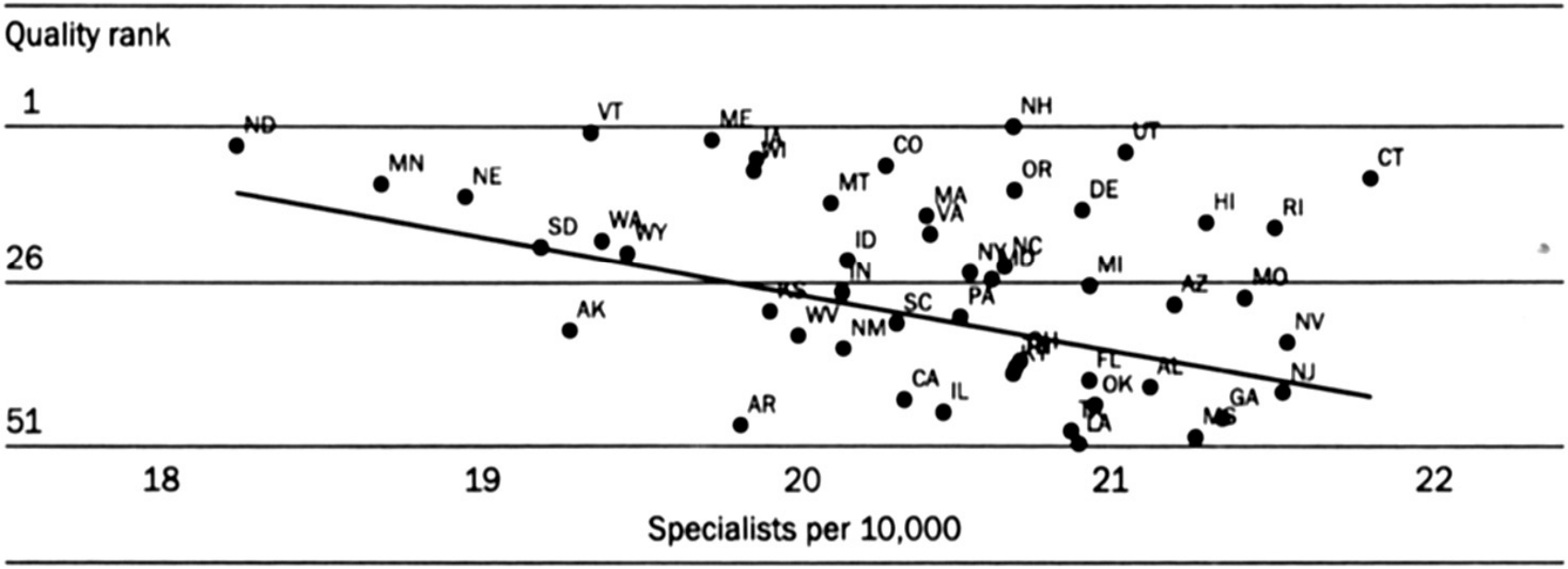
SOURCES: Medicare claims data; and S.F. Jencks et al., "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289, no. 3 (2003): 305–312.
NOTE: For quality ranking, smaller values equal higher quality.

Source Baicker and Chandra, Health Affairs 2004

Quality goes down when there are too many subspecialists

EXHIBIT 6

Relationship Between Provider Workforce And Quality: Specialists Per 10,000 And Quality Rank In 2000



SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTES: For quality ranking, smaller values indicate higher quality. Total physicians held constant.

