



AACP

AUSTRALIAN ASSOCIATION  
OF CONSULTANT PHYSICIANS

**Supplementary Submission  
to the  
National Health and Hospitals Review Commission**

**Consultant Physicians/Paediatricians  
and the  
Delivery of Primary/Ambulatory Medical Care**

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### **Introduction**

The AACP has reviewed and made a response to the NHHRC's Interim Report. However, the AACP's concerns regarding the lack of recognition in the Interim Report of the role and contribution of consultant physicians and paediatricians (CPPs), together with other specialists, in the provision of non-hospital – i.e. primary and ambulatory – treatment, remain.

The Department of Health and Ageing appropriately acknowledges the broader definition with the title of its Division of "Primary and Ambulatory Care". It is not just general practitioners and allied health providers who deliver health and medical care in primary/out of hospital settings. Across the whole spectrum of services, consultant physicians and paediatricians and other specialists deliver medical services.

The reform directions in the Interim Report raise the possibility of significant changes in the funding of "primary health care" and canvass a broader role for non-medical health professionals, such as being able to request diagnostic services and prescribe medication, under specified guidelines. However, while the role of CPPs who work in areas such as general medicine, paediatrics, aged care and rehabilitation – all of which are principally delivered in non-hospital settings – are not factored into the future directions being adequately considered by the NHHRC, its report will be flawed.

### **A vision for primary/ambulatory care in Australia**

The NHHRC has invited the AACP to put forward a vision for primary/ambulatory care in Australia.

The AACP believes:

- It is essential that there be due recognition of all providers of medical and health care in the "primary" setting – and that includes those services that are not GP or allied health, but those delivered in the ambulatory setting. This includes

consultant physician and paediatrician services (as described under “The role of consultant physicians and paediatricians); specialist services; diagnostic imaging; pathology; oncology and radiotherapy.

To not recognise such services, or worse, to recommend radical changes in structure and/or funding that diminish the ability of all the above CPPs and specialists to effectively and efficiently provide the quality services they currently deliver in the out-of-hospital setting, will greatly disadvantage Australian health care.

- Multipurpose or comprehensive medical centres are being considered as a means of capturing general practice and allied health care in a single location aimed at facilitating the delivery of health care services. However, equally, there is a specialist care model operating in the non-hospital sector that encompasses a wide range of consultant physician/paediatrician/specialist services, together with complementary services such as allied health, nurse practitioners, nursing and general practice. These models of care must be appropriately recognised in any framework since they have equal validity to the MPC model being considered by NHHRC; such centres present a viable component of non-hospital care in the future.

The AACCP was asked there would be widespread support for a move of CPPs from independent practice to multipurpose or comprehensive medical centres; the AACCP has noted that a proportion of CPPs currently provide services in these settings. While future health care models may involve much greater use of these sorts of health centres, “hub and spoke” or similar arrangements, there needs to be wider consultation about how they will affect the provision of medical and health care in the longer term. A large number of GPs and allied health providers currently deliver services outside such settings, any widespread change in this regard would equally require consultation at that level.

- A functional referral system is the cornerstone to the delivery of quality care to the Australian community. This does not mean rationing or restriction, but appropriate referral when a diagnosis or complex assessment and treatment is required. Equally, for patients whose condition is being well managed, they should not require ongoing CPP or specialist care, but can be effectively managed by their GP, with referral when and as required for additional advice for where the patient’s condition has changed. There is no justification for “rationing” or restriction on referral; in reasonable circumstances, there is no justification for restriction on the number of attendances required to achieve effective management of complex or chronic condition. The referral system needs to be maintained.
- In any comprehensive chronic disease management arrangements the contributions of general practitioners, allied health providers and those of consultant physicians/paediatricians/specialists that are delivered non-hospital setting need to be considered, including cancer care, diagnostic imaging and pathology. A framework that is based on allied health and GP services.
- Consultant physicians and paediatricians are involved in all aspects of the care of the members of the Australian community throughout their lives – from the

newborn to the frail elderly. They are fundamental to primary/ambulatory care and any chronic disease management or primary care framework needs to acknowledge their role.

Therefore, in addressing the best way to deliver quality care to Australians, any proposals arising from the NHHRC's consideration need to take a broader view of how primary/ambulatory care is provided and who provides this care, with due acknowledgement of the roles of all contributors to non-hospital medical care.

## **The Role of Consultant Physicians and Paediatricians**

Consultant physicians and paediatricians have a key role in the provision of best practice high quality care to patients across Australia and have a pivotal role in the delivery of best practice quality health care in all health settings: primary and ambulatory, hospital and nursing home. Consultant physicians are responsible for treating the most complex and serious medical conditions designated by COAG as key National Health Priorities – asthma, cancer, cardiovascular diseases (including stroke), diabetes and musculoskeletal diseases.

