



AACP

AUSTRALIAN ASSOCIATION
OF CONSULTANT PHYSICIANS

Submission on:

**New Attendance Items
for Consultant
Physicians and Paediatricians**

Confidential

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Executive Summary

Government and the medical and health community share a responsibility to maintain a productive and healthy population, a central theme which has been reinforced most recently in both the Intergenerational Report (Budget Paper No. 5, 2002-03) and Australia's Health Workforce (Productivity Commission, 2006).

A significant shortfall exists in the numbers of doctors required to meet the needs of the Australian community. The Federal Government has moved swiftly to establish new medical schools and to increase places at existing schools and it is deserving of credit for the extent and speed of its response.

The Australian Association of Consultant Physicians (AACP) represents the consultant physicians and paediatricians in economic and workforce matters. The Royal Australasian College of Physicians (RACP) is responsible for the consultant physicians in training, post graduate education and other professional matters in Australia and New Zealand. The consultant physician workforce comprises the spectrum of physicians ranging from consultant paediatricians through to consultant geriatricians, who treat every age group and, through the range of specialty interests treat the whole person.

The supply and distribution of consultant physicians practising general medicine embracing paediatric, adolescent, adult and geriatric patients is a matter of growing concern. Many specialist appointments and training positions in those sub-specialties that are primarily consultative (assessment, diagnosis and management) rather than procedural are unable to be filled. These sub-specialties, which include amongst others, geriatrics, general medicine, renal medicine, rheumatology, haematology, endocrinology and diabetes, respiratory medicine, rehabilitation and cancer medicine, are financially unattractive, particularly to new trainees, considering the duration and intensity of training followed by the skill, responsibility and complexity required to practise as a consultant physician or paediatrician.

The impact of this shortage of consultant physicians and paediatricians is increasing progressively across the health system, but is particularly significant for the provision of medical care for an ageing population and for outer metropolitan and rural areas.

The consultant physician and paediatrician have a pivotal role in the delivery of best practice quality health care. Due to their specialist postgraduate training and skills, consultant physicians and paediatricians provide advice to general practitioners, surgeons and other specialists on the diagnosis and management of patients with complex and difficult disorders. This is particularly significant in the older population as the number of co-morbidities and thus disease complexities increases with age. 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 current trend whereby medical graduates are choosing to train in other specialties, rather than as consultant physicians and paediatricians, is a significant concern to the AACP and the RACP. If this trend is allowed to continue, it will have a significant impact on the delivery and efficiency of the health care system over the next decade and in particular the Federal Government's capacity to provide a medical workforce with the relevant skills and expertise to treat the diseases identified by COAG as National Health Priorities. To this end the AACP and the RACP consider that it is imperative to work in partnership with the Federal Government on strategies designed to ensure the sustainability and viability of consulting practice commensurate with the current and future health needs of the Australian community.

The RACP is embarking on a new postgraduate education strategy designed to attract medical graduates to a career as consultant physicians or paediatricians. The RACP training programs have been re-engineered to reflect modern educational methods based on evidence-based medicine and aims to produce consultant physicians and paediatricians capable of providing high quality, cost efficient and responsive health care to meet the emerging needs of Australian communities.

However, an essential tool in attracting new entrants to a career as a consultant physician or paediatrician will be in assuring medical graduates at the time of choice that their future remuneration will be on a par with other 'specialists'. In particular, recognition of the consultant physician and paediatrician's training and skill to manage the complexity of the referred patient, often with multiple medical complaints, should be recognised with the introduction of new attendance items in the Medical Benefits Schedule (MBS).

The current referral system whereby general practitioners seek the expertise and skills of consultant physicians and paediatricians represents the cornerstone of the health care system in Australia. This referral system is predicated on the higher skill and expertise required of consultant physicians and paediatricians which has been acknowledged in all previous medical benefit schedules with a differential schedule fee rebate rate. The current MBS item descriptors do not reflect the complexity of contemporary consultant physician practice. This in turn influences the level of out of pocket expenses for patients and thus creates potential barriers to their access to medical care.

This Submission proposes that the Federal Government recognise that a change in the nature of consultative medicine is taking place by the introduction of two new attendance items covering the treatment of patients with increasingly complex disorders and disabilities. The proposed new attendance items, 111 and 117, would be specifically for patients with complex medical conditions, including those with multiple co-morbidities; in other words, many patients consultations would remain under the current attendance items, 110 and 116. To facilitate

discussion, the Submission provides draft indicative guidelines to serve as model for the new item numbers. The guidelines are based on the experience of AACP members in a wide range of medical specialties, and provide a considered overview of the expected coverage for the comprehensive assessments of patients with complex medical problems and multiple co morbidities. The proposed new items also encompass the Governments desired development of electronic medical records and communications.

