



# AUSTRALIAN ASSOCIATION OF CONSULTANT PHYSICIANS

## PRESIDENT'S NEWSLETTER

March 2009

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## From the President

2009 is proving a challenging year, especially in the current economic climate of uncertainty for many people. It is important to remember that the AACCP is even more relevant in times where there is cost cutting and projects are being put on hold. There is no doubt that the economic downturn will affect many areas of health care.

That's why your membership of AACCP is now more important than ever. The AACCP's core purpose is to represent the best interests of all consultant physicians and paediatricians, and those of your patients. We ensure that you are not overlooked or forgotten by providing representation on your behalf on issues that affect you, your practice and your patients.

A major focus of the AACCP is the initiation and coordination of efforts to achieve new MBS items for all consult-

ant physicians and paediatricians. Given that the Department of Health and Ageing is currently reviewing the 'primary care items' in the MBS with a view to reducing the overall number of items (due to concerns about the burgeoning size of the MBS) it is important to avoid unnecessary proliferation of items. That is why the AACCP urges you to support our comprehensive approach, rather than a fragmented approach that may ultimately restrict the access of many of our colleagues and their patients to appropriate items. The AACCP welcomes early discussion about the need for different items; please check our website for current activities, or contact the AACCP. The AACCP's strength is through a unified approach.

Les Bolitho  
President

## Membership Drive

Thank you to the members who have already renewed for 2009 - we have close to 80%. Most of you would have already received your 2009 membership certificate in the mail.

We have included a flyer and application form for you to pass onto your colleagues, to encourage them to join you in supporting the AACCP. We appreciate your help in enlisting new members - the more CPPs we represent, the greater influ-

ence we will have on decisions that may affect you, your practice and your patients.

Our target for 2009 is to increase our membership by 10% - help us reach our goal!

If you require more forms, please contact the Secretariat.

**Help us, help you.  
Sign up a  
member today!**



### Contact Us:



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## Towards a National Primary Health Care Strategy: A Discussion Paper from the Australian Government

The AACP has also made a submission to the National Primary Health Care Strategy (NPHCS). The NPHCS's stated priorities include:

- Better rewarding prevention.
- Promoting evidence-based management of chronic disease.
- Supporting patients with chronic disease to manage their condition.
- Supporting the role GPs play in the health care team.
- Addressing the growing need for access to other health professionals, including practice nurses and allied health professionals like physiotherapists and dietitians.
- Encouraging a greater focus on multidisciplinary team-based care.

**The AACP's major concern was the failure of the NPHCS's priorities to recognise the crucial role of consultant physicians and paediatricians (CPP) in the delivery primary care in its broadest definition, that is: in the provision of ambulatory, out-of-hospital treatment.**

CPPs have a significant role in the delivery of care in primary/ambulatory care. The Department of Health and Ageing itself acknowledges this wider definition; the relevant division is known as "Primary and Ambulatory Care".

The AACP has addressed the stated priorities, noting that CPPs are closely involved in chronic disease management, in team care arrangements with GPs (although this aspect needs significant improvement) and in working closely with allied health providers (with

the need for expanded referral provisions associated with the use of 132 and 133). Other issues raised were the importance of maintaining the integrity of the referral system, the need for changes in access to some Medicare items to better support CPP's care in rural and regional areas, and the value to community health of expanding the access of public health physicians to the Medicare scheme and encouraging their involvement with primary/ambulatory care centres.

The President and Executive Officer are meeting with the NPHCS External Reference Group on 31 March to discuss the Strategy and the matters raised in the AACP's submission.

