A service of the Ministry of Social Development

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MEMO

To	SDD	Date	5 June, 2007
CC			
From	Dr David Rankin		

GP SECOND OPINION

Action	Date required by	

Purpose

This paper outlines a new service – the GP Second Opinion, aimed at transitioning the Designated Doctor role to meet requirements arising from the Working New Zealand program.

Recommendations

It is recommended that SDD:

- **Note** the issues with the current Designated Doctor process
- **Endorse** the Service Specifications for the GP Second Opinion service including the qualifications framework for practitioners
- **Endorse** the preferred engagement of PHOs or primary care organisations as GPSO service providers
- **Endorse** the cost basis
- **Note** the transition arrangements

Background

One of the aims of the Working New Zealand program is to reduce the burden of application, particularly for those eligible for Invalid's Benefit. As part of this change, it has been agreed that case manages will rely on existing reports and available information where practicable, rather than routinely requesting an opinion from a Designated Doctor prior to granting benefit.

The new medical certificate offers the GP the option to indicate that they may not be the best person to complete the certificate and that a second opinion may be warranted.

In determining entitlement and developing an employment plan for clients, the case manager may require additional information, particularly when the medical certificate is inadequately completed or is ambiguous, confusing or at odds with expectations.

Current Practice

Use of Designated Doctors

Although Designated Doctors primarily provide MSD with a medical opinion on entitlement for the Invalids Benefit, they also provide second opinion consultations around eligibility or appropriateness for Sickness Benefit when requested to do so by a case manager or the client's GP.

The cost of completing an assessment by a Designated Doctor is met by MSD. The fee is currently set at $106 ($150 for specialists). This equates to around 40 minutes of a GP's time. Last year MSD spent $1.403 million engaging Designated Doctors made up of $1,356,000 for IB assessments and $46,000 for SB assessments. It is likely that many public hospital based doctors do not invoice for their reports.

There were 24,366 IB related Designated Doctor transactions recorded on SWIFTT last year, although only 11,687 people were granted IB in this period. Although only 89 reports are recorded for SB clients, the expenditure was $46,000 would indicate that around 400 second opinion consultations were funded.

However, there are a range of significant problems with the implementation of Designated Doctors which suggest a new approach is required.

Designated Doctors are self selecting. There is no formal recruitment process for Designated Doctors, so any doctor who expresses an interest is considered. The directions on MAP indicate that case manager should take into account the doctor's location, expertise and ability to meet Work and Income's reporting time frames of one week. Designated doctors must be registered to practice medicine in New Zealand with preference given to vocationally registered General Practitioners.

The Designated Doctor database is of poor quality. SWIFTT contains a large number of duplicates, mis-spellings and incorrect practice type information. Three GPs are recorded as psychiatrists and six psychiatrists are recorded as GPs. A wide range of medical practitioners are recorded as specialists, when they are on the general register.

There is a range of practitioners and their qualifications. There are currently 1090 Designated Doctors registered on SWIFTT. Of these 224 are hospital based, 522 are vocationally registered in General Practice and 226 are on the general register (required to work under supervision or oversight).

Twenty percent of all vocationally registered GPs are recorded as Designated Doctors. Similarly 23% of all psychiatrists are Designated Doctors. Only three practitioners are identified as psychologists.

There is a range in the volumes of reports each doctor writes
Forty-one (of 522) GPs who wrote more than 100 reports accounted for 26% of all reports written. The 224 hospital based doctors (20%) completed 1,470 certificates (6%). Eight of the 14 highest volume SB certificate writers (each writing more than 500 SB certificates) are also Designated Doctors.

Reviews to date

Two reviews of the Invalid's Benefit process and the "Designated Doctor" scheme have been undertaken.[1] Key issues and points noted in these reports include:

- GPs support the scheme as it removes the onus on them having to make difficult decisions around entitlement for their patients.
- Designated Doctors seldom overturn the opinion from the client's own GP.
- There is generalised confusion over the interpretation of the 15 hour work incapacity rule for entitlement. This has led Designated Doctors to develop their own interpretation of "permanent" and "severe". Doctors found it impossible to state if a person can work 15 hours, when the job is not known.
- Interpretation of 'permanent' and severe' is compounded by a lack of orientation, training or support. There is little definition of MSD's expectations.
- There is considerable dissatisfaction with the forms.
- Re-assessing terminal patients and those on hospital waiting lists was a waste of the doctor's time and an imposition on a sick patient.
- *The perceived inability of the doctors to contact MSD to discuss specific* issues was a major problem. The lack of clinical expertise within MSD was an issue.

