

'I want you to show me the way'

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Good morning and thank you very much

Before I start I would like to acknowledge the traditional owners of the land on which we meet and pay my respects to the elders past and present.

Thank you Simon for the introduction, thank you to the GPET Board for the invitation and in particular Steve and Anne for your invitation here.

Amongst you there are innovators, there are teachers, supervisors and registrars - learners who keep us on our toes - and of course our students who will be keeping us on our toes if they don't already do so. I acknowledge today my fellow AMA councillors Alex Markwell, who chairs the committee of doctors in training and who, although she is an emergency medicine trainee, still holds the training needs of general practitioners close to her heart.

Rodney Pearce, the chair of AMA Council of General Practice, and of course Michael Bonning the president of AMSA. To my colleagues of the RACGP, Chris Mitchell, president-elect, congratulations, and of course Morton Rawlin.

From ACRRM, Dennis Pashen, over from Mt Isa, over there with their rude mayor; Naomi Harris and Marita Cowie; the AGPN's Tony Hobbs, who I am delighted is chairing the Primary Care strategy, these are some people, but of course friends and colleagues, I acknowledge you all for being here and certainly it is a great pleasure to speak.

The last time I did speak with the group was in Melbourne that was when I had a different role and I had a very different presentation. Today I hope will be a slightly different tack. It is like coming home for me being amongst friends today, amongst people who understand health - those who understand the beauty and the futility of life, those who dare to care, dare to dream they can deliver improved care, those that know the daily highs and lows of medical practice, of practice management, of teaching and of being taught and of course dare I say it, being shown the need for further education - that is all of us by the way, we are all signed up to the notions of lifelong learning and continuous improvement.

So recognising that we are far from perfect, I would suggest that General Practitioners are pretty damn good at just what they do, what they can do and indeed what they can be doing in the future. We can do this only if the system is supporting us, the system around us is allowed to flourish, and allow us to provide that care, allow us to coordinate care and allow us to recruit a team of

ready and able other health professionals around us with whom we can work collaboratively.

What I would like to talk about today in the short time on the podium is a few things - these will be the changing face of medicine and the delivery of medicine in general; our own health; the value of General Practitioners to primary care; care in the community and indeed care in the whole healthcare system; a little about the reform agenda - we have heard a little about that already; the Millennium Development Goals, this is a little of my international flavour; and I can't get away without talking about IT because none of us can get away without talking about IT anymore. It is there it is in our face and we need to use it and embrace it.

So as I said when I was first approached to speak at this conference I was told I can talk about anything that I like. Great I can talk about anything that I like! Since being here I have had to modify it to take on an Olympic vision. That vision of self-respect and drive, commitment, training being subjected to competition, endurance, skill, support, experience, the human spirit, fellowship and challenging the boundaries that exist - these are not dissimilar to the requirements of being a General Practitioner and remaining so. The paradigm of faster, higher, stronger (I don't agree with them by the way) from which the Olympic ideal grew, now expands to include more skills - from

bouncing about on the beach scantily clad in the smog, shooting, archery, softball, god help us, gymnastics, swimming and of course synchronised swimming. Just like that medicine too has evolved - from the physicians and barber surgeons of old to a multiplicity of disciplines within medicine, greater specialisation, as well as a large number of attendant health professionals all so eager to make their contribution to patient care. So as the expansion of the health care provider sector has widened the field of attributes has widened with it, we all need to strive for excellence – but the core driver remains best patient outcomes.

When we talk about our own health we must remind ourselves of the lessons we remind our patients of everyday, the patients and their carers, if you don't look after yourself, who will look after you when you become unwell and how will you be able to continue to look after those around you? How can you look after yourself?

Our health is vital, by this I don't just mean physical health; to this I add mental health, emotional, spiritual important though they are. I also bring attention to our exposure to dangers of violence on the frontline but I mean more than this, I add unashamedly financial health. If the business is not viable it will fail. If remuneration is not worthy it will not attract staff, this applies whoever or however the practice of medicine is set up and funded. If the terms and

conditions under which people work are not adequate people will leave. If there is no value, worth or respect placed on the skills of our brilliant people why would they stay? Packages that we discuss, in terms of maintaining workforce include but are not restricted to money - they include academic positions and their ability to teach, which are vital to some, and the need to have with them time for teachers and the students and learners alike to participate. Research is another driver and it needs to be in a supported and accessible environment that keeps us at the cutting edge of health research and health delivery. And of course there is flexibility, flexibility in our work hours, flexibility to work in different places, in rural and remote Australia, Aboriginal and Torres Strait Island communities and internationally to keep the interest up in medicine, keep the sword sharp and enable us to keep some retention.