*A copy of the AACP's submission is available via the "News and Events" section of our website.*

## Proposed arrangements for specialists within the National Registration and Accreditation Scheme for the Health Professions

The AACP has also made a submission on the proposed arrangements. While the proposal to streamline medical registration was seen as having many merits, there were aspects of the proposed arrangements that were of concern. The AACP's view is that delivery of safe, high quality medical services to the Australian community is supported by a robust registration and specialist recognition arrangement. Particular concerns with the proposed "Arrangements for Specialists", identified by the AACP included:

- **the lack of information provided about the arrangements;**
- **the lack of involvement, or even acknowledgement of the role, of medical colleges, societies and associations that currently are a source of advice and expertise in relation to the qualifica-**

**tions and expertise of medical specialists (in this case CPP) to the Government;**

- **the apparent focus more on standardised training, rather than on the capabilities of the individual seeking to be registered;**
- **the proposition of having the widest possible capacity for registration "consistent with public safety" but without adequately defining what that meant;**
- **the lack of detail as to how "continuing competence" or "continuing professional development" were to be defined or assessed.**

The AACP believes the proposal does not adequately address these issues and requires further clarification and amendment before it is likely to be widely accepted.

*A copy of the AACP's submission*

*is available via the "News and Events" section of our website.*

### **Stop Press:**

*As reported in The Australian on 6 March 2009, "...consensus has been strained as more details of the scheme have emerged and resistance has grown among medical colleges and associates over the powers to be vested in health ministers and a new Canberra-based agency".*

*It was further reported that "West Australian Health Minister Kim Hames presented a rival model to (the) meeting" noting that "more detail is required before we can reach agreement between all the ministers" and "NSW has become the second state to break ranks on a new national registration scheme for doctors and other health professionals, airing concerns the scheme could undermine the handling of healthcare complaints."*

## Strategic Review of Future Funding Arrangements for Diagnostic Imaging & Pathology Services

The AACP has made a submission to the Department of Health and Ageing in relation to the Strategic Review of Future Arrangements for Diagnostic Imaging and Pathology Services.

The review is considering options for the future funding of diagnostic imaging services, includ-

ing the impact of those arrangements on Government expenditure and the availability and affordability for patients of diagnostic imaging and pathology services.

This review will have an impact on any consultant physician or paediatrician who performs any imaging services, such as cardiol-

ogy and nuclear medicine.

The outcome of the Review will be announced as part of the 2009 Federal Budget.

*A copy of the AACP's submission is available via the "News and Events" section of our website.*

## National Health and Hospitals Reform Commission Interim Report

The AACP has made a response to the Interim Report. The Commission made the unusual decision to invite responses via an online survey, with provision for additional comment. The following outlines a number of the points made by the AACP in response to the report.

The AACP responded to the dozens of "reform directions", separated into 15 chapters. The AACP's greatest concern about the Interim Report is the absence of adequate recognition of the role and contribution of consultant physicians and paediatricians (CPPs) in the provision of non-hospital – i.e. primary and ambulatory – treatment. As pointed out, the Department of Health and Ageing appropriately acknowledges the broader definition with the title of its Division of "Primary and Ambulatory Care". The private sector has been mentioned in the context of private insurance, but not in the context of the vast majority of medical practitioners who are private providers of medical care.

The "reform directions" include a range of statements of principle and very broad directions, as well as quite specific recommendations across the various areas being addressed. As has been reported in the media, the possibility of significant changes in the funding of "primary health care" has been canvassed. Again, the AACP has pointed out that the definition of

"primary health care" used by the Commission does not recognise that CPPs who work in general medicine, paediatrics, aged care, rehabilitation ... all of which are delivered in the non-hospital environment.

There were a number of "reform directions" concerning reporting and the provision of statistics, as well as additional standards requirements as part of training and expanded training needs – all of which need to be adequately resourced if they are to deliver benefits to Australian health. The Report also does not adequately address the extent to which a number of proposals would appear to require significant increases in bureaucracies. One of the issues with the Interim Report is the lack of information about the implementation of such proposals.

A number of "reform directions" canvass the possibility of rewards for "good performance", although how this could be assessed and treated equitably is not addressed. The possibility of the enrolment of patients by "primary health care centres" has been raised; the AACP reiterated its concerns about diminishing patient choice, but also the focus of health care funding on a very small proportion of the health care sector.

As has been reported in the media, the possibility of non-medical professionals being able to request

diagnostic services and prescribe medication, under specified guidelines, was raised. The AACP suggested that such proposed arrangements raised questions as to how reports would be provided to such non-medical professionals for treatment management, and how and by whom the "scope of practice" would be determined.