The AACP believes that in the development of these new attendance items, attention should be given to the maintenance of the relativity in the fees for medical benefits available. This relativity has been recognised since the first medical benefit schedule was created 36 years ago, and remains a valid marker of the degree of difference in expertise required in current medical practise.

Cognisance of the complexity of specialist medical practice by consultant physicians and paediatricians, through the development of the proposed new attendance items will make consultative careers more attractive to the next generation of medical graduates. This incentive is an essential step in assuring the sustainability and viability of a consultant physician and paediatrician workforce. Such a significant measure by the Federal Government will have a positive impact on the numbers of consultant physicians and paediatricians in the medical workforce generally. Moreover, this will flow through to the number of consultative physician and paediatricians working in outer metropolitan, regional, rural and remote areas where, due to population growth and/or isolation, the need for consultant physicians and paediatricians with 'generalist skills' is greatest.

Importantly, the introduction of the proposed new attendance items will underpin the Federal Government's commitment to the COAG national health priorities by promoting greater efficiency in the health care system particularly for the increasing number of patients with co-morbidities requiring highly complex and comprehensive medical management.

1. The Issue

Central to the delivery of health care is the role played by consultant physicians and paediatricians who, by virtue of their extensive post graduate training and continuing professional development as Fellows of the Royal Australasian College of Physicians, are responsible for the provision of best practice high quality care to all patients and in all jurisdictions within Australia. An essential element in the continuum of this delivery of health care lies in the integrity and effectiveness of the referral system whereby general practitioners have access to and seek the added expertise and skills of consultant physicians, paediatricians and other medical specialists to contribute to the treatment of their patients.

Referral from a general practitioner to a 'specialist' is a long-standing and essential part of the Australian health care system. The referral process was enshrined in the 1969 Committee of Inquiry into Health Insurance (the *Nimmo Report*), which led to the establishment of the Schedule of fees for medical benefit and the introduction of relativity between attendance items for consultant physicians and general practitioners. The referral process indicated the need for a higher level of expertise and justified the differential in the levels of patient benefit. Such relativities between general practitioners and specialists, including consultant physicians and paediatricians were generally accepted and maintained until the introduction of the Enhanced Primary Care items in 2000.

The introduction of the Enhanced Primary Care items implied a recognition of the change in the nature of medical practice as it related to primary health care. It is logical to recognise that such changes in medical practice are not confined to general practice. Therefore the maintenance of these relativities, consistent with the added complexity of patient management requiring specialised skill of the consultant physician and paediatrician, is essential to:

- (a) attracting consultant physicians and paediatricians to the non-procedural sub-specialties; and
- (b) preserving the referral system. This system has enhanced the gate-keeping function of general practice and thus served the Australian community well over many decades.

There is a responsibility shared by Government and the medical and health community to maintain a productive and healthy population, a central theme which has been reinforced most recently in both the Intergenerational Report (*Budget Paper No. 5, 2002-03*) and Australia's Health Workforce (*Productivity Commission Position Paper, 2006*) and in the Government's responses.

Over the past decade a significant shortfall has developed in the numbers of doctors required to meet the needs of the Australian community. To redress this shortfall the Federal Government has moved swiftly in recent years to establish new medical schools and to increase places at existing

schools and it is deserving of credit and praise for the extent and speed of its response.

However, the supply and distribution of consultant physicians and paediatricians is a matter of growing concern on four specific grounds:

- (1) the Budget and Productivity Commission Reports referred to above project a significant increase in the ageing population coupled with a real need to retain older workers in the labour force. The consultant physician is integral to the medical management of this population;
- (2) while government has provided much greater funding both to general practitioners and certain procedural items of service entailing a range of new descriptors, there has been no change to MBS consultant physician attendance item descriptors since 1984. As a result, fewer medical graduates are electing to specialise in those sub-specialties that are primarily consultative (assessment, diagnosis and management) rather than procedural. Many specialist and training positions in these sub-specialties, which include geriatrics, general medicine, renal medicine, rheumatology, haematology, endocrinology and diabetes, respiratory medicine, cancer medicine and other related fields are unable to be filled. The numerous consultative sub-specialties are considered to be financially unattractive given the duration, intensity and complexity of training and the skill, knowledge and responsibility required to practise. In NSW alone, in July 2006 there were 25 unfilled positions for consultant physicians identified as Area of Need.

Moreover, future full fee paying Australian students entering medical schools will inevitably result in graduates with increasing student debt. This debt is likely to be a deciding factor in career choice, and to this end, further encourage trainees into the better-remunerated specialties;

- (3) expert care of complex paediatric cases has led to an increasing number of young Australians surviving to adulthood with complex congenital and developmental disorders. Similarly, increased survival of younger people after trauma with the need for lifelong complex care; and
- (4) analysis of the RACP Fellowship numbers undertaken by the AACP indicates that the majority of consultant physicians and paediatricians practise primarily within the inner metropolitan setting. While the population of the Inner Metropolitan Federal Electorates is 28% of the Australian population, 57% of consultant physicians in adult medicine work in these electorates whilst 61% of paediatricians are similarly engaged¹. Thus, in outer metropolitan, regional and rural centres, significant difficulties are being experienced by general practitioners and their patients in securing

¹ Dr Robert Wilson - Data on distribution and Federal electorates, July 2006.

access to adequate consultant physician and paediatricians' services. Whilst this is due primarily to shortages in the workforce it is exacerbated by the concentration of specialists in the inner metropolitan areas.