We as GPs are still the most sought-after carers. The recent study from the MJA confirms what we already know – when people are sick, it is a GP they turn to; when it is about their health and wellbeing, it is again the GP that they turn to. The study confirmed a positive perception of Australia's health professionals - GPs are deemed more trustworthy than specialists or hospitals and all medical practitioners were more trusted than alternative practitioners. Other journal articles rate general practice highly in respect of access to

practice, continuity of care, communication, nursing care and the practice overall.

There are problems around access - we (NHHRC) have done a tour around the country to every single capital city and regional centres around the country and have had 550 submissions. One thing that comes up over and over again is lack of access to general practice, to the way in which we provide that service - we think we need to be aware of that and change some things. Work by Barbara Starfield is a clear marker of the benefits and value of health care and where primary care in Australia and GP and other community health care providers fit. My personal mentor speaks of the GP as physician, philosopher and friend; 20 years of medical practice has not swayed me from that point of view. Nor the unsolicited but nevertheless valued comments of a business adviser - look after them and treat them well, and they in turn will look after you. The notion of knowledge, of experience or judgment must never be lost but to these we must add respect for others with whom we work; clear communication between us; and a clear understanding that it is the patient to whom we are ultimately responsible. We need to understand the competencies of, and demand the same stringencies from, other health professionals with whom we work and what care they give and provide for our patients. This needs to be complementary and team-based care, they are not

mutually exclusive and nor are they conflicting. Bearing in mind the legal aspects of what is called joint and several liabilities - which can expose a GP when care is given by another health professional - team-based care needs to be properly worked out. We should remind our patients what a GP is and what a GP does and be sure of the manner in which our services are provided. Do those services themselves add value? And be aware of the value that we add. The General Practitioner is not substitutable but the care that they provide can be leveraged and can be optimised and that's what our goal should be.

Governments often feel they can intrude in this relationship, I say they cannot. The role of government should be around sound policy and implementation frameworks with the help of experts with experience and judgment providing the prerequisite factual and practical advice and direction. Their other role is to ensure access and health funding mechanisms to allow this care to be available, in particular where services are hard to find - the Aboriginal and Torres Strait Island services, regional, rural and remote Australia, and our metropolitan Australia and its fringes.

Other areas include mental health, dental health and health for the disabled and again, what we found in our consultations around the country is on the whole - and we know from international statistics - our services are excellent, but there are significant pockets that are not accessing the services and we

need to provide the care and we need to be innovative. Another thing we picked up going around the country is that it is in regional remote areas that the activity happens and we need to learn from those experiences and make them more central. We need to ensure the same standard of care and access is available and this of course means health care reform.

Accountability for the decisions taken by practitioners, by governments, by bureaucrats also needs reform. Where services are by necessity at a distance from where a patient lives, this means reforms to the support we provide, for the care away from home in which that is provided including care for the carers and the families of those people who need that care away from home.

One of the comments that I picked up that I think is quite good is that bureaucrats are not bureaucratic enough. This revelation astounded me when I first heard it described, but meaning when it is spelt out it makes a lot of sense. If the bureaucrats, who are an integral and necessary part of the health care system by the way, behave to ensure the success of the system they are a part of, properly and holistically, the system would actually be better off for it.

To the reform agenda then - this is something that wouldn't have escaped your attention and we've heard a little bit about the many committees from Simon.

Rather than describe the work of our committee, the National Health and Hospitals Reform Commission, I refer you to our first report – Beyond the

Blame Game. That was produced between the time we set up on 26 February and the end of April, a very short time scale, but it is a pretty good pointer to the direction we want to take in health care reform. We have a very ambitious target to produce our next report to the federal Minister of Health and Ageing and the Prime Minister by mid November. Key to this work is reversing what I would consider the lack of support for what I also term the three Ps - Primary Care, Public Health and Prevention of Disease. These are fundamental to overall care. These, well designed and implemented and supported with people and resources and with good support from the hospitals sector, would in fact reduce the demands from the community for care. It will however require more community based services to be provided. There will need to be more pathways provided into and out of community through to hospital care, through to aged care beds and other places where people need their care, so we need to think of new ways of doing what we currently do. The way we provide services to those who have chronic and complex care needs and those requiring the more coordinated care framework and a variety of support and guidance is really what is taxing us for the moment. In particular we are working through how to get the services of health professionals to people who can't currently afford them in a more accessible and affordable manner.