Source Baicker and Chandra, Health Affairs 2004

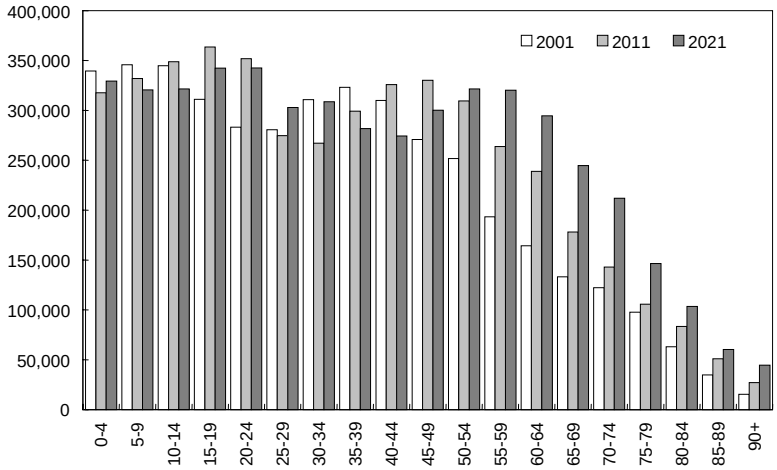
Generalism is good for health care systems

- Helps to reverse the “inverse care law”

  Hart 1971
- Filtering and holding pattern roles
  - helps to ensure hi-tech interventions appropriately applied

  Ferrer 2005
- Integrative function between elements in the system

Population projections by cohort



Source NZIER 2005

Projected excess of demand over supply in 2021

In 2001 there were 66,989 registered health professionals in NZ

Scenario 1 18,957 (28% of 2001 no.)
Scenario 2 23,467 (35%)
Scenario 3 28,117 (42%)

Source NZIER 2005

In order to meet demands

1. Healthier older population
   - Morbidity compression, accurate health info
2. Technology advances and "transfer"
   - Skills in teamwork and supervision
3. Workforce may be more more productive **but**
   - more women, less hours
4. Greater proportion of workforce in health?

Source NZIER 2005, HWAC 2005

Inequities in care

- Maori life expectancy now 9 years lower than for Pakeha
  - Benefiting from improvements, but less so than Pakeha
  - Greater than difference between American whites and native Americans

Source Bramley D. NZ Med j 2005

The inescapable reality

The medical profession will need (radical) new ways of working if we are to meet the health needs of the population in 2021

General physicians are well-placed to help meet the supply / demand imbalance

What is a General Physician?

"one whose training and expertise enables practice as a consultant who provides learned opinions and care recommendations for patients with a broad spectrum of medical illnesses that affect one or more organ systems. "

- Undifferentiated problems
  - SOB, fatigue, weight loss, chest pain, confusion
- Multi system diseases
- Acute presentations of common diseases
  - incl. heart failure, COPD, asthma, infections, stroke, ulcers

Relevant scopes

- acute medical admissions
  - a single organ-system subspecialty care team is often impossible, undesirable or unnecessary
- patients with complex chronic and multisystem problems (inpatient or outpatient)
- liaison e.g. pregnancy, peri operative
- patients in rural and regional areas with complex problems

General Physician activities

Private Practice	42%	[cf 52% subspec]
Public Hospital	92%	
Community Clinic	15%	[cf 7% subspec]
Teaching	60%	
Research	39%	[cf 50% subspec]
Administration	50%	

A General Physician is a medical expert / clinical decision maker with the ability to:

- undertake timely, comprehensive and systematic clinical assessments
- efficiently formulate diagnosis and management plans in partnership with patients
- prioritise care according to clinical circumstances and treatment goals
- care for patients at all stages of life from adolescence onwards
- **care for a diversity of patients with multiple problems**
- care for acute and chronic undifferentiated illness and well-defined clinical syndromes
- **show willingness and capability to manage a diverse spectrum of clinical problems and patient casemix in a variety of clinical settings**
- **demonstrate rational, cost-effective and appropriate use of interventions, investigations and medication**
- competently perform procedures according to current and future practice settings, patient needs, and credentialling requirements
- manage patients in spite of clinical uncertainty

Source RACP Advanced Training Curriculum in General Medicine

Other competencies

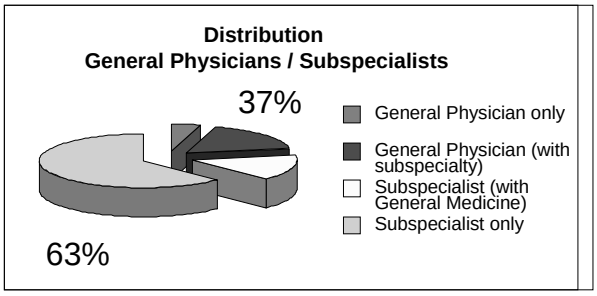
1. Communicator
2. Collaborator
3. Manager
4. Health advocate
5. Scholar / researcher (incl. teacher)
6. Professional