The impact of this shortage of consultant physicians and paediatricians is increasing progressively across the health system, but is particularly significant for the provision of medical care for two demographic and geographic groups: the young and the aged and outer metropolitan, regional and rural services.

Equity of access to health care is a clear and reasonable expectation of the community and accepted by governments as an equally clear responsibility on their behalf. The RACP and the AACCP believe that the current imbalance in distribution of, and access to, consultant physician and paediatric services in outer metropolitan, regional and rural Australia will become greater, unless the pool of these specialists is augmented by making consultative careers significantly more attractive to graduate medical students.

The purpose of this Submission is to present a viable solution to this problem for consideration by Government.

2. The Place of the Consultant Physician and Paediatrician in the Community

The Australian community would, in general, recognise 'consultant physicians' as medical specialists. Consultant physicians and paediatricians are Fellows of The Royal Australasian College of Physicians (RACP). The term 'consultant physician and paediatrician' describes:

- (a) consultant paediatricians who provide specialist medical care from birth through to adolescence; and
- (b) consultant physicians who provide specialist medical care for all other age groups from adulthood to frail age.

The consultant physician may provide specialist care for the patient as a whole and is thus termed a general consultant physician, or may specialise in an area of disease; for instance, heart, lung, kidney, cancer, diabetes or arthritis, or other related fields. These specialists are generally termed sub-specialist consultant physicians and paediatricians.

The question of what makes a physician 'consultant' is best answered as follows:

- (a) Consultant physicians and paediatricians only see patients who are referred from other doctors, both general practitioners and other specialists. For example, this includes surgeons requesting an assessment of the fitness of patients prior to surgery and

obstetricians with pregnant women presenting with intercurrent conditions, such as diabetes, requiring specialist medical care. In general these referrals occur because the referring doctors are experiencing difficulties with the diagnosis or management of a particular patient. When a patient is referred to a consultant physician a comprehensive history and examination is performed, a diagnosis is made and a plan of integrated management determined. This plan, which is carried out in conjunction with the referring doctor, forms the basis of ongoing management of that patient's condition. It is noteworthy that these management plans are aimed at preventing patients developing a health crisis and presenting to hospital in a critical condition.

- (b) Consultant physicians have completed an additional eight years or more of training after their initial university medical training and are required to meet stringent continuing education requirements throughout their careers. Many consultant physicians and paediatricians have, in addition, completed doctoral research degrees which take a minimum of an additional three years.
- (c) Consultant physicians and paediatricians work in hospitals, private practice and community based medical centres as well as in research and in administration. They provide leadership and guidance in their fields of specialisation, particularly with regard to the introduction, effective and efficient utilisation of complex and expensive technologies and treatments. Moreover, with the decentralisation of medical education beyond the traditional teaching hospitals, most are playing an expanding role as teachers, supervisors and mentors for future generations.

It is also important to recognise that the most complex and serious medical conditions, designated as key National Health Priorities by the Federal and State Health Ministers, are most commonly managed by consultant physicians and paediatricians. These include:

- Aboriginal Health
- Asthma
- Cancer
- Cardiac Disease, including stroke
- Diabetes
- Injury
- Mental health
- Musculo-skeletal disease

With the exception of injury and mental health, the sufferers from the remaining six health priority areas will generally be referred by a general practitioner to a consultant physician or paediatrician, for consultative advice, assessment, diagnosis and management. Even in the case of mental health, the consultant physician, as a geriatrician treating patients with dementia, may be the first contact after the general practitioner. Similarly approximately thirty percent of general paediatric consultations are for mental health problems in child health.

In other words, whilst the general practitioner has the central role as the first point of contact with patients, consultant physicians and paediatricians are the cornerstone of patient care in the Australian health system.

3. Roles of The Royal Australasian College of Physicians (RACP) and the Australian Association of Consultant Physicians (AACP)

The RACP was established in 1938. Currently there are 10,336 Fellows and members of the RACP in Australia and New Zealand.

There are 8,538 consultant physicians working in adult medicine in 22 Specialty Societies including 2,275 Fellows in seven Faculties and Chapters. There are 690 Life Fellows (over 70 years old), many of whom are still practising physicians.²

Consultant paediatricians number 1,674, in 24 specialties and specialty interest groups.

In addition to granting Fellowship the role of the RACP is in education, training and continuing professional development as well as quality and safety issues involving consultant physicians and paediatricians.

