RNZCGP DIGEST

The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

THE ROYAL NEW ZEALAND COLLEGE OF GENERAL PRACTITIONERS

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Welcome to the RNZCGP digest. The digest contains a selection of recent New Zealand and overseas journal articles and other publications that might be of interest to general practice and to those working in the primary care sector. Some of the articles are available in full at the links provided. Others require an online subscription. Click on any of the bullet points below to go to a section of interest.

## TOPICS IN THIS ISSUE



**Approved CME activity**
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## Models of care

### An inconvenient truth: urgent care is not primary care

**Author:** Loxterkamp D.

This opinion piece from New England discusses the growth of urgent care facilities in the US and, in particular, the growth in numbers of walk-in care centres. By way of example, it describes the transformation of CVS Caremark from a retail pharmacy chain into a health care company that has branches of its 'MinuteClinics' in 900 stores.

The author compares walk-in health centres to fast food chains: they fill a niche for society on the go, providing a quick service at all hours for a fraction of the cost of traditional services. Urgent care centres are good at fixing what is simple to fix. However, urgent care shies away from placing illness in the context of genetics, lifestyle and the social milieu. It also does not help willing patients to overcome the individual obstacles to their wellbeing.

The author adds that good primary care relies on connection and context, not convenience. It takes time, perspective and team work to tackle the biopsychological dimensions of chronic disease. More importantly, primary care is built on trusting and caring relationships, forged over time. He concludes that primary care doctors need to adapt and find ways to expand their hours, free up time in their schedules for the unexpected, and ensure that their services remain affordable – otherwise they will concede the care of all emergencies to urgent care silos. However, adaption should not cater to convenience, consumerism, or shortcuts to the comprehensive care that patients deserve.

**Reference:** BMJ. 2015;350:h1657

## Rural practice

### Which dimensions of access are most important when rural residents decide to visit a general practitioner for non-emergency care?

FREE

**Authors:** Ward B, Humphreys J, Wakeram J, et al.

This article outlines the results of research conducted in Australia in 2012. Over four thousand questionnaires were sent to every household in five sparsely or closely settled rural communities. The questionnaire sought to ascertain the importance of four key dimensions of access: availability (the existence of the service); accessibility (distance to the service); affordability (cost of the service); and acceptability (preference for the service) in relation to respondents' decisions to use a GP service for non-emergency care.

The study found that preference for a GP and GP availability were far more important than distance to, and cost of, the service when deciding to visit a GP for non-emergency care. For residents in sparsely settled areas, availability of a GP was marginally more important than preference for a GP. For all analyses, distance to a GP was ranked consistently as the third most important dimension, well below the top two (i.e. preference and availability). In all instances, cost was rated the least important dimension. Interestingly, females ranked preference for their GP as most important, whereas males reported that availability was most important. In closely settled areas, both males and females reported that preference for their GP was the most important dimension, followed by availability, whereas in sparsely settled areas, these rankings were reversed.

The authors conclude that ensuring 'good' access requires policy makers and planners to consider other dimensions of access to services besides geography.

**Reference:** Aust Health Rev. 2015;39:121–126.

## Health workforce


### Workforce planning in the NHS

**Authors:** Addicott R, Maguire D, Honeyman M, et al.

This report explores workforce planning in the UK, and how planning has aligned with strategic policy in mental health, general practice and community nursing. The authors are concerned that the rate of increase in the number of GPs in the UK has been dramatically outstripped by increases in the secondary care medical workforce. The UK medical workforce also faces:

- a fourfold increase in the number of unfilled GP posts since 2010
- unfilled training posts (12% of places were unfilled in 2014)
- an increase in the number of GPs aged below 50 who plan to stop providing direct patient care within five years
- lower job satisfaction compared to the previous 10 years, increased workload and stress, and low morale.

