



AACP

AUSTRALIAN ASSOCIATION  
OF CONSULTANT PHYSICIANS

**SUBMISSION**  
to the

**NATIONAL PRIMARY HEALTH CARE STRATEGY**

from the

**AUSTRALIAN ASSOCIATION OF  
CONSULTANT PHYSICIANS**

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## SUMMARY OF RECOMMENDATIONS

- 1 The AACP recommends that “primary care” be redefined as “primary and ambulatory care” since this recognises the full range of providers involved in non-hospital care.
- 2 Given the established referral system has served the Australian community well and there appears no good reason to remove a system that works well, the AACP recommends that the integrity of the referral system be maintained.
- 3 The AACP recommends in relation to the chronic disease management arrangements in the Medicare Benefits Schedule that these be amended such that:
  - (i) Patients should not be eligible for a management plan unless they have been previously assessed by a consultant physician, paediatrician (under item 132) or psychiatrist, and the plan should then be based on the plan provided by the consultant physician or paediatrician. The appropriate Medicare item for the general practitioner consultation prior to referral should be a normal consultation based on duration.
  - (ii) If a general practitioner prepares a management plan for a patient who has not been referred to a consultant physician, the plan must be linked to both a Team Care Arrangement and a Case Conference. The case conference should be attended, usually by telephone, by a consultant physician or paediatrician. At this conference the consultant physician will concur with the plan, suggest an alternative course of action, or determine that referral for an initial consultation is required.
- 4 Recognising this is an important component of chronic disease management, the AACP recommends that, where appropriate, the patients of public health and occupational health physicians have access to the relevant Medicare benefit for the following items:
  - Management Plans for chronic disease
  - Team Care Arrangements
  - Case conferences
  - Health assessments for refugees and other humanitarian entrants
  - Aboriginal and Torres Strait Islander adult health check
- 5 The AACP recommends that to facilitate patient access to ongoing care and to make the best use of valuable health care resources, including general practitioner time, the current provision preventing the payment of Medicare benefits for allied health services unless there is a GP referral under an EPC plan be removed so that patients of CPP who are treated under items 132 and 133 and then are referred direct by the CPP for allied health services are eligible for Medicare benefits for those services.
- 6 The AACP recommends 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.

## INTRODUCTION

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, postgraduate 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. As a rule, the AACP is more relevant to the practising consultant physician and paediatrician, whereas the RACP is more relevant to the doctor in training to attain consultant physician/paediatrician qualifications. In addition, the AACP membership encompasses those Fellows of Faculties of the RACP – public health and occupational health physicians, consultant specialists in rehabilitation medicine, physicians in palliative care and sexual health and addiction medicine.

Central to the delivery of health care is the role that is played by consultant physicians and paediatricians who, by virtue of their extensive postgraduate training and continuing professional development, are responsible for the provision of best practice high quality care to patients across Australia. The consultant physician and paediatrician have a pivotal role in the delivery of best practice quality health care in all health settings: primary and ambulatory, hospital and nursing home.

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 disorders. 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.

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, as a result of improved care, there is increased survival of younger people after trauma with the need for lifelong complex care. In both of these cases, these types of patients will be cared for in primary and ambulatory settings wherever possible.

For many of these patients, ongoing management is provided outside the hospital setting, i.e. in the primary and ambulatory care setting. As such, consultant physicians and paediatricians clearly have an important role in the provision of primary and ambulatory care.

## KEY THEMES OF THE NATIONAL PRIMARY HEALTH CARE STRATEGY

The discussion paper “Towards a National Primary Health Care Strategy” groups the current challenges and future directions around four key themes:

- Quality of care and health outcomes for consumers
- Health care service delivery arrangements
- Health workforce capacity issues
- Fiscal sustainability

The focus of these programs is on integrated primary health care service delivery, and the development of programs that reduce the need for hospital admission.

The Discussion Paper further notes that preventative, primary and acute health care are interdependent and that improvements in primary health care are critical to improvements in the overall health system.