The RACP, under its memorandum and articles, cannot engage directly in matters relating to the terms and conditions concerning the derivation of consultant physician income.

Accordingly, the AACP, founded in 1989, is the peak body representing consultant physicians and paediatricians and relevant Faculty and Chapter Fellows in matters of economic and related workforce issues; hence, its role in presenting this case for two new Medicare items for consultant physicians.

4. The Proposal

This Submission aims to ensure that policies and programs are in place which will maintain the continuing entry and presence of an adequate cohort of consultant physicians and paediatricians in the health workforce to meet the current and future needs of the Australian community.

There has been no change to the MBS Consultant Physician Attendance Item descriptors since 1984. Currently, Physician Attendance Items 110, 116 and 119 are available as fees for Medicare benefits for consultant

² RACP College Workforce Data, June 2006.

physicians and paediatricians. However, these items do not take into account:

- (a) the complex and comprehensive consultations required by patients with co-morbidities;
- (b) the increasing need for consultant physicians and paediatricians to devise sophisticated clinical care plans;
- (c) the changing nature of a consultation for patients with complex co-morbidities including the need to communicate electronically with general practitioners, referring doctors, hospital clinics, and pathology and radiology services, as is being encouraged by the Department of Health and Ageing; and
- (d) the increasing out of pocket expenses and "gap payments" for patients created by the increasing costs of the consultant physician and paediatrician's practice.

This Submission proposes the introduction of two new consultant physician and paediatrician attendance items into the MBS; item 111 for Initial Comprehensive Consultant Physician Attendance and item 117 for Subsequent Comprehensive Consultant Physician and Paediatrician Review Attendance.

Proposed initial attendance item 111:

with a recommended schedule fee for Medicare benefit of \$300³, is intended to provide for care of the patient presenting with complex diseases and/or multiple system problems (i.e. co-morbidities) where, without such an attendance item, the patient may be referred to multiple sub-specialists, each assigned to treat one of the attendant problems.

The structure and proposed Medicare fee for the new item recognise the additional input required from the consultant physician and paediatrician to assess, diagnose and manage such a patient over and above the requirements for treating patients under items 110.

Proposed review item 117:

with a recommended schedule fee for Medicare benefit of \$150⁴, is based on the same premise as that for Item 111, but for subsequent comprehensive review of such patients.

To facilitate discussion, indicative descriptor guidelines identifying the type of activities envisaged to be undertaken by a consultant physician or paediatrician under the proposed new item numbers is provided at Appendix 1. These indicative guidelines are based on the experiences of AACP members in their clinical practices. Although time has been considered it has not been articulated in any substantial way in the Submission and will be a matter for further discussion.

³ 100% \$300.00 75% \$225.00 85% \$255.00

⁴ 100% \$150.00 75% \$112.50 85% \$127.50

The substantive case for the level of benefit for the proposed new items is set out in Appendix 2.

5. Budgetary Implications

The introduction of the new consultant physician and paediatrician attendance items will require additional funding to be provided through the MBS. The AACP will participate in discussions with the relevant government departments in relation to the likely level of additional funding. Figures will emerge from the calculations when made in conjunction with the Department which will be the subject of a supplementary submission.

The ability of consultant physicians and paediatricians to distinguish between the current MBS items 110 and 116 and the proposed items 111 and 117 lies in their ability to identify patients with complex problems and multiple co-morbidities requiring comprehensive assessment and management plans. However, it should not be assumed that this recommendation for the introduction of new Item numbers 111 and 117 will result in these new numbers replacing all previously identified Items 110 and 116.

To this end, in a pilot survey a number of consultant physicians were asked to review a series of de-identified cases and 'assign' patients to current MBS items or to the proposed new items. The results of this survey were analysed using rigorous statistical methods by the Monash University Department of Econometrics and Business Statistics Consulting Service⁵. This review confirmed that consultant physicians are able to reliably assess and assign cases appropriately to either the "Standard" 110/116 or "Comprehensive" 111/117 consultation/review (thus demonstrating inter-assessor reliability) and that this occurred in a statistically significant fashion.

The information available from the study would indicate, for the range of patients seen by consultant physicians in general medicine, a trend to the proposed new consultant physician attendance item 111 that constitutes 50 per cent of initial consultations, and 117 in 60 per cent of review consultations. These proportions are likely to vary between different areas of sub-specialty practice, and to be substantially lower in inner metropolitan practice where the prime reason for the visit is for single specialty based procedures.

⁵ Agreement of 110/116 and 111/117 items by Consultant Physicians. Monash University Department of Econometrics and Business Statistics Consulting Service, June 2006.

6. The Consultant Physician and Paediatrician Workforce

Within this Submission is consideration of the numbers, nature and current distribution of the consultant physician and paediatrician workforce.