The authors say these challenges pose a serious risk to future care models aimed at delivering more community care. They also argue that there has been no clear attempt to rebalance the workforce into primary care settings. In comparison, the commitment to reduce waiting times in the acute sector after the year 2000 led to a sharp and sustained increase in the number of consultants. Two factors are thought to have contributed to the difficulty in balancing supply and demand in the primary care workforce:

1. There are no clear ways to measure demand for primary care services, compounded by the absence of any recent measures of activity. This means policy makers could add more responsibilities to primary care without a clear view of the pressures under which staff are working.
2. Broad national commitments to better primary care have not translated into a strategy to increase the proportion of NHS resources (and staff) going into primary care. The authors note the share of NHS resources going into general practice has actually been declining.

**Reference:** The King's Fund; April 2015.

## Quality improvement


### Choosing wisely in the UK: the Academy of Medical Royal Colleges' initiative to reduce the harms of too much medicine

**Authors:** Malhotra A, Maughan D, Ansell J, et al.

This article looks at the US/Canadian Choosing Wisely initiative and why it is being brought to the UK. Choosing Wisely (www.choosingwisely.org) aims to stop doctors using various interventions that are not supported by evidence, free from harm, or truly necessary. The authors argue that a culture of 'more is better', where the onus is on doctors to 'do something' at each consultation, has bred unbalanced decision-making, so that patients are sometimes offered treatments with only minor benefit and minimal evidence despite potential harm and expense. This culture threatens the sustainability of high quality health care and stems from defensive medicine, patient pressures, biased reporting in medical journals, commercial conflicts of interest, and a lack of understanding of health statistics and risk. Furthermore, the NHS in England has the Quality and Outcomes Framework (QOF), a pay-for-performance instrument that encourages health providers to do more.

The Academy of Medical Royal Colleges, which represents all UK medical royal colleges, is launching a Choosing Wisely programme in collaboration with other clinical, patient, and health care organisations. Participating organisations will work together to develop 'top five' lists of tests or interventions with questionable value. These interventions are not to be used routinely, if at all. The authors also identify the initiative's potential limitations. There has been no evidence that these lists reduce the use of low-value medical practices. Further, the level of public awareness of the campaign has not been assessed. Reducing wasteful and harmful health care requires commitment from doctors and patients, as well as objective

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evidence of effectiveness. The authors conclude doctors, medical students, patients, funders, the media, and medical publications all play a role in ensuring the development of a Choosing Wisely culture in clinical practice. Organisations responsible for postgraduate and continuing medical education should also ensure that practising doctors are educated about overusing tests and interventions.

**Comment:** We note the Royal College of Pathologists of Australasia's list of five things clinicians and consumers should question (April 2015) targets asymptomatic bacteriuria, inappropriate PSA testing, population-based testing for vitamin D deficiency, serum tumour marker tests, and hyperlipidaemia in some patients (http://www.choosingwisely.org.au/recommendations/rcpa).

**Reference:** BMJ. 2015; 350: h2308.


### The use of financial incentives in Australian general practice

**Author:** Kecmanovic M, Hall J.

This article considers the use of financial incentives to improve the quality and outcomes of health care. The research aims to explore the uptake of financial incentive payments (i.e. income from government incentive schemes and grants) in general practice in Australia, and to identify the types of practitioners who participate in these schemes. The study used data from the Medicine in Australia: Balancing Employment and Life (MABEL) longitudinal panel survey of doctors between 2008 and 2011.

The researchers found that the proportion of income derived from incentive schemes and grants in primary care has been low. Less than half (47%) of GPs received any income from incentives in 2008 and, three years later, that fell to 43%. Around one-third of doctors changed their participation in any year, but the rate of exit from the scheme was higher that the entry rate.