A number of initiatives proposed were directed towards the integration of care for children and while they address appropriate principles of providing coordination and integration of care for children, there are also assumptions of "enrolment in a primary care service". There were a number of areas not adequately detailed, particularly with respect to how consultant physicians, paediatricians and medical specialists were factored into the current definitions and models. These concerns were identified.

The Interim Report has proposed a number of funding options based on "performance in outcomes and timeliness of care", a "National Access Guarantee", "National Access Targets", activity based funding and casemix classifications for inpatient and outpatient treatment. It was not clear how this would relate to treatment currently provided in the private sector by the medical profession, including CPPs and the AACP noted that there was not enough information to comment in detail

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on the proposals. It was also noted that the cost and added bureaucracy of implementing such proposals needed to be explored in greater detail.

In relation to workforce, the AACP proposed there should be greater acknowledgement of the broader skill base of consultant physicians, whose training encompasses a wide range of sub-specialty areas. For example, in many areas of Australia, where there are no or very few specialist geriatricians or rehabilitation specialists, consultant physicians provide the same type of assessments and management for patients requiring these services and this should be recognised by any funding or patient benefit arrangement. This is particularly the case in rural and regional Australia.

This lack of acknowledgement of the broad skills base of consultant physicians was inadequately addressed throughout the Interim Report and thus the "reform directions" also do not recognise the contribution of both CPs and paediatricians. This was noted in relation to a large number of the "reform directions".

There appeared to be some inconsistency between current policy and the proposals: for example, the aged care projections for patient care places and the current age related geriatric assessments in the Medicare Benefits Schedule are based on 85 year olds and 65 year olds respectively.

The matter of telehealth was raised. The AACP, which is currently developing a discussion paper on telehealth, has noted that any such proposals that do not involve personal supervision need to be considered in detail within each specialty area to ensure there can be a guarantee of quality and appropriate patient care.

The proposal concerning a "denticare" scheme effectively rec-

ommends that Australians can be in one scheme only; that is, unlike Medicare that provides universal access, the proposed "denticare" that would be funded through taxation, would require individuals to opt into either "denticare" or private dental insurance. The AACP expressed the view that, like Medicare, any dental scheme should be based on cover for all, irrespective of whether they chose to purchase additional private cover.

The Interim Report put forward three possible options for a changed health system, namely:

## **Option A - Continued shared responsibility between governments, with clearer accountability and more direct Commonwealth involvement.**

*This option would retain both Commonwealth and state and territory involvement but re-align responsibilities between them, with the Commonwealth: Becoming responsible for all funding, policy and regulation for primary health care and community health services, including those funded by the states; paying the states and territories a substantial hospital benefit per episode of the efficient costs of inpatient treatment and of emergency department treatment (for example, 40 per cent); and paying, using a casemix classification, 100 per cent of the efficient costs of delivery of hospital outpatient treatments.*

## **Option B - Commonwealth solely responsible, with regional providers of some services.**

*Under this option, the Commonwealth would assume responsibility for public funding, policy and regulation (and presumably many of the staff) for former state health services. This includes responsibility for: Public hospitals; community health services, including*

*community mental health services; patient transport; alcohol and drug services; sexual and reproductive health services; child and maternal health services; school and public dental services; health promotion and prevention programs; public health protection services; and ambulance services.*

*Under this option, the Commonwealth would establish regional statutory authorities with responsibility to plan and operate public health services for that population. That is, these authorities would take over most of the formerly state government funded health services within each region.*

## **Option C - Commonwealth solely responsible, with competing health plans responsible for providing cover for most services.**

*This option would involve transferring all responsibility for public funding, policy and regulation to the Commonwealth, with the Commonwealth establishing a tax funded community insurance scheme under which people would choose from multiple, competing health plans. These plans would be required to cover mandatory set of services including, for example, hospital, medical, pharmaceutical and allied health services.*

*Health plans would be required by regulation to cover essentially all of the same services covered under existing universal and state government schemes. However, they would be free to strike their own arrangements with providers, including entering into preferred provider arrangements.*

The AACP saw some merit in the Commonwealth taking responsibility for primary health care, however such support could only be conditional on the basis that it would NOT involve fund holding

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by one sector of the health care system, e.g. by a "primary health care centre" or similar entity.