Source RACP Advanced Training Curriculum in General Medicine
Domains derived from CANMEDS 2000

Distribution of NZ physicians

835 physicians in NZ

Source MCNZ 2003



Threats to General Medicine

1. **Workforce**
   - Older by 5 years
2. **Relative values vs. other subspecialties**
   - Money / conditions / workload
   - "Cherry picking", "Squeezing", "Dumping"
   - Undervalued for its educational role for whole system – doctors / nurses / PTs / OTs / SWs
     - relatively junior staff
   - Student debt driving choices

Note: GM disappeared in Sydney in 2000

There are already shortages

- General Physicians (~ 50 nationwide)
  - Middlemore 2.5 general physicians (+ 2 more end 2006)
  - Invercargill and Dunedin
  - Auckland City (3)
  - other regional centres
- Medical registrars
  - Night cover

Internal Medicine Society of Australia & New Zealand

Position Paper

Restoring the balance

An action plan for ensuring the equitable delivery of consultant services in General Medicine in Australia & New Zealand 2005-2008

July 31, 2005

Available at: www.imsanz.org.au/resources/pubs.cfm

Strategic action 1

1) strengthening hospital departments of general medicine
2) increasing the opportunities for physician training in general medicine
3) enhancing services in general medicine in regional, rural and remote areas
4) improving conditions of remuneration and support in both public and private practice

Acute medical assessment

"Safe decisions about clinical care depend greatly on the quality and accuracy of the initial assessment… …acute care physicians.. are readily able to lead, guide and support ED and "on take" medical teams. It represents a key standard of care and is strongly recommended"

