



# AUSTRALIAN ASSOCIATION OF CONSULTANT PHYSICIANS

## PRESIDENT'S NEWSLETTER

December 2008

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## 2008

The year 2008 has proved both challenging and stimulating with continuing activity on behalf of the AACCP membership.

A new Federal Government, with significant new health policy from the Hon Nicola Roxon MP, Minister for Health and Ageing has provided new directions, especially with the Primary and Ambulatory Care Division of the DoHA. The consultation papers from the National Health and Hospitals Reform Commission, and the submissions coordinated via the RACP, the National Primary Health Care Strategy and discussion paper and changes in the DoHA structure all reinforce the anticipated new directions in health care delivery and distribution.

The speech by Hon Nicola Roxon, MP at the Annual Ben Chifley Memorial "light on the Hill" Dinner, held in September 2008 was of particular interest as the Minister wrote the speech herself - as such this is the direction she visualises for health care delivery in Australia.

There are a number of major issues facing all medical practitioners, including consultant physicians and paediatricians, which will affect our practices and patients during the coming years. Legislation and discussion papers on the National Registration and Accreditation Scheme, although providing transparency, accountability and portability between jurisdictions is silent on the role of medical colleges in training, education and certification of competence and continuing professional development of trainees and fellows.

The recently released discussion paper from the AMC working party on behalf of Medical Boards of Australian States and territories 'Good Medical Practice: A Draft Code of Professional Conduct' provides a code 'designed to reflect the understanding of both the community and the medical profession about the accepted standards of good professional conduct of Australia's doctors in modern medical practice'. Concurrently there is a paper from the Medicare Benefits Branch, DoHA on 'Increased MBS compliance audits' on which comment has been invited.

The "Strategic Review of Future Funding for Diagnostic Imaging and Pathology Services" will involve many of our CPP service providers and potentially affects the accessibility, and affordability, by patients of these vital diagnostic and therapeutic services.

There are many additional issues, which are being presented by the DoHA, and requiring attention and timely replies.

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## Current Issues

### Items 132 and 133

The introduction of new CPPs consultation items 132 and 133, in November 2007, has led to a number of discussions, and the need for information papers, to clarify the correct interpretation of the Descriptors and Explanatory notes for these items. The DoHA is committed to the correct application and usage of these items. Please ensure you understand your obligations when providing accounts to patients whom will receive reimbursements from Medicare Australia for services rendered using these MBS items.

The DoHA has provided an update on conditions when we can 'upgrade' to 132 and 133 for a previous referral initially provided as an MBS item 110 and 116, without the need for a new referral. Please ensure your consultation or review complies with the criteria suggested in the Descriptors and Explanatory notes.

### Pervasive development disorders

MBS items for **pervasive development disorders including Autism** were introduced from November 2007. The AACCP negotiated the interim use by CPPs of items 132 and 133 initially, with additional budget allocation, until specific items 135 and 289 were introduced in July 2008.

### Prolonged review item

There have been preliminary discussions with the Department on the need to introduce a **Prolonged review item (e.g. 118)**. The expansion of the use of MBS Items 132 and 133 following an initial 110 and 116 consultation has partially removed the urgency to introduce a new "item 118". However, there remains a need for a prolonged review item – e.g. in chronic renal failure, and other chronic diseases.

### The role of CPPs in primary and ambulatory health care.

Currently the DoHA is focussed on the role of GPs, allied health providers and potential role substitution providers. The essential role of consultant physicians and paediatricians, and all medical specialists, in community based ambulatory care is not well recognised or acknowledged. The role of CPPs will continue to be emphasised by the AACCP and our role on chronic disease management and prevention of illness will remain a priority in all discussions and deliberations. CPPs have a major role in out of hospital care and this needs better recognition.

### Allied health referrals

Referrals by CPPs to **Allied health** providers remain open for discussion. The DoHA is sympathetic to changing the arrangements, whereby patients could receive Medicare benefits for services following referral by CPPs, but to date the legislative requirements remain under discussion. The AACCP is continuing to put forward its proposals in this area.

### Telehealth

**Telehealth** is an area of interest to CPPs and DoHA representatives. Changing medical practice will see a greater need for a clearer definition of how appropriate medical care can be delivered under a "telehealth" banner. There are ongoing discussions and a draft discussion document is currently being developed.