The AACP agrees that a strong primary and ambulatory sector underpins the overall health system. Consultant physicians and paediatricians are essential providers of ambulatory health care and can significantly influence the wellbeing of people in the community, and consequently reduce the need for hospital admissions.

The term “primary” should be redefined as “primary and ambulatory” – just as the relevant Division within the Department of Health and Ageing is titled the Primary and Ambulatory Care Division and thus recognises the full range of medical practitioners, including general practitioners, medical specialists, consultant physicians and paediatricians, who contribute to delivering health care to the Australian community in non-hospital settings.

It is not just general practitioners and allied health service providers who provide these services in the primary and ambulatory setting; **consultant physicians and paediatricians also provide a wide range of treatment in the primary and ambulatory setting**, as do the various consultant specialists covered by the Faculties and Chapters.

Consideration of the provision of primary and ambulatory health care therefore must include the contribution of consultant physicians, paediatricians and the range of specialists covered by the Faculties and Chapters of the RACP.

The AACP has addressed below a number of elements within the primary and ambulatory health care system that may, as part of this Review, be strengthened to improve the delivery of services and enhance the overall quality of care provided.

The AACP **recommends** that “primary care” be redefined as “primary and ambulatory care” since this recognises the full range of providers involved in non-hospital care.

## THE REFERRAL SYSTEM

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 additional skill and expertise that consultant physicians and paediatricians can call upon where patients have complex medical conditions with multiple co-morbidities. This is particularly significant in the older population as the number of co-morbidities and thus disease complexities increases with age.

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 diagnose and determine the appropriate 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 report of 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 established referral system has served the Australian community well and there appears no good reason to remove a system that works well. Therefore, the AACP **recommends** that the integrity of the referral system be maintained.

## MANAGING CHRONIC CARE

Among the Federal Government's commitments in the Health Portfolio has been a greater focus on primary health care, with a range of measures being considered as potentially contributing to enhanced primary care for the Australian community. This focus has been reinforced in the 3 July 2008 Council of Australian Governments (COAG) meeting at which "significant and far reaching ... proposed reforms" were identified for a number of areas including:

- preventative health
- complex chronic disease management
- hospital and primary care interface
- the "intersection" of aged care and disability services, roles and responsibilities.

Key objectives under this commitment include:

- reducing avoidable hospitalisations and re-admissions to hospital
- reducing non-urgent accident and emergency presentations
- reducing waiting times for those people who require essential hospital services, such as elective surgery; and
- providing more appropriate non-acute care for older Australians.

The announcement in February 2008 of the National Health and Hospital Reform Commission noted that the Commission *inter alia* 'will provide a blueprint for tackling future challenges in the Australian health system including:

- the rapidly increasing burden of chronic disease;
- the ageing of the population, and
- rising health costs.

with improving rural health one of its key objectives.

The AACP acknowledges the importance of a broader view of the delivery of services outside the hospital setting and enhancement of the management of chronic conditions through patient focussed, ambulatory approaches.

As noted earlier, consultant physicians and paediatricians are represented in all aspects of the delivery of medical and health care outside hospital settings and are equally crucial to the delivery of such health care as general practitioners. In the context of providing non-hospital medical services, consultant physicians include:

- consultant paediatricians and community and child health physicians;
- consultant physicians who have a significant role in non-hospital care;
- consultant physicians who work in chronic disease management and participate and/or lead case conferences;
- consultant physicians, including paediatricians whose practice in rural and regional areas encompasses a wide range of services that fall within the broad definition of "primary care";
- public health physicians working in preventative care;

- occupational health physicians; and
- fellows of the Chapters where palliative care, sexual health and addiction medicine are linked to chronic disease management.

Consultant physicians are integral with general practitioners and allied health care providers in providing health care to the Australian community in the community-based/ambulatory non-hospital setting (hospital based care is secondary or tertiary health care) as well as in the provision of secondary and tertiary services, on referral from general practitioners and specialists.

In recent years there have been a significant number of new GP items created to recognise both the potential range of activities beyond the descriptor of the single attendance item and also to acknowledge increased complexity in the conditions being treated. However, at the same time the role of consultant physicians and paediatricians in relation to such activities has not been factored into these items.