Analysis of the RACP membership undertaken by the AACP indicates four main findings:

- there are 6,634 Fellows whose interest is in adult medicine and a further 1,674 consultant paediatricians;
- a substantial number are either working overseas as part of professional development, engaged in non-consultant physician activities such as medical administration, dermatology, psychiatry, radiation oncology or other related fields or are Life Fellows;
- it is estimated that currently in Australia there are 4,568 Fellows practising adult medicine and 1,674 clinically active paediatricians⁶; and
- the majority of consultant physicians and paediatricians practise in one location and primarily within the inner metropolitan setting⁷.

Tables 1 and 2 show that the outer metropolitan, provincial and rural centres experience significant difficulties in securing adequate consultant physician and paediatrician services due primarily to shortages in the workforce.

In the case of consultant physicians there are approximately 2.5 times more consultant physicians per capita in inner metropolitan Federal electorates⁸ compared to outer metropolitan and provincial electorates. For rural electorates the per capita ratio extends to approximately 7:1.

⁶ Included are Life Fellows (279) and Semi-retired (16) listed as having one or more workplace postcodes. While it is probable that these Fellows are not working full time it is not possible from the data available to assess this with accuracy. Thus in these estimates they have been assumed to be full-time, which in the context of this submission is a conservative estimate, given the argument of the submission is that there is a shortage of consultant physicians in Australia. It is noted that the Department of Health and Ageing uses a different method of estimating the number of FTEs based on the distribution by their definition of specialty of the gross fees raised at MBS fee level. Costs are excluded and a FTE is determined by arbitrarily chosen percentiles of the distribution of gross revenue. These differ by specialty. Conversations with officers of the Department indicate that their estimates are lower than those shown in Tables 1 and 2 below. Suggested causes may be the extent to which consultant physicians are also remunerated from activities such as being salaried staff specialists, sessionally paid Visiting Medical Officers, or being paid through Workcover and Motor Accident arrangements.

⁷ Dr Robert Wilson - Data on distribution and Federal electorates, July 2006.

⁸ All electorates referred to in this section are Federal electorates.

For consultant paediatricians the disparities are even greater: Approximately 4:1 for outer metropolitan and provincial electorates and 7.5:1 for rural electorates. Closer examination of the data by the AACCP indicates that the greater disparity for consultant paediatricians is the concentration of Childrens' Hospitals in metropolitan areas.

The following tables show the distribution of consultant physicians and paediatricians active in practice in Australia:

Table 1

Distribution of Adult Physicians per Capital by Federal Electorate Status

Federal Electorate Status	Population 19+	Pop/FTE* Cardiologists	Pop/FTE Gastro-enterologists	Pop/FTE General Medicine	Pop/FTE Geriatric and Rehabilitation Medicine	Pop/FT E Other	Pop/FTE Total
Inner Metropolitan	4,138,015	11,431	17,387	24,928	34,773	2,395	1,584
Outer Metropolitan	4,019,636	28,712	36,542	41,017	59,112	5,638	3,560
Provincial	1,587,659	23,348	36,083	44,102	63,506	6,561	3,826
Rural	4,038,882	89,753	109,159	46,424	155,342	18,699	9,827
Total	13,784,192	22,413	32,131	35,618	57,917	4,755	3,018

*FTE: Full time equivalent

Table 2

Distribution of Paediatricians per Capita by Federal Electorate Status

Federal Electorate Status	Population (0-18 yrs)	Paediatricians	Pop (0-18yrs) / Paediatrician
Inner Metropolitan	1,196,305	824	1,452
Outer Metropolitan	1,585,438	272	5,829
Provincial	586,015	98	5,980
Rural	1,608,387	158	10,180
Total	4,976,145	1,352	3,681

Sources: The Australian Bureau of Statistics, The Australian Electoral Commission and the RACP

7. Issues Impacting on the Consultant Physician Workforce

As identified in the Federal Government's Intergenerational Report the consultant physician is now serving an increasingly ageing Australian community. At the same time, the treatment of paediatric disease from the neonate through to adolescence is becoming increasingly complex.

Services to regional, rural and remote Australia, where 30 per cent of the population are living, are thus provided by a limited number of consultant physicians and paediatricians with a broad range of skills adapted to each location. In these rural and remote regions medical services are often a considerable distance from the local communities and there is significant mortality and morbidity with the higher proportion of advanced common, degenerative disease states – eg diabetes, vascular disease, hypertension, strokes and heart disease.

Accepting that the aim is to enhance equity in the distribution of the health workforce across Australia, the likelihood of the outer urban, provincial and rural health services each acquiring a 'critical mass'⁹ of consultant physicians and paediatricians will be enhanced if greater numbers can provide 'generalist' specialist skills where the emphasis is on consultation and where increasingly the preventative aspects of health care can be demonstrated through the advice provided by both consultant physicians and paediatricians.