### Rural and remote health

**Rural and remote health**, and the role of CPPs in quality service delivery, continues to be a major issue. Adequate and timely service provision, the viability and sustainability of medical practice, the role in chronic disease management detection, treatment and prevention will remain a challenge now, and in the future.

### Geriatrician Items

The introduction of specific **MBS Items 141-147** for assessment of geriatric patients, restricted to practising geriatricians, has provided an inequity of access for the majority of senior Australians. The Medicare benefits for these items should be available for all patients who receive appropriate services by suitably trained and skilled physicians, not just a limited number of certified geriatricians.

### Medical graduates

The expected increase in numbers of **medical graduates** entering the workforce as trainees over the next 5 years will require a substantial increase in resources for training and supervision, let alone the increase in infrastructure developments. There will be a need to increase training opportunities outside the public hospital system- especially in the private hospital system, and also in private consulting rooms, clinic, and ambulatory care settings- e.g. outreach clinics in rural areas. Funding for these positions- either via Medicare item numbers for use by trainee registrars, or block funding by Federal or State jurisdictions remains under discussion.

### Bowel Cancer Screening

**National Bowel Cancer Screening Program** provides early detection of bowel cancer, and should lead to reduced mortality and morbidity, if patients can be screened and operated on at an earlier stage of malignancy. There has been funding for the initial FOBT screening, but little or negligible additional funding for public hospital-based colonoscopy or surgical procedures. The AACCP has raised these issues as a quality and safety issue for timely delivery of essential medical services. Discussions are continuing, with the DoHA reviewing Federal-State funding arrangements for the NBCSP.

## Enhanced Primary Care

A discussion paper 'Improved management of chronic disease in the context of the enhanced primary care initiative: The role of Consultant Physicians and Paediatricians' has been submitted by the AACP on behalf of the Australasian Faculty of Public Health Medicine and the AACP. The paper explores the role of CPPs in chronic disease management, preventative health and lifestyle modification. The role of CPPs in advising

on and revising GP management plans, their active role in team care arrangements, and the use of case conference items to ensure teaching, education and quality processes, and assist in ensuring the long term viability of the Australian Medicare Benefits Scheme are currently being considered

A copy of this paper came to the notice of the *Australian Doctor* and

comment was sought from the AACP. The subsequent article under the heading "GP care plans under fire" noted the RACGP's "outrage" at the paper, together with the views of the ACCP. This article generated minimal further discussion in the magazine but the issues are now clearly out in the public arena for wider discussion.

## Membership & Renewals

The AACP membership numbers for 2008 are encouraging with strong support from CPPs. Feedback from members is that they greatly appreciate the AACP gaining item numbers 132 and 133.

However, to be most effective, the

AACP needs to represent a significant number of CPPs. I personally ask each and every one of you to encourage your colleagues to join AACP.

2009 membership renewal notices have been sent out to members, if

you haven't received your renewal notice, please contact the Secretariat or download a form via the AACP website. Thank you to the members that have already renewed, your continued support is invaluable. Membership certificates will be posted to renewed members in January 2009

## 2008 Annual General Meeting

The AACP's AGM was held on 20 November. The following Council members were re-elected: Dr John Best, Dr Leslie Bolitho, A/Prof Gerard Carroll, Dr William Heddle and Dr Andrew Nunn. Prof Rick McLean was confirmed as a member of Council. At the Council meeting following the AGM, as required by the Memorandum and Articles, elections

for office bearers for 2009 were held. Dr Leslie Bolitho was elected President, Dr William Heddle was elected Vice-President and Dr John Best was elected Treasurer.

Prof Jerry Koutts retired from Council at this AGM. We thank Jerry for his time on Council, being a founding member of the AACP and an original

Council member. Jerry was integral in the establishment of the AACP.



## Principal and future role of the AACP

The principal, and future, role of the AACP is in representing Consultant Physicians and Paediatricians on issues relating to practice and workforce issues, their essential role in medical healthcare strategies, and the viability and sustainability of workforce participation and distribution in negotiations with the Federal and State and Territory Governments as well as looking after the interests of their patients.