The most significant predictor of the use of incentive schemes was the location of the GP's practice, reflecting the larger numbers of incentive schemes available to GPs in rural areas. More interestingly, practice size was a significant factor in incentive use, consistent with the large administrative burden associated with claiming incentives. Principals were more likely to claim incentive payments; this might largely be due to payments to the practice rather than the practitioner. On the implications for continuing or extending the use of financial incentives in general practice, the authors conclude:

- it is important to consider the administrative cost of claiming any incentive, as well as the cost of providing the service relative to the reward
- the decreasing participation by urban GPs may reflect some blunting of the incentive effect of relatively small payments, which become less effective over time
- the higher retention of rural practitioners in claiming incentives may be a reflection of higher reward relative to effort for rural incentives or the characteristics of rural practice
- the response to incentives depends not just on their design, but also on other conditions, e.g. faced with increased demand, it may involve less effort for a GP to increase the number of consultations than to claim additional payments.

**Reference:** Med J Aust. 2015 May 18;202(9):488–91

## Quality improvement

### Michigan's fee-for-value physician incentive program reduces spending and improves quality in primary care

**Authors:** Lemak CH, Nahra TA, Cohen GR, et al.

This was one of several recent papers in *Health Affairs* looking at programmes that provide incentives to health services as a means of reducing the cost and improving the quality of care provided. This article looks at the Physician Group Incentive Program, a pay-for-performance programme aimed at umbrella organisations such as independent practice associations, physician–hospital organisations, and large multispecialty group practices. It includes more than 19 000 physicians, including 68% of Michigan's primary care physicians. The study analysed the programme's effect on quality and spending for over three million patients in over 11 000 practices between 2008 and 2011.

Physicians in the programme are eligible for a variety of financial and non-financial incentives that target improvement on population-based cost measure and evidence-based processes of care. Incentives are split between rewarding past performance and supporting future-orientated, capability-building efforts. Doctors who meet the patient-centred medical home requirement are eligible for up to 20% increased reimbursement in their office visit fees. They may also bill for care coordination and care management services by ancillary providers, and may earn an additional 5% in fees for achieving high performance on quality measures.

The authors found that participation in the incentive programme was associated with approximately 1.1% lower total spending for adults (5.1% lower for children) and the same or improved performance on 11 of 14 quality measures over time. Significant improvement was noted in three of seven quality measures for preventative care, and four of seven measures for diabetes care.

The overall conclusion of this study, and other recent research, appears to be that comprehensive incentive programmes are associated with a modest reduction in cost and moderate improvement in quality. However, the authors add some caveats, particularly that geography, differences between the control and study group, and engagement in other initiatives, reforms and interventions may have contributed to the outcomes. Improvements could also have been achieved in measured and rewarded domains at the expense of performance in unmeasured and unrewarded domains.

**Reference:** Health Aff. April 2015; 34(4):645–652

### More comprehensive care among family physicians is associated with lower costs and fewer hospitalizations

FREE

**Authors:** Bazemore A, Petterson S, Peterson LE, et al.

The authors of this US study explore the associations between comprehensiveness of care (the provision of a wider range of services), cost and hospitalisations based on data collected between 2007 and 2011. Two measures of comprehensiveness were used: one based on mandatory self-reported survey items collected as part of the family physician recertification process; the second, derived from Medicare's Berenson-Eggers Type of Service (BETOS) code (which characterises the services each family physician provides to patients across a range of care settings and modalities). Cost and hospitalisation data was obtained from Medicare claim files. The authors examined the association between the two measures of comprehensiveness and hospitalisations, Medicare Part B (medical insurance) payments, and combined Part A (hospital insurance) and B payments.

The study found that, after adjusting for beneficiary and physician characteristics, increasing comprehensiveness was associated with lower total Medicare Part A and B costs combined, and Part B costs alone, but not with hospitalisations. The association with spending was stronger for the type of service (BETOS) measure than for the self-reported measure; higher BETOS scores significantly reduced the likelihood of a hospitalisation. The authors conclude that increasing family physician comprehensiveness of care, especially as measured by claims measures, is associated with decreasing Medicare costs and hospitalisations.