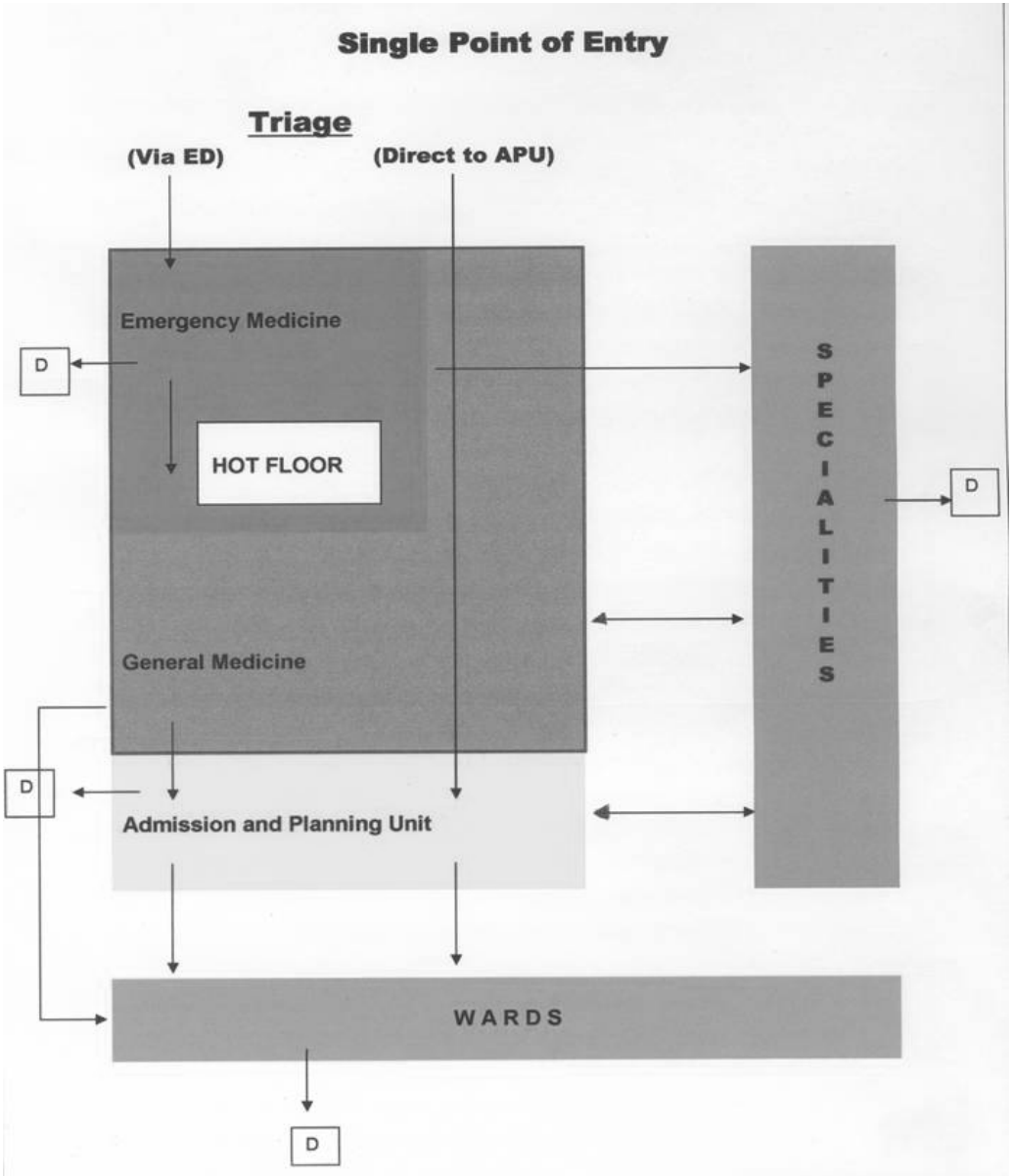
RACP Working Party 2002

The Royal College of Physicians recommends all patients admitted medically-

- be admitted to a dedicated medical unit
- with >= 3 physicians with acute care as primary responsibility
- post acute ward round within 24 hours, 15 minutes per patient

RCP 2003

“Grunt at the Front” aka Medical Acute Assessment Team ACH



ACH General Medicine 2004

90 beds, plus APU

15,546 admissions per year (incr. 800 / year)

12 medical teams

Formal handover 0800 every day incl. WEs

Mean admissions / day	42
Max. per team / day	35 (aim < 20)
Mean LOS	3 days 7 hrs
Median LOS	1 day 9 hrs

Some traction already…..

- Gen medicine / some sub specialties working more closely together
  - patient centred, cost effective care, “best care”
- Positive working relationships with ED / older people’s health / critical care
- Nurse specialists – COPD, asthma, HF, diabetes, vascular, etc
- Bed management systems
- Electronic patient information systems
- Financial and volumes reporting

Some way to go….

- Governance and funding that promotes interdisciplinary and integrated care
  - Outcomes from the system, rather than discipline
- Gen medicine working more closely with subspecialists re: waitlists for clinics in high demand areas e.g. headache, weakness (neuro) / SOB (resp) / chest pain (cardio)
- Exploration of working with other grades of health worker (e.g. physician's assistant)