Over time the AACP will be developing information for the assistance of referrers in order that they may more effectively use Consultant Physician and Paediatrician services in order to continue to deliver high quality care and improved health outcomes for their patients.

The AACP develops well-researched, discussion papers and undertakes comprehensive discussions with the

Department of Health and Ageing. There are many ongoing issues requiring the attention of the AACP.

I look forward to an active and stimulating 2009. Best wishes for the Christmas holidays and a happy New Year.

Les Bolitho



## Light on the Hill?

The following article is the Editorial that will appear in the November-December 2008 issue of *Outback.doc*, the quarterly magazine of the Australian College of Rural & Remote Medicine.

In September this year, the Australian Minister for Health, Nicola Roxon, journeyed to the Panthers Leagues Club at Bathurst to deliver the speech to the annual Ben Chifley Memorial Light on the Hill Dinner. The title of her presentation was "The Light on the Hill, History Repeating". What was particularly important about this speech was that the Minister wrote it herself. Therefore, at a time when public policy has been stalled in a number of reviews, this speech provides an insight into the Minister's thinking.

She used as her text a quote from the then Prime Minister, Ben Chifley, at the NSW ALP Conference in 1949. The quote was:

"a movement bringing something better to the people, better standards of living, greater happiness to the mass of the people. We have a great objective – the light on the hill – which we aim to reach by working for the betterment of mankind not only here but anywhere we may give a helping hand. If it were not for that, the Labor movement would not be worth fighting for."



The sentiments expressed in this Chifley quote are those of Jeremy Bentham, whose utilitarian approach has often been criticised as enabling tyranny by the majority. However, interweaved within this quote is a strong sense of social justice. This is not surprising. The Bathurst born Ben Chifley had been educated "firstly at the privately run De Clouett's night school and then the Workers' Educational Association, the Technical School and later with the Railway Institute".

Chifley had himself been largely brought up by a ferocious grandfather and which his biographer (David Day) attributes Chifley's tendency to keep his innermost feelings to himself "betraying none of the turbulent emotions that he must have been feeling".

Nineteen forty nine was a very stressful year for Chifley. Nicola Roxon rightly points out that among the difficulties the Labor Government was having was dealing with doctors. Following the successful referendum of 1946, when the ability to set prices for medical, dental, pharmaceutical and hospital services was ceded to the Commonwealth under certain provisos, Commonwealth powers in the health area had expanded greatly. The most contentious of the powers was the matter of dental and medical services not being subject to civil conscription.

It is somewhat ironic that one of the first initiatives of the Menzies Government was a national health insurance scheme, attributed to Earl Page, himself a country doctor. As Nicola Roxon notes, the major changes to the health system occurred in 1974 and 1983 with the introduction of Medibank and Medicare respectively. It can be said that the success of health policy can be attributed to the efforts of Bill Hayden and Neal Blewett with advice from John Deeble and Dick Scotton as the architects of these proposals, which had arisen from the Nimmo Inquiry in 1969.

Unlike Neal Blewett, who inherited a patchwork following the Fraser years fiddling with Medicare, Nicola Roxon inherits a health scheme that bears the hallmarks of the interventional yet innovative period when Michael Wooldridge was Health Minister.

While the medical profession remains a substantial voice, often reactive, in development of health policy, it certainly does not have the monolithic quality which the then British Medical Association injected into the debates of the 1940s. The medical profession, through the sheer volume of knowledge and the increasing diversity and technological skills, is these days a very diverse set of tribes.

Nicola Roxon has identified three areas for her consideration. The first is preventative health which, despite its oxymoronic title, emphasises in her mind its failure because of the inequities that she sees between various areas of the community, both social and geographic, where discrepancy exists.

Improving the health of the population is as much about injecting money directly into these worthy endeavours as shifting community attitudes and then community behaviour. This is no better illustrated than the case of smoking. When I was a junior resident medical officer in the 1960s, I well remember lighting one cigarette off another in the emergency department of the hospital where I worked up to 100 hours a week – another issue that has been the subject of a shift in community attitudes called "safe working hours". I am now a non-smoker and have been for nearly 30 years.

Another example where government intervention has shifted public attitudes has been in the mandatory use of seatbelts, which were pioneered in this country and random breath testing. Road tolls have diminished markedly across Australia.