**Reference:** Ann Fam Med. May/June 2015; 13(3):206–13

## Quality improvement


### To be or not to be comprehensive

**Author:** Grumbach K.

In an accompanying editorial to the aforementioned article, the author acknowledges that more comprehensive care was associated with significantly lower Medicare expenditures per patient and says the cost reduction (of 10 to 15%) represents a substantial policy saving. He notes the eroding scope of family medicine and questions the effect of this on the Triple Aim of better care, better health, and more affordable costs. He also notes that Bazemore et al. did not measure quality of care or patient experience, thus making it impossible to know if the findings represent just less expensive care, or better value. He suggests a need for more research to examine the components of comprehensiveness that are most strongly associated with reduced costs and hospitalisations.

The author also says comprehensive primary care will not simply be achieved by promoting a broad scope of training during residency education. Payment policies need to fairly compensate family physicians and their practice teams who invest the time and effort to provide the type of holistic care that brings value to patients and the health system.

**Reference:** Ann Fam Med. May/June 2015; 13(3):204–205

## Medico-legal and ethical issues

### Medical students and informed consent: A consensus statement prepared by the Faculties of Medical and Health Science of the Universities of Auckland and Otago, Chief Medical Officers of District Health Boards, New Zealand Medical Students' Association and the Medical Council of New Zealand

**Authors:** Bagg W, Adams J, Anderson L, et al.

In this article, the authors set out a consensus statement on informed consent to assist medical students, doctors, and other registered health professionals who are responsible for supervising medical students. The authors note that medical students learn in an apprenticeship model under the supervision of registered health care professionals. Before becoming involved in a patient's care, the patient's consent must be obtained. The Code of Health and Disability Services Consumers' Rights establishes the rights on the informed consent process. However, there is evidence that the practice of obtaining consent for student involvement is variable. The consensus statement is an attempt to promote a pragmatic, appropriate, and unified approach to seeking such consent.

The document aims to deal with the potential (and at times actual) tension between the requirement to respect patients and their rights, and the obligation on the health system and health professional educators to provide learning opportunities for students. The statement sets out 19 principles, illustrated by examples. Some of the specific topics covered include:

- patients on wards and the responsibility for seeking consent
- the need to explain who a medical student is
- examples where a patient might not be competent to make a decision or give consent
- patients in intensive care under sedation and/or on ventilators
- circumstances where the potential vulnerability of patients or their families is increased and extra sensitivity is required
- anaesthesia attachments
- primary or community care.

**Reference:** N Z Med J. May 2015; 128(1414).

## Access to care

### Patient access to general practice: ideas and challenges from the front line

FREE

**Authors:** Ware J, Mawby R.

This UK Royal College of General Practitioners' paper explores new approaches to providing patients with access to general practice services. It focuses on three aspects: availability and proximity of care; timeliness of care; and ability to see a preferred GP or nurse. Initiatives to bring GP services closer to patients include:

- online booking systems
- smartphone apps
- web consultations such as Skype
- co-location of general practice with other services, e.g. attachment to hospital emergency departments
- home visits and district nursing
- ensuring homeless people and other socially excluded groups can access general practice, e.g. greater community engagement
- working with the voluntary sector to reach patient groups who typically report poorer levels of GP access
- allowing practices to register new patients who live outside their practice boundary areas.

Initiatives to improve timeliness of care include extended hours and improving systems that manage patient flow (e.g. by placing GPs at the front-end of the service). Initiatives aimed at ensuring patients see a preferred GP or nurse include GP 'micro teams' that involve allocating a shared group of patients to a small number of GPs within a practice, and proactive care planning and promotion of self-care.

The authors admit there is only minimal evidence of the effectiveness of the initiatives, but conclude that there is now an important opportunity to properly test and evaluate different initiatives. However, patients and professionals should be given adequate time and support to evaluate and share information about what has been shown to work. They stress the importance of developing initiatives focusing both on patients who want to prioritise speed and on the growing number of people who would benefit from greater continuity of care with their GP.

**Reference:** RCGP; February 2015.

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We welcome your comments or suggestions. Please contact the RNZCGP's Policy Team at policy@rnzcgp.org.nz

**The Royal New Zealand College of General Practitioners** is the professional body that provides training and ongoing professional development for general practitioners and rural hospital generalists, and sets standards for general practice.

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