The number of new consultant physicians and paediatricians required is affected by:

- the changing nature of the workforce, its feminisation (60 per cent of medical graduates are female) and the older age of post-graduate entry students;
- a reduction in working hours by new graduates of both sexes to refocus on life-work balance issues; and
- increasing levels of student debt influencing the younger generation to choose careers in the financially secure and sustainable specialties.

Senior consultant physicians and paediatricians are experiencing difficulty with succession planning as the number of new consultant physicians and paediatricians is not adequate to replace, let alone expand current constrained service delivery patterns, especially in outer metropolitan, regional, rural and remote regions.

The implementation of the proposed new consultant physician attendance items *inter alia* aims to support the greater involvement of consultant physicians in meeting the highly complex care needs of such communities.

⁹ 'Critical mass' refers to there being sufficient consultant physicians / paediatricians to cover the after hours and weekend on call requirements on a 'one in three days or preferably 'one in four days' roster.

8. The Need for a Partnership Approach

The Federal Government, the Department of Health and Ageing and the central agencies have recognised the impending problem of diminishing medical specialists and progressive medical workforce shortage in Australia which is compounded by shortages in the global medical workforce. Thus there is an increasing need for close co-operation between the RACP and the Federal Government to ensure the highest quality education and training of the future consultant physician and paediatrician workforce, with a focus on providing medical services to a diverse, multicultural population in areas of population growth and greatest need – especially outer metropolitan, provincial, rural and remote Australia.

At the same time it is recognised that the numbers and distribution of specialist training positions is the responsibility of the State Governments in the respective hospital systems. To this end, the RACP and the AACP also work in close cooperation with State and Territory Governments, health services and hospitals to ensure the combination of service delivery and training requirements are satisfactory and optimal to all parties. Given the cooperative intents of the Council of Australian Governments (COAG) process, the proposal being put forward in this Submission offers the opportunity to cooperate in restoring the primacy of attendance items for consultant physicians and paediatricians and the cognitive skills provided.

The Federal Government has the levers to effect change in the medical workforce in order to meet the health needs of the Australian community. Many of those health needs have been most recently identified in the Productivity Commission's report of December 2005 on the Health Workforce. The Federal Government has indicated on a number of occasions in the past decade that it is prepared to use 'the levers' available to it through the MBS and other instruments to effect change where good policy demanded.

The RACP and the AACP consider that the needs of the current and emerging consultant physician and paediatrician workforce, identified in this Submission, require a partnership approach between governments and the specialist medical workforce represented by the RACP and the AACP.

The RACP is in the final stages of implementing a comprehensive Education Strategy to guide consultant physician and paediatrician training and continuing professional development (CPD). It has been developed as an educationally rigorous, clinically relevant program aimed at enhancing the competencies, knowledge base and skills of consultant physicians and paediatricians.

With the Education Strategy under the direction of a newly-appointed Director of Education and Training¹⁰, the RACP is well positioned to respond to changing service demands in innovative ways, in order to train consultant physicians and paediatricians 'fit for purpose, in the right numbers and in the right place, at the right times'¹¹. A summary of the Education Strategy can be found at Appendix 3.

The Educational Strategy will be backed up by an increased and more focused campaign by the RACP and the AACP as well as by individual consultant physicians, to better promote to medical graduates the intellectual and lifestyle appeal of choosing a career as a consultant physician or paediatrician. The maldistribution so evident in the previous tables setting out workforce can thus be redressed. However, without the proposed change in the MBS items for consultant physicians and paediatricians, this campaign may not be effective particularly where the MBS is perceived to undervalue the importance of, and appropriately reward the consultant physician's work.

This partnership has the potential to redress the existing and growing distribution imbalance on a geographical basis, between general medicine and other consultant physician sub-specialities and between the procedural and non-procedural specialties. Thus, the AACP believes that one key area where the Federal Government can 'use the levers' available to it is to ensure that the MBS values and provides appropriate recognition of the consultation aspect of physician practice.

9. The Importance of the Physician Consultation in the Delivery of Medical Care and the Recognition of its Role in the Face of an Ageing Population and Increasing Community Expectations

How will Australia cope in the next 40 years in terms of the ageing population? The *Intergenerational Report* in the Commonwealth Budget Papers for 2002/2003 set out the proposition that life expectancy for males over the next 40 years will rise by five years to 82.5 years; and for women, about the same rise to 87.5 years.

About a third of the expected population of 25 million will then be over 55 years of age. Projected Federal Government health and aged care spending is provided in Table 8 of the Report. All health spending by the Federal Government will rise from 3.96 per cent of GDP to 8.13 per cent of GDP in the 40-year period 2001-02 to 2041-42, the biggest component of this being the Pharmaceutical Benefits Scheme. Aged care, as a separate expenditure item, will rise from 0.72 per cent to 1.77 per cent of GDP.