Consultant physicians cover a wide range of sub-specialties, such as:

- internal/general medicine
- geriatric medicine
- endocrinology
- rheumatology
- immunology and allergy
- nephrology
- haematology
- cancer care/oncology
- paediatrics
- cardiology
- gastroenterology
- neurology
- nuclear medicine
- public health
- rehabilitation
- respiratory medicine
- thoracic medicine
- palliative care

and for the majority of these patients, medical advice is provided by consultant physicians and paediatricians in the community and close to the home of the patient – not in a hospital.

## **The Particular Importance of Rural Physicians**

Similarly, in many areas of Australia where there are no or very few sub-specialist consultant physicians (such as geriatricians or rehabilitation specialists) consultant physicians provide the same types of assessments and management for patients requiring these services as “specialists” in those areas. Again, this medical care is frequently provided in an ambulatory setting or is provided in a manner that engages general practitioners in comprehensive care management.

## **What does the NHHRC need to do?**

In its submission, the AACP made a number of specific recommendations aimed at enhancing the coordination of patient care between general practitioners and consultant physicians / paediatricians and improving the delivery of chronic disease

management through the recognition of the roles of both consultant physicians/paediatricians and general practitioners. These are set out below.

However, the AACP has been asked by the NHHRC to consider a “broader vision”; to consider where changes can be made, both short term and longer term relevant to the role of CPPs.

## **Short Term**

In the short term, the AACP believes there is a significant need to build on the CPP workforce currently available, particularly to non-metropolitan Australia. There are a number of ways this can be addressed.

### ***e-health***

The contribution of e-health will help to improve linkages between different care providers and with the patient, however at present, the developments do not adequately address the CPP/specialist strata adequately. All e-health developments need to have a wider focus if the goals being pursued in developing electronic health records are to be realised. A proper, comprehensive e-health system not only will assist patients when they need to see a range of medical providers, but will also strongly support other services such as case conferencing, telephone consultation and related chronic disease management where it may not be possible to have all relevant consultant physicians on site. In the short term, the e-health agenda must address how e-health can facilitate communication across all health care providers, not just within the GP framework. After all, Australia has been the leader from the time of John Flynn and his vision, which led to the Royal Flying Doctor Service and the early use of radio contact for health services.

### ***Referral***

The referral system is the backbone of quality health care in Australia, as it has been for decades. This was one of the major elements highlighted by the AACP in its submission to the NHHRC.

However, under some of the options being considered, there is potential for the traditional referral system disregarded, leading to sub-optimal care, or to become unnecessarily burdensome.

In the short term, CPPs must be able to refer patients direct to allied health providers when utilising items 132/133. There is no suggestion that GPs will not follow advice of the CPP in terms of the patient requiring allied health services; to require the patient to attend for another GP consultation simply to secure a referral to an allied health provider is a waste of resources, a waste of the patient’s time and potentially, introduces an unacceptable delay in getting the service. This area of referrals needs to be addressed in order to facilitate the patient’s access to necessary services. There is no question of the patient not being “returned” to the GP as appropriate; this appears to be a completely unnecessary requirement that should be addressed.

The second element of concern about referrals is the potential for referral to specialists and CPPs by non-medical health care providers. This concern was particularly noted by

members of the AACCP in that there will be instances (for example) where a patient's treatment may require the use of pharmaceuticals that should be overseen by a medical practitioner. As such, the patient's treatment may be amended because the overseeing health practitioner is not a medical practitioner.

The AACCP does not necessarily oppose referral from a non-medical practitioner, and in remote areas, nurse practitioners, for example, are important in the provision of health services. However, the potential impact on the treatment of some patients must be acknowledged.

The third element of concern about referrals is the growing use of GP "care plans" as a substitute for a referral. This is a source of constant complaint from CPPs where "care plans" that are nothing more than a computer-generated list of information increasingly are being sent by GPs. This is akin to being sent an extract from a medical textbook, not the distillation of the particular patient's treatment. Given these "care plans" can be computer-generated and often by non-medical practitioners, their use as referrals should be seriously questioned by the NHHRC as one short-term solution to the diminishing quality of referrals to CPPs.

### ***GP Care Planning***

The AACCP has recommended that a patient should not be eligible for a management plan unless the patient has previously been assessed by a CPP (under item 132) or a psychiatrist, and that the management plan should then be based on the advice provided by the CPP. The appropriate Medicare item for the general practitioner consultation prior to referral should be a normal consultation based on duration.

The AACCP has also recommended that where a GP 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 CPP. 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.