Strategic action 2

1) strengthening hospital departments of general medicine
2) increasing the opportunities for physician training in general medicine
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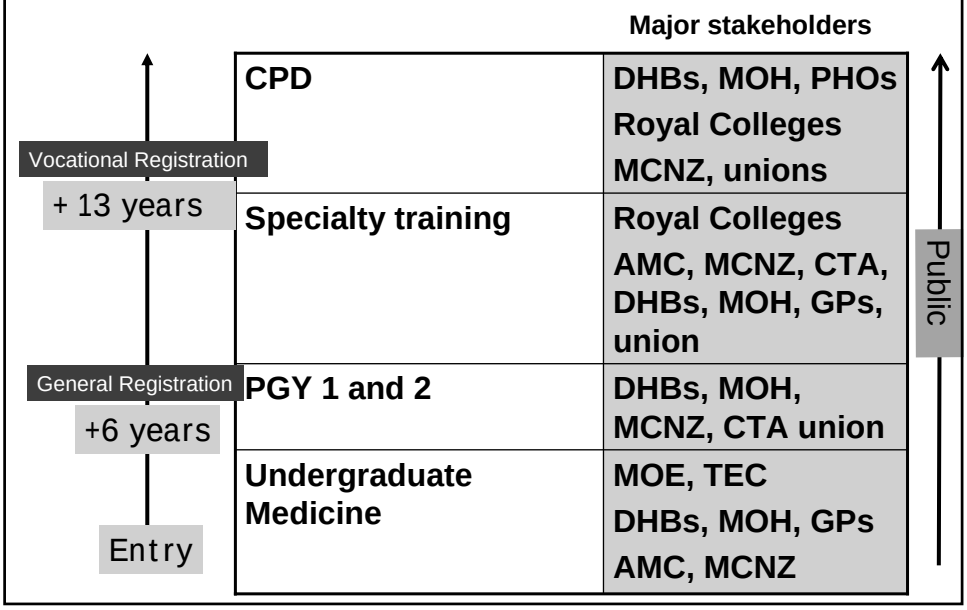
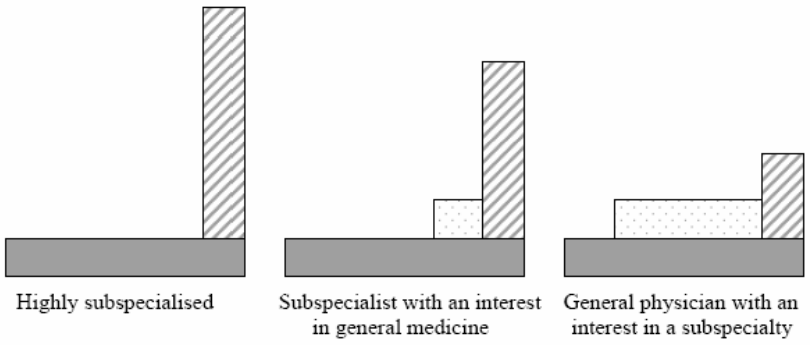
The medical training continuum



Advanced trainees in General Medicine

- 110 in NZ (c.f. 60 in Australia)
- 60 / 110 joint training
  - many drift to subspecialty practice
- Curriculum being formalised
- Training networks slow to develop



Source RACP 2005

Retention of registrars doing gen med or dual training

Opportunities for general med registrars in sub specialty rotations

Sub spec registrars to contribute meaningfully to general med services

Incentives to do general medical jobs

- debt forgiveness for registrars who stay in specialties / localities of demand
- senior resident status
- conditions

Caps on sub spec registrar positions vs those in gen med or dual training

Strategic action 3

1) strengthening hospital departments of general medicine
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Interventions at several levels

- Selection from rural areas
- Good undergraduate experiences
- Relationships bet metro / regional DHBs
  - registrar training networks
  - workforce development for SMOs
  - service provision

JOBS MUST BE GOOD TO DO

Strategic action 4

1) strengthening hospital departments of general medicine
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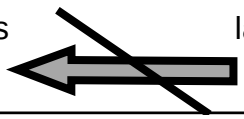
Remove current perverse incentives

Attractive	*Less well rewarded*
overseas	stay in NZ
private	public
urban	rural
highly procedural	non procedural / time intensive / "cognitive"
acute, single system	sub acute, chronic care
individual care	population care
"worried well"	unwell but difficult to access
no trainees	large training role



The future for General Medicine

- General medicine has a pivotal position in NZ health system
  - Need to match services with needs
  - Older patients, workforce shortages
  - Relatively affordable
- General medicine has demonstrated ongoing commitment to patients, service integration and workforce development
- It must be supported meaningfully by all stakeholders to survive

Websites

http://www.imsanz.org.au/

http://www.racp.edu.au/

http://www.rcplondon.ac.uk/pubs/books/AcuteMedicine/AcuteMedicineSummary.pdf

http://www.hwac.govt.nz/publications/fitforpurpose.htm