The AACP noted that Option A included a recommendation of payment on a casemix basis, at 100 per cent efficiency for the delivery of hospital outpatient treatments. It was difficult to see how this would not underfund services.

In relation to Option B, the AACP was concerned that there was insufficient detail about the complexity of an additional layer of bureaucracy (regional statutory authorities) and irrespective of whether there is an intention that services would be shifted from one level of government/bureaucracy to another, the concern remained that there will be additional administrative burden.

Option C presented a proposal that the AACP believed would reduce patient choice and potentially diminished the role of the doctor to determine with the patient the best course of treatment for that patient.

On balance, the AACP could not support any of the options as presented on the basis of the current information presented.

In a section on "raising and spending money" the Interim Report asked about the establishment of "comprehensive primary health care centres" (not supported—further information needed about how this would affect CPPs); expansion of sub-acute services (supported); expansion of clinical education (supported); and public hospitals seemingly having the role of determining care provided in the community (not supported).

The provision of capital funding was raised and the AACP, in view of the limited success of combined funding, did not support widespread combined government and private financing. However, the AACP supported ongoing capital funding being factored into service

payments.

The "reform directions" covering sustainable health workforce addressed the expansion of the scope of practice for some categories of health professionals in order to make some services more widely available. The AACP raised the question as to who would define the scope of practice in such instances.

The AACP also noted that, in relation to the proposal that technical staff be able to undertake procedures under the direction of a doctor, the AACP has noted that the situation already exists whereby technical staff carry out aspects of work under the direction of a medical practitioner. It was pointed out that in these instances, such work is included in the "technical component" of the Medicare Benefit (there being a professional, a technical and a capital component to Medicare items). It was not clear what would be achieved by expanding Medicare items when this situation is already covered within the existing Medicare Schedule. In the event that there was widespread support for an expanded role of those health professionals currently covered by the "technical component" the AACP's view was that such an expanded role could and should be addressed within the current MBS structure, rather than adding a range of new MBS items that are unnecessary.

This section of the Interim Report also sought support for the national registration scheme. However, as the final nature of the scheme remains unclear, the AACP noted it was not possible to agree or not agree to this particular question. National registration per se is an appropriate objective, however as has been pointed out in relation to the current scheme concerning specialists, there is no recognition of the important role of the medical colleges, associations and societies in defining appropri-

ate standards and training and until this aspect is addressed, the scheme in its current format has not received support, including by the AACP.

In a more general section in which additional issues could be raised, the AACP reiterated its view that consultant physicians and paediatricians, by virtue of their extensive postgraduate training and continuing professional development, have a key role in the provision of best practice high quality care to patients across Australia and have a pivotal role in the delivery of best practice quality health care in all health settings: primary and ambulatory, hospital and nursing home. Moreover, consultant physicians are responsible for treating the most complex and serious medical conditions designated by COAG as key National Health Priorities including asthma, cancer, cardiovascular diseases including stroke as well as diabetes and arthritis.

The AACP stated there needs to be acknowledgement by the NHHRC of the distinct roles and contribution of consultant physicians and paediatricians as well as those identified in the report in relation to other primary care providers. The definition of "primary health care" thus should incorporate "ambulatory" as that reflects all out-of-hospital care.

A number of specific recommendations already made to the National Primary Health Care Strategy, with the broad intent of improving the coordination and quality of patient care between general practitioners and consultant physicians/paediatricians and enhancing chronic disease management were reiterated.