¹⁰ Professor Kevin Forsyth MBChB FRACP FRCPA PhD

¹¹ The Review of the Medical Workforce in New Zealand 'Fit for Purpose and for Practise' (2005)

The *Intergenerational Report* highlights the uncertainties surrounding any adjustment to the fiscal position of this country. To quote directly: '...labour shortages arising from an ageing population may increase the labour force participation of older workers'.¹² This would delay retirement and increase this group's incomes, reducing the budgetary impact of population ageing. However, to maintain a budget balance requires a five per cent growth in GDP over the next 40 years. And more of the growth in payments will circle around the health costs, and employment - with the cost of unemployment merging with the cost of retirement.

According to the Report's projections, while the ageing of the population will require increased health spending, a greater effect on the spending will be from the 'growing cost of new health care technology, increasing use of services and strong consumer demand and expectations'.¹³

In fact, in the Treasury calculation, 82 per cent of projected growth is ascribed to non-demographic factors as mentioned above, nine per cent to population ageing and nine per cent to population growth.

However, the recent report from the Australian Institute of Health and Welfare¹⁴ indicates that, during the 15 years from 1988 to 2003, gains in life expectancy were accompanied by increases in both expected years with and without disability. For example for older males, 67% of gains in life expectancy at age 65 were years with disability and 27% of their gains were years with a severe or profound core activity limitation. Similarly for older females, over 90% of their gains in life expectancy at age 65 were years with disability and about 58% of their gains were years with a severe or profound core activity limitation

If it is accepted that through both the consultation expertise of the consultant physician and paediatrician, and their procedural skills in using technology they will make a positive contribution to a more productive and healthy aged population with a "strong consumer demand and expectation", then the proposal that is being put forward is a cost-effective expression of what the *Intergenerational Report* requires from consultant physicians.

¹² Commonwealth of Australia. 2002-03 Budget Paper No. 5. *Intergenerational Report*, p 66.

¹³ *ibid*, p 38.

¹⁴ Australian Institute of Health and Welfare (AIHW) 2006. *Life expectancy and disability in Australia 1988 to 2003*. Disability Series. Cat. no. DIS 47. Canberra: AIHW.

10. Conclusion

The AACP believes this Submission charts a direction in accord with the appropriate recommendations from the Productivity Commission and with the recent decisions of COAG.

The introduction of the new attendance items 111 and 117 as proposed will contribute substantially to recognizing the key role of the consultant physician and paediatrician in the medical workforce which in turn will influence availability and access to consultant physicians and paediatricians geographically as well as in terms of clinical coverage. Importantly, the central theme of this proposal is to ensure that the Federal Government has a medical workforce capable of meeting the current and future needs of the Australian community.

Indicative Guidelines for Proposed New Items 111 and 117

Item 111 - New Patient or New Consultation with Significant Problems

Comprehensive history

- an extensive history of the present illness and a full system review
- including a psychosocial history
- documentation and review of medication and interactions, and
- formulation of differential diagnoses.

Comprehensive examination

- involving a complete general multi-system examination, or an examination of a single organ system and an assessment of other pertinent systems.

Medical decision making of significant complexity

- multiple diagnostic or treatment options evaluated
- and/or significant medical information to assess and review
- and/or the development of a treatment and medication plan of significant complexity.

Communication with referring practitioner(s)

A written report to the referring practitioner outlining:

- key findings – clinically and on investigation
- an opinion on diagnosis and risk assessment, and
- management decisions and options.

Explanatory Notes:

Item 111 should be applied in circumstances where comprehensive assessment and integration of history, examination and investigations requires a lengthy consultation and significant cognitive input by the consultant physician.

The development of options for discussion with the patient and family members, if present, the exploration of treatment modalities and the development of a comprehensive management plan, with discussion and coordination of appropriate health providers.

Patients referred for further assessment but with a health assessment, management plan or care plan developed by a general practitioner with the provision of the EPC items require comprehensive assessment of co-morbidities, with review of diagnosis, investigations and therapeutic options and endorsement of plan or development of revised health outcomes.

The appropriate use of information technology (IT) – with the integration and interpretation of data provided through:

- (a) computerised electronic medical records (EMR), electronic medication documentation and prescribing; and
- (b) secure electronic messaging.

Item 117 - Review Consultation

Comprehensive review of history and decision making

- system review of initial presenting problem(s) and response to treatment measures initiated at time of Initial consultation,
- documentation and review of medication and interactions
- assess of investigations and update of diagnosis and management options
- review of management plan including referral to appropriate allied health management team members

Appropriate examination

- Involving a general multi-system examination, or an examination of a single organ system and an assessment of related systems.

Communication with referring practitioner(s)

A written report to the referring practitioner outlining:

- key findings – clinically and on investigation
- confirmation of diagnosis and risk assessment, and
- management decisions and options.

Explanatory Notes:

Item 117 should be applied in circumstances where comprehensive assessment and integration of history, examination and investigations requires prolonged consultation and significant cognitive ability on behalf of the consultant physician.