Yet any amount of government funding for campaigns to reduce juvenile drinking and drug taking have had only a marginal effect. What is important in these public health campaigns is to find out what works and not repeat the

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previous campaigns where they have patently not worked. The problem which politicians face the whole time is being seen to do something, or anything – appearance is face-saving.

Nicola Roxon in her speech said: “health policy can’t exist in a vacuum”, but equally health policy itself cannot be a vacuum. The concept that we can live without hospitals is one that is seductive. However, if we improve the health of the population, by improving the quantity of life as the same time as improving the quality, we are faced at the very minimum with a custodial requirement for an increasingly ageing population, irrespective of how evangelical we may be in our attempts to prevent disease. If we had a campaign against “preventative ageing”, it would be akin to embracing the rhetoric of the cosmetics industry. Is that what we really want to be campaigning for?

Unlike our ancestors we do not leave our aged population out in the desert to die when they are no longer able to contribute to the community. While there is a changing role for hospitals in rural communities, it is important to realise that if a government closes a hospital this elicits a grief reaction within a community because it is where the community has been born and has died over the past 100 years or more. The hospital is the community talisman for health care.

Having a hospital is a sign that the community is committed to improved health care although, as with all general statements, exceptions can be found.

As Nicola Roxon said in her speech “we also need to develop ways of encouraging people to invest early, and effectively, in their own health – and getting these incentives right will be a tough challenge”. The problem is that we never get these incentives right all at the same time. Instead, it is an incremental process. Trying to develop a monolithic government policy in this area with set timetables is impossible.

The second component of Nicola Roxon’s speech concentrates on her desire for role substitution. Underneath much of the rhetoric in this area is the concern that doctors are earning too much and that many of their tasks could be undertaken by other health professionals. This may be so. However, the Medicare Benefits Schedule already recognises three components of the health service: the capital component involving investment in machinery, the professional component recognising that element of the benefit that is directly related to the doctor’s service and the technical component that is related to the input of the technologists, scientists and support staff. This has worked extremely satisfactorily. Therefore, before contemplating the creation of a whole range of items, which have doubtful constitutionality, it would seem appropriate

to review the construction of the Medicare Benefits Schedule to expand the technical component of the various items of service as appropriate. *De facto* this has occurred in relation to many general practice items for the GP gateway to allied health professional services that can be initiated under certain circumstances.

One has to be sure the intention of this piece of health policy is not a visceral anti-doctor sentiment, but one that is founded on good policy. There is a strong argument to reduce the number of MBS items, particularly among the GP items, which could be done by tightening descriptors and questioning the efficacy of what was basically an initiative which came from the coordinated care trials of the late 1990s. It is important therefore that the Minister, in her search for the light on the hill, carefully considers the policy implications of proposing a wholesale change in the delivery of health care.

Finally, the Minister is concerned to reform Commonwealth State relations and fund the States based on a combination of outcomes, activities and quality. The consideration of these three matters in the past has generated an industry of accreditation, credentialling and data collection without any substantive agreement as to the best course of action. As Joseph Steiglitz has written about (and which was a subject of an early issue of *Outback.doc*) there is a problem of asymmetrical information – some people know more than others. This is particularly so in the health system.

While not trying to douse the light on the hill that the Minister is so keen to see, she should be very worried if the light on the hill in this instance becomes a candle festival, with each proponent of change holding a separate candle without providing much illumination.

The Minister concludes by reference back to Chifley being, in Shavian terms, “the unreasonable man (who) adapts surrounding conditions to himself”. One of the most important comments that David Day, Chifley’s biographer, about what made Chifley such a great Australian, was his “principled opposition to the political persecution of those who held unpopular opinions appeared, in the context of the late 1940s and early 1950s, to be dangerously naïve, if not downright pro-communist. Chifley could have sailed with these harsh political winds, but chose not to do so. As a result, and aided by Evatt’s courageous opposition on the hustings and in the courts, Australia was largely saved from undergoing the sort of McCarthyite witch-hunts that were such a blight on American politics and society during those years.”

The Minister also needs to consider this comment if she is considering American style changes to the health system.

John Best, AACP Treasurer.