Management and care plans are intended to set out a course of action for the treatment and/or management of a patient's presenting condition/s. The logical course of action, where a patient is referred to by a GP to a CPP for assessment and diagnosis of the condition/s or for confirmation of a diagnosis, is that the CPP/specialist recommends a course of action after which the patient returns to the GP for development of a comprehensive management plan and to oversee the ongoing management, except in those cases where management by the CPP for a longer period is indicated. Accordingly, the AACCP has recommended the current arrangement whereby the GP prepares a management plan, and then forwards the management plan for "sign off" be adjusted so that:

- (i) where a care plan is prepared by a GP in the absence of a referral to a CPP, that care plan must be linked to a team care arrangement and a case conference that is attended by a CPP and that there be an appropriate patient benefit associated with the CPP's involvement;

- (ii) a patient should not be eligible where there has not been a consultation with a CPP and that the management plan prepared by the GP should reflect the advice of the CPP.

***Recognition in the Medicare benefits of longer items for patients with complex conditions and treatment needs***

While there has been recent recognition of the need for attendance items in the Medicare Benefits Schedule that reflect the increasing complexity of presenting conditions, there remains the need for Medicare benefits that acknowledge that, for a proportion of patients, there will be a need for extended assessment and treatment planning. For such patients, whose conditions are more complex than those envisaged as applying to items 132 and 133, there remains a need for a longer attendance and a follow up item.

As has been recognised with the recent creation of specific items for geriatric assessment, there are cases where the complexity of the presenting conditions warrants much longer attendances than currently provided. The AACCP notes that the provision of appropriate Medicare benefits that are related to a longer consultation and a set of assessment guidelines (while not necessarily supporting a time-tiered structure) have provided a precedent. The AACCP therefore strongly recommends that there be appropriate Medicare items, with an appropriate level of Medicare benefits that reflect the increasing complexity of presenting conditions in a proportion of patients. This is relevant to both an initial attendance, and follow up attendances.

***Recognition in the Medicare benefits that there may be a need for interim arrangements to meet short term needs***

As the AACCP has pointed out previously, the recent creation of a number of geriatric assessment items, has created an anomaly, namely: while these items are available to consultant physicians who are recognised as “specialist geriatricians”, the assessments as required under those items are carried out in many situations by consultant physicians, who are not recognized as “specialist geriatricians”. This is particularly the situation in rural and regional areas, where there are few or no geriatricians. The AACCP’s concern is that for patients in these areas, they are being significantly disadvantaged by not being eligible for the same level of Medicare benefit as that available to metropolitan patients who may have access to a geriatrician.

As the AACCP has noted, it is acknowledged that a major reason for establishing the items in this manner was to try to encourage greater numbers of consultant physician trainees to undertake geriatrician training. However, consultant physicians already do advanced training in geriatric medicine; they are able to undertake these assessments.

The AACCP has proposed that, until such time as the number of geriatricians in rural and regional areas is increased, that the patients of consultant physicians who provide the assessments as defined, be eligible for the same level of Medicare benefit. Changes in the number of geriatricians can be closely monitored and the situation reviewed. The AACCP believes this provides appropriate access to geriatric assessment for older Australians who are in need of assessment, while at the same time supporting the initiative that saw the creation of the items.

## **The NHHRC's "Options" for providing Chronic Disease Management**

The AACP notes the NHHRC's "options". These raise a number of issues, not the least of which is that to address a growing requirement for chronic disease management. However, there is a need for the NHHRC's options to realistically address the contribution of a much wider primary/ambulatory sector than GPs and allied health providers. They will not just be in multipurpose clinics "MPCs"; they will be working in the community, in specialist clinics that incorporate a range of support services, or in hospitals and, in many cases, will provide these services in multiple settings. For example, a rural physician may well consult with patients in a number of geographic locations because this enables patients to see the consultant physician within their own communities. There does not appear to be an "option" that adequately addresses such a scenario across Australia.

The AACP believes that providing effective integrated care requires a system that supports integration of the providers, rather than trying to overlay a framework that does not recognise the existing models of care- eg eHealth linked 'virtual' clinics may be more realistic and achievable. Establishing a "superclinic" structure in a community is no guarantee of effective integration.

The current "options" do not include "blended" models whereby some elements of care are provided within circumscribed borders with well functioning links out to other providers, such as CPPs and specialists whose services may be funded under different arrangements, such as the existing fee for Medicare benefit.

As indicated, one of the recurring problems drawn to the attention of the AACP is that patients who attend at such MPCs do not see the same GP; this is a source of significant dissatisfaction. Any wider move to gather together providers must address these concerns as they are particularly valid. The NHHRC sees value in patients being referred to "a service" rather than to an individual (and this was considered a possible solution for the AACP's concern about being able to refer patients directly for allied health services). However, this does not address the needs of the patient, nor does it acknowledge that patients want to know by whom they will be treated.