The development of options for discussion with the patient, and family members if present, the exploration of treatment modalities and the development of a comprehensive management plan, with discussion and coordination of appropriate health providers.

Patients referred for assessment with a health assessment, management plan or care plan developed by a general practitioner require comprehensive assessment of co-morbidities, with review of diagnosis, investigations and therapeutic options and endorsement of plan or development of revised health outcomes.

The appropriate use of information technology (IT) – with the integration and interpretation of data provided through:

- (a) computerised electronic medical records (EMR), electronic medication documentation and prescribing; and
- (b) secure electronic messaging.

The Impact of the Proposed New Consultant Physician Attendance Items on the Maintenance of Pre-Existing Item Relativities

In 2000, Enhanced Primary Care (EPC) items were introduced into the Medicare Benefits Schedule following the establishment of Co-ordination Care Trials, which were set up primarily with general practitioner groups. Essentially closed systems, they did not recognise one essential element of medical care – referral for specialist care. The EPC items are:

- (a) health assessment items for those aged over 75 years of age (Aboriginal people have a much lower assessment age threshold);
- (b) clinical care planning; and
- (c) case conferencing

The introduction of these items has contributed to the large increase in the number of general practitioner MBS items. However, in the establishment of these items specialists were excluded apart from an item for case conferencing for consultant physicians¹⁵.

The language expressed in the 'enhanced primary care items', at least for case conferencing items, has recognised the applicability of these items for consultant physicians and paediatricians. The concept of clinical care planning for more complex patients being solely the province of the general practitioner contradicts contemporary medical practice.

The system of referral to a consultant physician or paediatrician remains a cornerstone of medical care where there is complexity in diagnosis and subsequent management; in other words, the consultant physicians and paediatricians as medical specialists are involved in complex clinical care planning and comprehensive patient management.

Recognition of the degree of difference in expertise has resulted in a differential in the comparable items for general practitioners and consultant physicians in that the value of the consultant physicians case conferencing items are 32 per cent higher. In the accompanying descriptors and notes to the case conferencing items there are some variations in the number of carers required to be in attendance.

However, the point is that a relativity in comparable consultant physician/general practitioner fees for Medicare benefit is recognised.

¹⁵ Access to case conferencing fee for Medicare benefit items with the same level of Medicare benefit available to consultant physicians has recently been extended to those specialists working in pain management and palliative care (many of the latter being consultant physicians or in the latter case Fellows of the Chapter of Palliative Care within the RACP). The consultant psychiatrists have a case conferencing item of the same value as consultant physicians.

When the schedule fees for medical benefit were originally set out, before the growth of complexity of service was recognised, there were presumed to be consultations undertaken by both general practitioners and consultant physicians, with a relativity set appropriately. If the current level of consultant physician initial consultation (i.e. 110) is compared against the most comprehensive consultation item 'Level D' for general practitioners then the fee for Medicare benefit is 33 per cent higher. The Level D consultation, unlike the consultant physician item 110, is not restricted to an initial consultation.

This submission recognises that the clinical care plan is the general practitioner comparator for the new consultant physician items 111 and 117. Therefore, these new items should be at least 33 per cent higher than for the clinical care plan item available for use by general practitioners. There are limitations on the number of clinical care items that a general practitioner is able to undertake over a one year period, although it is recognised that if there are any significant changes in the patient's condition, another clinical care plan can be invoked. The pattern of consultant physician practice is such that there is a self-imposed limitation on consultations imposed by the rigour of the execution of the inherent skills which consultant physicians and paediatricians possess. Hence, the proposed items would recognise, as the clinical care items do for general practitioners, the increasing complexity of medical care and have an appropriate value to these proposed new attendance items.

Key Points of the RACP Education Strategy

- The RACP is developing competency based curricula as opposed to time based training to enhance the training experience as well as moving to minimise training time. This will contribute to a more available, flexible and accessible workforce.
- Hence, competency-based curricula for basic and advanced training in each of the specialties and integrated assessment processes are being developed.
- The College has re-engineered the training program so that it:
 - Reflects modern educational methods
 - Articulates clearly what is expected of trainees
 - Matches assessments to the articulated curriculum; and
 - Enables the College to drive a process to develop a continuum of training from medical school through Post Graduate years 1 and 2, postgraduate training and continuing professional development
- Alongside and in addition to the Basic and Advanced Training Curricula there is a Professional Qualities Curriculum. The key elements below are important for Basic and Advanced trainees, but also for physicians in everyday practice:
 - Communication
 - Quality and Safety
 - Teaching and Learning (Scholar)
 - Cultural Competency
 - Ethics
 - Clinical Decision Making
 - Leadership and Management
 - Health Advocacy
 - The Broader Context of Health

The new Basic Curriculum and the Professional Qualities Curriculum is being implemented in 2007. The Advanced Training Curriculum will be rapidly and progressively introduced.