This has been particularly evident, for example, in the manner of creation of management planning for patients with chronic diseases and for which patients are typically referred by a GP to a consultant physician/paediatrician for diagnosis or for expanded treatment or management options, not normally delivered by GPs. In this regard, the provision of a management plan by a GP prior to consultation with a consultant physician/paediatrician does not follow the normal course of referral and the provision of advice back to the GP.

The MBS notes (A.30.12) state that: “This item is for patients with a chronic or terminal medical condition who will benefit from a structured approach to management of their care needs.”

With the exception of chronic mental illness, the other chronic conditions that are frequently listed and that are the subject of templates for use by general practitioners in preparation of a management plan and team care arrangements are those that are frequently referred to consultant physicians and paediatricians. In particular the frail, vulnerable, aged patients with chronic conditions are referred to consultant physicians. The young with congenital, developmental and behaviour disorders and psychosocial conditions generally are referred to paediatricians. These major conditions, recognised as National Health Priorities, include diabetes, asthma, cancer, heart disease, chronic lung disease and arthritis, to which can be added – with an emphasis on Aboriginal health – renal disease and chronic infectious disease. It is likely that a substantial proportion of, although not all, patients with these conditions, particularly those with more severe and complex illness, will see a consultant physician or paediatrician at some stage during their illness.

The steps identified in the MBS notes (A.30.13) include the need to agree on management goals with the patient and to identify the “treatment and services that the patient is likely to need.”

It is noted (A.30.12) that: “The GP may be assisted by their practice nurse, Aboriginal Health Worker or other health professional in the GP’s medical practice or health service. The service must include a personal attendance by the GP with the patient, as part of Item 721”; however it is silent on the nature or duration of this attendance.

In comparison, Level D attendance items “cover the difficult problems where the diagnosis is elusive and highly complex, requiring consideration of several possible differential diagnoses, and the making of decisions about the most appropriate investigations and the order in which they should be performed. These items also cover cases which need prolonged discussion. Physical attendance of at least 40 minutes is necessary.” It is noted that the patient benefit for a service that appears to require greater cognitive input and time from the general practitioner is less than that for a computer-generated plan, much of which can be performed by another health professional.

In relation to development of Team Care Arrangements, (A.30.20), the notes state that “... at least two health or care providers who will be providing ongoing treatment or services to the patient must collaborate with the GP in the development of the team care arrangements ... One of the minimum two service providers collaborating with the GP may be another medical practitioner (normally a specialist or consultant physician...)”

It has already been noted that the existence of a functional referral system is fundamental to the effective operation of the health system. However, one of the unintended consequences of the existence of the current care planning items has been the development of computer programs that generate essentially generic care plans, with little cognitive input from the medical practitioner, and secondly, the use of such computer generated care plans as replacements for a proper referral. In addition, the computer generated plan may, in fact, be generated by another health professional.

As has been pointed out in previous documentation, the use of the care planning items in this manner does not serve the patient interests well.

Increasingly, consultant physicians are raising concerns about receiving such computer-generated plans and team care arrangements as a substitute for a formal referral. The computer-generated plans frequently provide little useful information or appropriate background to the “referral”. The seeking of participation in the team care arrangement in this manner implies that all the specialist should do is sign a piece of paper, rather than engage in meaningful clinical exchange with the GP. It is noted that there is no patient benefit associated with the consultant physicians/paediatricians’ participation in such processes.

The current situation whereby a consultant physician or paediatrician is to be involved in the development of a treatment/management plan for a patient with a chronic illness does not follow the established referral process. The GP plan should augment the consultant physicians or paediatrician’s plan rather than the reverse since the purpose of a referral is to seek additional advice on a patient’s condition.

The AACP has previously proposed and **recommends** that the arrangements be amended such that:

- (i) Patients should not be eligible for a management plan unless they have been previously assessed by a consultant physician, paediatrician (under item 132) or psychiatrist, and the plan should then be based on the plan provided by the consultant physician/paediatrician. The appropriate Medicare item for the general practitioner consultation prior to referral should be a normal consultation based on duration.
- (ii) If a general practitioner prepares a management plan for a patient who has not been referred to a consultant physician, the plan must be linked to both a Team Care Arrangement and a Case Conference. The case conference should be attended, usually by telephone, by a consultant physician or paediatrician. At this conference the consultant physician will concur with the plan, suggest an alternative course of action, or determine that referral for an initial consultation is required.