Equally, patients want to be able to see the same CPP or specialist from year to year. GPs and CPPs build up long term relationships that benefit their patients.

The AACP does not believe that a system whereby patients are referred to a facility, rather than a person (be they GP, CPP or specialist) is in the long-term interests of patient care.

The NHHRC is focussed on chronic disease management, however it is faced with the dilemma of how to define chronic and complex care. As noted, it is beyond the scope of the NHHRC to deal with the role of services such as medical imaging and pathology and yet these are routinely part of chronic disease management. Conditions such as breast cancer, lymphoma, leukaemia and diabetes - all have acute phases, and all are frequently long term, but with requirements that the NHHRC is unable to address.

For example, treatment for breast cancer may involve surgery, radiotherapy and chemotherapy – the latter being provided out of hospital as ambulatory services. As such, the role of services outside the narrow definition of “primary care” have to be acknowledged to ensure that any future health funding scheme that changes the current arrangements does not have unintended consequences that mean patients can be denied essential medical care. Furthermore, although a cancer case conferencing Medicare item was established, the patient benefit was not appropriate and the organiser was not recognised as a medical practitioner. Cancer case conferencing has not been able to involve all those concerned with the care of patients.

## **Short Term / Longer Term**

### **The Contribution of Public Health Physicians to the assess and meet the health needs of communities, rather than individuals**

The proposed GP *superclinics* provide an ideal opportunity to involve public health physicians in the management of chronic disease, which has been identified as a priority for the clinics. The proposed structure of the *superclinics*/MPCs means it will be possible to define the denominator of the patients seen. In other words, it will be possible to know the characteristics of the population, to match the actual number of patients attending with the number expected, and consequently to determine if there is unmet need in the community. More importantly, if the health assessments, care plans and case conferences are part of the management, it will be important to monitor the outcomes of the care plans and to determine the extent to which best practice is being applied and is leading to an improvement in health outcomes. A public health physician could take responsibility for the population-based component of the chronic disease management, including responsibility for ensuring that preventive programs were in place.

However, in the absence of a range of appropriate Medicare items to which public health physicians have access, it is unlikely that this opportunity to enhance the delivery of primary health care and improve the health status of communities, as sought by Government under its primary health care initiatives, can be fully realised.

The AACP recommends again that public health physicians have access to EPC and CDM items for management plans for chronic disease, team care arrangements, case conferences, health assessments for refugees and other humanitarian entrants and Aboriginal and Torres Strait Islander adult health checks.

This change will facilitate the employment of public health physicians to develop knowledge of the overall health of communities in a way that will enhance the capacity of the health care providers to better plan and deliver health care to their communities. The AACP’s view is that providing a mechanism whereby public health physicians can be involved in the assessment of community health in this way will have a significant benefit on the capacity of health care providers at all levels to more effectively and efficiently meet the ongoing health needs of the community.

Similarly, as was raised in recent discussions in relation to the National Primary Health Care Strategy, in many cases public health physicians are the “primary care doctors” for

Indigenous Australians, because there are no GPs available to provide this care. There is little recognition of this role.

### ***Workforce***

The NHHRC has acknowledged the potential difficulties of dealing with increasing numbers of patients with chronic and complex diseases in the future. The NHHRC has tended to look to allied health providers as one means of resolving this dilemma.

However, a more efficient and effective inter-relationship with CPPs that duly acknowledges the roles of both is crucial in addressing this issue. As the NHHRC has noted, there is a need for greater numbers of general consultant physicians and paediatricians to support primary care centres or GPs. The AACP agrees this is important and notes there are important training issues to be addressed, both in the short term and in the long term. This needs to be reflected at all levels of training, starting with the requirements for placement of 3,000 medical students annually, from 2011.

The other matter that has been raised in relation to addressing some of the workforce issues in the short term is for the Government to significantly expand the capacity of the Medical Specialist Outreach Assistance Program (MSOAP) and to better support the use of locums. MSOAP currently provides valuable support to rural and remote areas; however, the AACP believes MSOAP could also be used as a mechanism to attract currently non-practising specialists back into the workforce on a part time basis to deliver specialist level services to areas where it is currently difficult to attract full time CPPs and specialists.

Similarly, support for locum services will assist established CPPs and specialists, again in non-metropolitan areas, to maintain services. One such example, that has been brought to the attention of the Minister and Department already, is that the follow up item 133 cannot be used by a locum where that service is being provided as part of a course of management and thus the patient is not eligible to receive the appropriate benefit for a complex follow up. The AACP has requested this anomaly be addressed since it disadvantages the patient where the principal CPP has taken leave, or is ill, and requires a locum.