Experience

In order to provide advice on entitlement, a practitioner should have an understanding of the New Zealand health system. This knowledge can only come from working in the sector.

Quality Assurance

There is no present process to ensure that Designated Doctors complete reports in a reasonable way. Anecdotal reports indicate that much of the information provided by Designated Doctors is cursory and does not contribute to what is already contained on the medical certificate.

GP Second Opinion Proposal

Of the 89 recorded Designated Doctor reports for SB clients in 2005, 82 (92%) were completed by GPs (vocationally registered or general registered). This implies that most second opinions suggested on the medical certificate will be to GPs. Case managers who have concerns about the medical certificate are also most likely to seek an opinion from a GP.

This paper therefore focuses on the development of a robust GP Second Opinion process. It is assumed that where an opinion is required from a specialist, the Regional Health Advisor (RHA) will arrange the appropriate referral and payment will be made at the standard specialist report rate.

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[1] These include Michelle Lennan's report – "Review of the Designated Doctor Scheme" of March 2000 and Dr Phil White's paper on "The Role of Designated Doctors", also of March 2000

The overall process and specifications are documented in the attached service specification. The following highlights some key issues.

Referral

Case managers will initiate a referral based on information contained in the medical certificate and discussions at the case manager interview. Before organising a referral to a GPSO provider, the case manager will check with the RHA/RDA.

It is anticipated that RHA/RDAs will work with the Principal Health Advisor (PHA) and the Principal Disability Advisor (PDA) to develop standard protocols for referral. These protocols should cover the majority of incidents leading to referrals for a GPSO.

Range of Providers

Rather than contracting with individual practitioners, it is envisaged that most GPSO contracts will be held by larger practices or Primary Health Organisations.
Contracting with an organisation creates the following opportunities:

- Service continuity can be assured as when one practitioner is on leave or unavailable the organisation can spread the referrals around other contracted practitioners.
- The organisation can block book a practitioner's time. A doctor can be engaged to work one afternoon a week undertaking GPSO sessions. The bookings and appointments are handled by the (DHB/PHO contracted) service co-ordinator.
- An organisation is not a competitor of the original GP. Patients cannot enrol with the assessing doctor when they meet the doctor outside his/her practice setting, or when the appointment is made by an independent service co-ordinator.
- An organisation can provide a point of first reference for any complaints received from clients about a particular doctor
- An organisation could also arrange a first tier appeals process. The organisation would select a panel of two or three of their more respected practitioners who would be able to consider a report and advise on the robustness and appropriateness of the GPSO opinion. A Work and Income Health Advisor could be an observer on such a panel.
- The organisation may provide dedicated rooms for the service, where there are sufficient volumes. Again this provides the opportunity to brand the service separately from that of an individual practitioner.
- The organisation can provide a filter and quality check on the reports written by their sub-contracted practitioners.

Role of the RHA and RDA

The RHA/RDA will endorse referrals to the GPSO service (either through protocols or individual consideration). They will also likely be the point of first contact with the GPSO practitioner if there are clinical questions or clarifications.

The GPSO service co-ordinator is most likely to interface with the case manager as the issues raised by the co-ordinator are expected to be around contacting the client, arranging appointments and availability of assessments.

Service Co-ordination

The service specification outlines the role of a service co-ordinator. While this person is likely to be the practice receptionist when the GPSO contract is held by an individual GP, where the contract is held by an organisation such as a PHO, the volume of local referrals and the number of sub-contracted practitioners is likely to warrant a full time person to co-ordinate the service.