It has also been **recommended** that public health and occupational health physicians should have access to the chronic disease management items following involvement of the consultant physician, as described below.

The creation of health assessment, care planning and case conference items in the MBS were aimed at improving the approach of the health system to dealing with chronic health conditions. However, without ongoing monitoring of the outcomes of the care plans and to determine the extent to which best practice is being applied it is difficult to know whether there is an improvement in health outcomes over time. Further, it is important to understand the extent of chronic disease in the population being served.

As such, the AACP has suggested that the chronic disease management items could also have a valuable population health application, as noted in the AACP discussion paper. For example, a public health physician would assume responsibility for the population-based component of the chronic disease management, including responsibility for ensuring that preventive programs were in place. Similarly, an occupational health physician could contribute relevant clinical information taken from the employment situation.

Recognising that this was an important component of chronic disease management the AACP has previously **recommended** that where appropriate the patients of public health and occupational health physicians have access to the relevant Medicare benefit for the following items:

- Management Plans for chronic disease
- Team Care Arrangements
- Case conferences
- Health assessments for refugees and other humanitarian entrants
- Aboriginal and Torres Strait Islander adult health check

The AACP believes that this arrangement would greatly enhance the ability of medical practices to deliver care to their communities because they would have a greater understanding of the health care needs of that population. Further, appreciating the nature of general practice, the addition of a specialist in population health can allow a focus on these broader aspects of primary and ambulatory care.

## REFERRAL TO ALLIED HEALTH PROVIDERS

At present, there is an anomaly in the Medicare arrangements whereby in some circumstances a patient of a consultant physician or paediatrician who is referred direct to an allied health provider by the consultant physician or paediatrician is not eligible to receive a Medicare benefit.

At the same time, the same patient referred to the same allied health provider, for the same service – as recommended by the consultant physician or paediatrician – is eligible for Medicare benefits for that service if it is recommended in the patient’s Enhanced Primary Care (EPC) Plan as part of the management of a chronic condition. Thus, the patient, who has just seen a consultant physician or paediatrician, has to make an appointment to see his/her general practitioner, in order to obtain a referral for allied health services that have been deemed by the CPP as necessary for the patient’s treatment.

Consultant physicians and paediatricians see patients on referral from GPs, other consultant physicians or paediatricians and specialists. Such referral “...must include: the patient’s history, relevant pathology results, details of medications and interactions, with particular focus on presenting symptoms and current difficulties. Assessments by other health professionals, including GPs and specialists, relevant care plans and health assessments should also be noted” [Medicare Australia].

The expectation of the referring practitioner is that they will receive, with respect to the care of the referred patient, “...the results of a comprehensive medical examination of the patient and a treatment and management plan, including a risk assessment, management decisions and options” [Medicare Australia].

As such, there is a significant flow of information between the referring practitioner and the CPP. The expectation of both sides of this “transaction” is that the patient “returns” at the appropriate time to the referring practitioner and is not “captured” by the CPP. However, at the same time, for many patients who have complex problems, they will require ongoing care by a CPP until such time as their condition stabilises or improves sufficiently for their GP to manage their care; for some, the CPP may continue to manage their care indefinitely.

Patients of consultant physicians and paediatricians who are treated under items 132 and 133 are not eligible for Medicare benefits for allied health care services when referred direct to allied health professionals. By definition, these patients have more complicated conditions than those treated under item 110 and 116. Patients who are treated under item 110 and 116 are eligible for such benefits.

As such, patients at the complex end of the care spectrum and who require allied health services have to return to the GP simply in order to obtain a referral for allied health services under a GP EPC plan.

Thus, there is additional cost to the health care budget, additional time and inconvenience for the patient and, for the busy GP, a consultation to note the advice of the CPP regarding recommended services and to provide a referral.