It is pertinent for people to develop standards and frameworks, quality and safety, ensure that the standards are pertinent, are achievable, reflect current practice, take into account developments that we do have in practice.

Standards of practice and competencies have to be professionally determined and implemented. One of the first pieces of work we did in the Commission was to delineate and benchmark the indicators to help frame the Australian Health Care Agreements that were signed off and currently being renegotiated - there were some 7,000 – 7,000 – markers of performance and we cut them down to 44. So that was a good start I believe to cut down the number of things that we actually report against. Governments may feel that they can direct care - for instance mandating HBA 1C level delivery in formulas to determine how in service funding might occur. I find that everyone is telling us “HBA 1C levels”. Why? Because it’s a number - this can be determined and you can measure against it and it may well reflect diabetic care. Those of us in active clinical practice of course know that HBA is only one marker in good diabetic care and we have to rein in the enthusiasm of those without that comprehensive view. Best practice guidelines are used when they suit governments’ purpose. I was staggered to learn on Monday that not only have they developed comprehensive national service improvement frameworks for heart disease, stroke, vascular disease, asthma, diabetes, arthritis and

osteoporosis, not only have they been developed, they have actually been to COAG and have actually been endorsed. And I said “I have a bit of an idea about the health care system, have been active in it I have never heard of them” - so there’s some problem about having frameworks that have not been implemented and they really need to be put in to good use.

We need to ask in daily practice what is the value add that I provide? Is there a way I can improve and show that I improve and improve my practice – the answer to this is an overwhelming “yes”. The NPCCP [National Primary Care Collaboratives Program] did just this – it’s a model that must be pursued, we don’t want to kill the goose that laid the golden egg, it must be supported. We must have a goal that every branch of every health related department in every jurisdiction has attached to it the feedback that these schemes provide; it needs to be timely. This scheme is private and drives change – it’s the improvement cycle at its best - best practice and evidence based practice, acute medical care, health promotion, illness prevention, this is what we do.

We do this daily, and yes we can do it better but the notion that it is not done today, that general practice is not active at duty I found reprehensible. The reason we can’t do much of this work is the blocks that have been put in the way by bureaucrats reducing their exposure to streams and governments reducing exposure to paying for them. All of these things – all of these

processes are not cost neutral nor are they cost reducing processes. The goals are to lengthen life - we can improve the quality of life and we can improve the productivity and the quality of the nation's economy, it is an investment in the future.

Good health and a secure welfare system are firm and comfortable foundations providing security. Aspirations and inspiration spring from this base. People can concentrate on innovation and on entrepreneurialism in the knowledge that the basic needs, demands and rights to health are fundamentally being looked after. In short they can lead flourishing lives, which is the United Nations Commission on Determinants of Health stated objective. But of course there are obligations that go with these rights. We need to delineate those and that is a challenge, how do we do it and what do we do?

Very briefly I just want to talk about international health and the World Medical Association, which I am an executive councillor of, that brings together many of the World Medical Association's thoughts about issues around ethics and practise of medicine and brings with it a lot of codes like Helsinki, which is currently being revised, around the experimentation and the drug trials and so on. There are international codes of ethics and advice on treatment of things like the treatment of multi-risk TB and for doctors working in prisons and also

including how to work with prisoners. The World Medical Association also works in combination with a variety of other groups called the World Health Professionals Alliance which includes doctors, nurses, pharmacists, midwives and physical therapists. In February this year we put out a joint statement on task shifting in direct response to WHO moves in this direction, which you might look up in the declaration. Some of that stuff is scary – these groups have come together internationally to work this out, there is no reason why we can't do this nationally.