Practitioner Qualifications

The service specifications outline qualifications for practitioners. These are similar to the criteria used by ACC to recruit Medical Assessors. ACC has over 150 such assessors with capacity to process over 5,000 reports a month. Many of these assessors are happy to travel to smaller towns and provide timely assessments on a fixed day each week basis.

Costs

While the volumes of GPSO assessments are unknown, it is anticipated that they will be substantially lower than the current Designated Doctor volumes.

It is recommended that the rate paid for the GPSO service be split into two components – service co-ordination and practitioner service.

The practitioner service should be paid at the current GP rate with inflation adjustment - approximately $ 114 (plus GST).

The service co-ordination is likely to take around 40 minutes of administrator/receptionist time, and so should be paid at around $20 (plus GST) - hourly rate of $25, plus 35% overheads plus 15% margin.

Transition

It is expected that the GPSO process will replace the current Designated Doctor program. Joint ministers have agreed (May 28) that IB clients should not be routinely assessed by a designated doctor; rather Work and Income should rely on existing sources of information to determine entitlement for most IB applicants.

The implementation of the new medical certificate will result in marked variation in content, quality and completeness amongst different GPs. The Regional Advisors (RHAs and RDAs) will initially have a key role in assessing existing reports for IB clients, leaving them with limited time to assist case managers assess the new medical certificate. Case managers are expected to rely on the GPSO process to assist in standardising medical certificates and educating GPs.

In order to transition from the current Designated Doctor process to the GPSO process, there are a range of actions that need to occur.

Recruitment

If GPSO services are available to assist case managers when the new certificate is introduced, recruitment needs to commence in July.

GPs need to be alerted to the change. This will encourage potential practitioners to think about their interest in taking up a contract.

Current Designated Doctors should be offered the service specifications and invited to apply for the role if they meet the qualifications.

All PHOs should be invited to consider providing the service. As soon as a PHO expresses an interest, they should be engaged as soon as possible. They will need at least six weeks to recruit practitioners, establish the service co-ordination role, engage with local regional staff and put processes in place to receive and process referrals.

Current IB clients

As new GPSO providers are being recruited, existing IB clients will have their entitlement expire and be required to be assessed by a Designated Doctor. The joint ministers have agreed that IB clients should not routinely be referred for a Designated Doctor assessment. The issue of re-assessment for continued entitlement has yet to be clarified, however it is assumed that the client's GP will complete future medical certificates – raising the option for GPSO assessments for some IB clients. SWIFTT changes will need to be made to reflect these changes.

The timing of the implementation of the IB changes will dictate the need to continue to have Designated Doctors available in each region.

Education of Case Managers

Case manages need clear guidelines for referral and education on what is expected of a GPSO service.

Education of Practitioners

Before practitioners can commence providing a GPSO service, they must be oriented to the new medical certificate, have an understanding of what is expected in the completion of a certificate and what is expected from a GPSO report.

Next Steps

Once the new service is agreed to, the contract needs to be written and recruitment commence.

The service should be in place and ready to offer assessments from the time the new medical certificate comes into use on 24th September 07.

Appendix 1

Scope of practice of Designated Doctors

	Designated Doctors	Total pool	SB	IB	Max	Avg
General Practice	522	2,605	66	17,531	296	34
Psychiatrist	115	490	2	1,021	169	9
Internal Medicine	69	747	1	179	20	3
Oncologists	27	51	0	174	55	6
Eye Specialists	18	125	0	33	3	2
Paediatrician	7	247	0	29	12	4
Accident & Medical Prac	6	108	0	193	77	32
Orthopaedic Surgeon	6	220	0	33	28	6
Rehabilitation Medicine	6	11	0	78	22	13
Surgeon	4	256	0	7	4	2
Palliative Care Medicine	3	32	0	4	2	1
Pathologist	3	259	0	4	2	1
Urologist	3	53	0	3	1	1
Other Specialist	7	448	4	29	11	4
General Register	226	6,038	16	4,428	239	20
Unknown	47		0	162	35	3
Overseas	11		0	124	41	11
Psychologists	3		0	4	2	1
Other	7		0	330	214	47
Total	**1,090**		**89**	**24,366**		

Volume of reports by GP Designated Doctors