As the Minister has noted, "... we have a GP shortage right around the country – a shortage that is exacerbated in our rural and remote communities. These shortages spread across 74 per cent of Australia and affect 59 per cent of the population. I am constantly reminded by people I speak to of the impact this has on the community. People wait weeks for an appointment, or can't get in at all as lists are closed, with GP surgeries bursting at the seams."<sup>1</sup>

This is an anomaly that can be readily corrected whereby patients are eligible for Medicare benefits for allied health services if referred by a GP under an EPC plan or if referred after a 110 or 116 service, but not if referred by a CPP under items 132 and 133 for significantly more complex presenting conditions. As noted, for many patients with multiple complex conditions their treatment may well be managed on an ongoing basis by the CPP and while the referring practitioner may have incorporated the consultant physician/paediatrician's advice into a care plan, that plan will be for the patients' treatment to be managed by the CPP. For this category of patients, the referral anomaly is both inequitable and unreasonable.

Accordingly, the AACCP **recommends** that to facilitate patient access to ongoing care and to make the best use of valuable health care resources, including general practitioner time, the current provision preventing the payment of Medicare benefits for allied health services unless there is a GP referral under an EPC plan be removed so that patients of CPP who are treated under items 132 and 133 and then are referred direct by the CPP for allied health services are eligible for Medicare benefits for those services.

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<sup>1</sup> Minister for Health and Ageing, the Hon Nicola Roxon, MP, Speech to the AGPN Primary Mental Health Care Forum, 11 June 2008.

## CARING FOR OLDER AUSTRALIANS

In 2007 a number of new geriatric assessment items were introduced in the Medicare Benefits Schedule. These items require a detailed set of assessments to be undertaken.

The AACP fully supports the availability of an appropriate patient benefit for assessment of older Australians in order that their care can be most effectively managed, particularly where such management will enable them to avoid inpatient or institutional care and to continue living in the community, with appropriate support that can be identified through a proper assessment. Such assessment and management falls clearly in the category of primary and ambulatory care.

However, at present, the availability of the benefits for these assessments is restricted to the patients of a limited number of geriatricians. The AACP believes access to these items should be expanded to any consultant physician providing the designated services so that older Australians who require these assessments receive them and receive an appropriate Medicare benefit. The AACP believes this will contribute significantly to improved health care.

At present there is an inequity created due to these items being limited to a small number of geriatricians. The inequity is that where a patient has access to a geriatrician who can undertake the required assessment, the patient is eligible to receive a particular benefit. However, for the many members of the Australian community who do not have access to a geriatrician and where the same assessment is undertaken by a consultant physician, the patient benefit is significantly lower. Accordingly, that patient is disadvantaged. This is particularly the case outside the major metropolitan centres.

While there has been a process of identifying additional geriatricians applicable to these arrangements, it is understood the additional number is very modest.

Therefore the AACP reiterates that to enable a greater number of older Australians who require such assessment receive these services, as set out in the recently introduced “geriatrician items”, it should be recognised that:

- (i) it is not only consultant geriatricians who can conduct these assessments according to the criteria in the descriptors, and
- (ii) other consultant physicians currently provide such services.

In many areas of Australia where there are very limited or no geriatricians, consultant physicians undertake these assessments. This is especially so given that the age of 65 has been set as the entry point for such professional attendance items to be publicly funded. There is a widely held view that a 65 year old person cannot (and should not) automatically be defined as “geriatric” and, as such, are more likely to choose to consult a consultant physician not a geriatrician (even assuming the latter is available).

The AACP believes the wider availability of this assessment item will assist older Australians and their families to determine appropriate care and management and to assist those who can be managed in the community to remain independent. This is regarded as a fundamental element of primary health care in Australia.

Therefore, the AACP **recommends** 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.

## TELEHEALTH / E-HEALTH

Telehealth covers a wide range of communications that lie outside the traditional face-to-face consultation for which Medicare benefits are traditionally available. There are a variety of patient benefits that are paid in the absence of a face-to-face consultation, but there are very few instances where patient benefits are paid for the services of doctors who are not present but who are in direct communication with other health professionals – the case in point being the case conference items.