The other thing I want you to be aware of as groups of practitioners and coming into WONCA in October is the need to be aware of the Millennium Development Goals - these are very broad but they are something that has to be reported by 2015 and many governments have signed up to it. They include eradication of extreme hunger and poverty, achieving universal primary health education, promoting gender equality and empowering women, reducing child mortality, improving mental health, combating HIV Aids, malaria and other diseases, and ensuring environmental sustainability as well as developing a global partnership for development. These are very worthy goals and can be found on the WHO website and Millennium Development Goals and the role of health in these is very important because good health underpins all those objectives. And we as a health community need to get involved in that and

give direction and advice about this - or other people will give that advice and it will probably not flow.

Finally I want to talk about a pet topic, that of IT data, voice and image communication. Improving the standard comprehensive nature of patient care, especially those with chronic care needs, is a developing art. These include by necessity the use of electronic health management systems. On Monday we had a consultation in Sydney where we brought together the other health professional groups, about 23 of them, and I said there are 23 groups around the table, potentially a patient with multiple complex needs would need all of you so if you all do a little bit of care who will take the overview of what is going on? And how will you communicate what you have done so we don't miss out on somebody doing something or we don't get duplication? This is something that will be enhanced by IT. In Australia and in regional and remote Australia the use of technology and information management is low - that is not the case in general practice of course where there is an abundance of data - problem is that there is no one to send it to in a useful format. I call this the super highway to nowhere. We have got great capacity from our desktop solutions, we can receive but we only receive pathology and diagnostic information and diagnostic imaging in a reasonable way. We can send information - the widest scale of operation of these technologies depends

on it being collected in an electronic format to what we call feeder systems. That means more people doing things electronically. More GPs, more other specialists and more other health professionals need to be brought into the communication tree. But there is one other party, that we have to try to glean information from that never seems to arrive, the holy grail - the discharge summary. Yes - that is something that has taxed me for my entire life and I am sure it will continue to tax us more. The current tragedy is that we can't get this information out of hospitals and we can't get pathology and we can't get diagnostic information either and this is a key disconnect for me. The current great tragedy of the current reform health agenda and realignment of services and service delivery and harnessing general practice to do more to look after more patients - to look after the community, to look after for longer more elderly people, those with more chronic care diseases, those discharged early into the community for us to look after - is that we have not resolved the communication tree into the hospital for our information, and more importantly our information out. This, for a lot of information technology, needs to happen and this is where we need to direct our efforts. Some stars shine out there - Goldfields of Western Australia come to mind, what I would call the beacon of the Northern Territory - shared health record processes and the bells and whistles that are going with that. Geelong in

Victoria and of course the GP Partners program in Brisbane north - these are great programs but we need to support, expand them. The demand for general practitioner training is increasing but no one is giving stuff to us. Greater buy-in sophistication involves more IT in the health care team and the use of web-based technology and also data voice and video communication and these speak volumes without having to speak volumes now. Such technology improves the accuracy and timeliness of information and improves the quality and safety of care, further it improves access to that information. In rural regional rural and remote areas in particular we need wider access to these services and not restricted areas. This requires infrastructure of information but also technology. If there is one thing people are screaming for in regional rural areas it's broadband, it goes everywhere and everyone goes ape about it and you can understand why. You talk about information and how you want quality information how do you get it – go on the internet – can't get internet - so there is a big problem and we need to supply it. We need to ensure patients can access world class facilities and health care providers, and the need to access high capacity telecommunications will help that along. In Australia as well as around the world we recognise that health care service delivery remains disjointed and very complex to navigate through and collate information from - that need not be the case forever, we can

change that. We health practitioners strive to improve the quality and safety of care that we provide to our patients to work in a more effective and efficient way and to engage a number of health professionals essential to optimise and tailor to individual care especially those with chronic and complex care. Resources such as electronic decision support and patient information and a safe environment for electronic interaction including data voice transmission will optimise available clinician time and optimise services.

So I hope that this dive through the tidal waves of reviews and other processes, the changes and challenges we face, enables you to be part of the process. Don't be passive. You have to be active in this. You are, we all are, part of this process. Change management is a key ingredient that needs to happen here. Change management is important to embed and enact this. This is over and above change being necessary; it is about sensible implementation and not being forced down our neck. Your future, and all of our future, is in your hands and as the red bus at the [Olympics] closing ceremony had an aging rocker (Peter Frampton) doing one thing, I thought – "I want you to show us the way".

Thank you very much.