These include:

- the maintenance of the integrity of the referral system;
- greater recognition of the role of consultant physicians and

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paediatricians in relation to chronic disease management under the Medicare benefits scheme in order that patients are eligible for appropriate benefits;

- better linking between general practitioner team care arrangements and case conferences and the role of the consultant physician or paediatrician
- enhancement of community and chronic disease management by the creation of additional access by the patients of public health and occupational health physicians to the relevant Medicare benefit for management plans for chronic disease, team care arrangements, case conferences, health assessments and Aboriginal and Torres Strait Islander adult health checks
- facilitating patient access to ongoing care and to make the best use of valuable health care resources, including general practitioner time, by allowing patients of consultant physicians and paediatricians who are treated under items 132 and 133 to be referred direct by the consultant physicians and paediatricians for allied health services and to be eligible for Medicare benefits for those services.
- that the patients of consultant physicians who are not necessarily designated as geriatricians be eligible to receive the Medicare benefits applicable to items 141-147 where the consultant physician has provided the assessment services as defined in the item descriptor – a provision that would be of particular assistance to the many Australians who do not have access to a geriatrician, but would benefit significantly from the assessment services – and who should not be disadvantaged by their lack of access to a specialist geriatrician;
- recognition under Medicare that for a proportion of patients presenting to consultant physicians and paediatricians the complexity of their condition, assessment, treatment and review is significantly more complex than provided for under the existing Medicare items.

*An outline of the AACP's response will be available online shortly.*

## Membership Subscriptions

2009 Membership fees were due on 1 January.

If you haven't already done so - *renew today!*

Renew online via [www.consultantphysicians.com.au](http://www.consultantphysicians.com.au), or download a renewal form and fax or post your payment to the AACP.

Your continued support in 2009 is vital.



## AACP Breakfast Session at Physicians Week

The AACP is pleased to announce that we will be presenting a session at this year's Physicians Week.

The speakers will be AACP Council members: **Dr Les Bolitho**, President; **Dr Bill Heddle**, Vice-President; **Dr Rick McLean**, Director.

**Date:** Tuesday 19 May

**Time:** 7:45am—8:45am

**Room:** Bayside 201

The theme of the session will be:

- The National Health and Hospital Reform Commission (NHHRC), which will deliver their final report in June 2009 and is recommending new directions for health care in Australia and the
- National Primary Health Care Strategy that is focusing on primary health care in Australia.
- National Registration
- Telehealth

The AACP aims to ensure the essential role of CPPs is reinforced and maintained in all these discussions. Many issues impinge on the vital role of CPPs in the Australian health care system.

We welcome open discussion and comments on issues affecting your practice, remuneration and workforce participation.

A discussion document on the Telehealth proposal will be available for comment at AACP booth.

## Physicians Week 2009

The AACP will be an exhibitor at Physicians Week 2009, to be held at the Sydney Convention & Exhibition Centre; please visit us at Booth No. 9. Physicians Week is an opportunity for the AACP to have a presence amongst CPPs and discuss with them the important work the AACP carries out, as well as encourage CPPs to join up.

Council members will be at the booth during the breaks ready to discuss any issues you would like to raise. We look forward to seeing you there.

Physicians Week incorporates the annual Royal Australasian College of Physicians (RACP) Congress which is the College's largest annual event.

**Registration for Physicians Week is now open!** Please visit the Physicians Week website to register now. [www.physiciansweek.com.au](http://www.physiciansweek.com.au) and come to visit the AACP



## Council

**Professor Craig Mellis** resigned from Council shortly after the AGM in November 2008. Craig was a highly respected and valued member of Council. We thank Craig for his time on Council and wish him all the best for his future endeavours.

As is the case with Boards, one person leaves and another arrives. We would like to welcome **Dr Greg Rowell**, a NSW Paediatrician, to Council. We look forward to Greg's participation on Council.

## PayPal link

The AACP's "renew your membership online" button was temporarily not linking to the AACP PayPal page during November & again in January as the link was inadvertently disabled when we were editing the website. We apologise for any inconvenience caused to members and want to assure you that it is a secure way for you to renew your membership using your MasterCard or Visa credit card. This is working correctly now.

While the link was down mem-

bers were still able to renew with an existing PayPal account or by creating a new PayPal account.

We encourage members who renew using their MasterCard or Visa credit cards to use the online facility for instant approval and confirmation.

The AACP will explore the possibility of direct debit payments for members in the future for your convenience. Feedback from members would be welcomed.