The matter of non face-to-face consultations has been under discussion for a number of years. The Australian Medical Association, for instance, for many years has made representations for short telephone consultations to attract a patient benefit. With the increase of other means of communication as part of the information revolution, the demand for the Medicare system to recognise such communications has intensified. There are also still views that it has yet to be demonstrated categorically that telehealth services improve patient outcomes, are cost effective and introduce essential efficiencies, with the need for further research proposed. Nevertheless, there has been significant investment in a number of countries in telehealth.

The AACP believes there should be due caution exercised about expanding the Medicare benefits system to encompass non face-to-face consultations especially where there are significant opportunities for their misuse. Nevertheless, at the same time, to impose a complete embargo on the availability of patient benefits for such services would be to “throw the baby out with the bathwater”.

The AACP would support telehealth items where the descriptors are written in such a way as to allow auditing of the use of such items and in the event of there being demonstrated excessive misuse, that there also be provision for either removing any loophole or else removing the item altogether.

Obviously in the latter case the AACP does not advocate “group punishment”. Therefore the AACP would be willing to participate in the development of any such items and in any subsequent process to remove such anomalies were they to be identified in the course of an audit.

The AACP will be making a separate submission on this matter in due course.

In the case of e-health, while Australia has focussed on the development of a national electronic health record, the implementation of national standards is yet to occur and its full functionality and the extent to which e-health can effectively contribute to widespread improvement of the management of chronic health disease in the primary and ambulatory setting is yet to be demonstrated. In order to maximise the effectiveness of future eHealth, there needs to be appropriate funding to support development across all levels of users to ensure the potential of an integrated electronic health record is maximised. Further, at such time as a national eHealth scheme is to be implemented, there must be adequate resources to support its implementation and use, again in order to maximise the potential of such a scheme to enhance quality health care.

## **THE 10 KEY ELEMENTS IDENTIFIED IN THE DISCUSSION PAPER**

The Discussion Paper proposes the following 10 key elements that could underpin a future Australian primary health care system. The AACP acknowledges these elements as representing an appropriate structure within which primary and ambulatory health care can be appropriately provided effectively, efficiently and safely. The AACP views these as appropriate principles and aspiration however it is recognised that it is now important to translate these good intentions into workable models that can be actively sourced. One of the problems is that such principles do not have any empirical backup.

**All Australians should have access to primary health care services, which keep people well and manage ill-health by being:**

1. Accessible, clinically and culturally appropriate, timely and affordable
2. Patient -centred and supportive of health literacy, self-management and individual preference
3. More focussed on preventative care, including support of healthy lifestyles;
4. Well integrated, coordinated and providing continuity of care, particularly for those with multiple, ongoing and complex conditions

**Service delivery arrangement should support:**

5. Safe, high quality care which is continually improving through relevant research and innovation;
6. Better management of health information, underpinned by efficient and effective use of eHealth;
7. Flexibility to best respond to local community needs and circumstances through sustainable and efficient operational models

**Supporting the primary health care workforce are:**

8. Working environments and conditions which attract, support and retain workforce;
9. High quality education and training arrangements for both new and existing workforce

**Primary health care is:**

10. Fiscally sustainable, efficient and cost effective

## The Role of the Consultant Physician and Paediatrician

In general, 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. However, consultant physicians are trained across the spectrum of medical conditions and therefore a general consultant physician may provide paediatric care, or geriatric care, or other sub-specialty care where a sub-specialist consultant physician may not be available, such as in rural areas.

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.
- (c) Consultant physicians and paediatricians work in the primary and ambulatory setting, 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, many have an expanding role as teachers, supervisors and mentors for future generations of medical practitioners.

It is also important to recognise that the most complex and serious medical conditions that have been designated as key National Health Priorities are 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 30 per cent of general paediatric consultations are for mental health problems in child health.

In other words, while the general practitioner is the first point of contact with patients, consultant physicians and paediatricians are a cornerstone of patient care in all settings in the Australian health system.