Submission from Dr Bertram Sutherland Vanrenen
to Productivity Commission. "Australia's Health Workforce"

Peter Costello has asked for a research study to examine issues impacting on the health workforce including the supply of ,and demand for, health workforce professionals, and **propose solutions** to ensure the continued (*improved I hope)* delivery of quality(*vastly improved and easily accessable)* health care over the next 10 years.

I have examined and considered each of the 346 pages of this Position Paper to find out " **why and how"there are such Deficie**ncies.**and what Solutions**

My area of expertise Viz:-Family medical care as an Aussie General Practitioner from 1951 till about 1974, after which little more than a Community Family Physician and from then on as a psuedo Employee indirectly of the Commonwealth Government's Health Department !(HIC)

In 1974 Bill Hayden Cunningly reduced GP rebates to that of his **Cheap Doctors. The AMA had** only taken up our GP fees 12% (see below)and we have never caught up!

Also in1974 Massive wage increases mounted up to17.4% with the inevitable marked loss of buying power for all consumers.. This of course snowballed into our first experience for decades of sudden high unemployment .

The worst hit were the thousands of medium to very large Manufacturing businesses employing 100's to thousands ,from old established Pre war , to employees seeing opportunities post war 2 and setting up business ;most became successful employers, creating employment for school leavers in businesses not there last year ,and immigrants , such was the yearly growth.

In 1972 all over Australia were small Private G P hospitals, in theCities big private Hospitals, Big regional towns, small towns With facilities for Gp's to perform emergency surgery within their experience and competence and a lots of other procedures under Anaesthetics using their local G P colleagues .Delivering Babies and treating a wide range of illnesses in the same hospitals .; and all minor injuries at their surgeries.
In Victoria The Bush Nursing Hospitals :-5to7 beds and two Nurses, for observation and treatment for the doctor miles away ,but close to family support group ,a most important part of therapy.

In the bigger towns the local people funded Community (charity) hospitals for the 10% of the population :- the poor:- pensioners,invalids,indigenous,seasonal workers etc.etc. and the local G P's serviced them free .

In the big cities Teaching Hospitals funded by the state
Each State had overall responsibility to only 10% of the population .

After 1979 with the loss of 10's of thousands of GP hospital beds and theatres , **the state** needed to create beds and theatres and find specialist surgeons etc.to take over all those operations ,Obstetrics and gynaecology ,Medical and Psychiatric Previosly handled locally by GP's.

The effect on the Aussie innovated world renowned fully funded private health services: Hospital /Nurses and Medical/Doctors Mutual Funds that protected 90% of key health services , was catastrophic as families were no longer able to maintain the weekly payments to Hospital and Medical Mutual funds which payed 90% of all Doctors Charges and likewise their Private Hospital costs .

In1973 Bill Hayden the first minister of Health in Whitlam's . .New Labor Federal Government was ordered to create a **Free ,fully Salaried health service. Their 50's** policy
Based on an already world wide failed systems when taken out of the hands of nurses and doctors (due to conflict of interest) and run by large government burocracies.
Had not worked,and still does not work .!
Hence ,the present revue.

Why is there a worrying shortage of "General Practitioners"in Australia .
Dedicated Medical Undergraduates, lots of postgraduates trained by the Royal Australian College of General Practitioners to go out in to the Community.
Of my 34 F M P trainees (Registers) 2/3 would have made excellent country familyDoctors academically very well prepared and with the manual dexterity so needed there ,the rest fitting more comfortably into the newer high density inner metropolitan areas and equally, the outer suburbs.

Why since 1979 has there been so little recruitment into these areas?
By 1979 the GP 's earning capacity had been halved ,Public patients Trebled ,not enough private patient s to refer to GP hospitals, So they closed:-
No GP surgery ,no midwifery ,no Medical inpatients.
No minor accident work in our rooms due to reduced rebates making it unaffordable.

My1960 audit showed that consulting only paid our costs.
Our net pay came from above manual work.
By 1979 consulting was all we had o live on .
By 1979 all our trainees in Medicine , including the business side of our practice and undergraduates were growing concerned by our very poor economic situation.

Therein lies the answer to-- **why** ----no or little Recruitment for The last 25 years into the Community.
Even those left are constricted in the work they can afford Like Treatment ,follow up and outcomes ,very restricted time allowance per consultation.
Early diagnosis of remedial illness is costly in time and resources and mostly unaffordable, hence a worried Community!

THE FUTURE ----------SOLUTIONS

Look around ,How do others who sell their intellectual capital cost their infrastructure ,staff ,expendibles After hours costs Etc, etc.
Then assess the necessary take home pay with 3 teenagers For a comfortable reward and affordable time with families!

How

Firstly update our job description! (attached)

Secondly update our infrastructure ,design of consulting rooms for the future
For communication (mental illness etc)and examination etc!

Thirdly Adequet staff Reception ,Nurses to prepare patients,expendibles etc.

Fourthly With proper costing we could look at retrieving All the minor trauma that chocks up public hospital Casualty /out patients. Much more convienent for the locals!

Fiftly Work this out on an hourly basis so that we can consult One or not more than 4 patients per hour. And Afford After hours services ,as in the past.

Six The individual personal responsibilities carried by community doctors require massive Undergraduate teaching of basic scientific knowledge(carpentry plumbing anatomy etc.etc.)and solid input by experienced Clinicians. It will all be retrieved as required over the next decades
With that base they are easily taught how to put it into action As I discovered with my 34 . Full responsibility in one month Meeting all my requirements but attracting patients in their own right by the end of 3 months as each had a different interest.

Seven SOLUTIONS Now the crunch.
With the low purchasing power of the Dollar we need to look at range of $370.00 to $ 470.00 per hour for updated infrastructure etc(above) and not forgetting factoring in non earning time(RACGP) and after hours.

Still to be finalised with others help!!!!

Eight With future recommended costs & incomes I think we should ask the Federal Government for our Private Medical(doctor)Mutual Funds back to allow people to insure for the big gap between the out of date HIC rebates and **real but fair fees** in the future.
For the years of dedicated massive training and life long tremendous personal responsibility to each and every individual,
THEN to train patients again how to use our expertise to their best advantage !

Most Australian born medical students enter to **care for** people
And that is as community doctors (still refered to as General Practitioners) because that is where personal care is to be found.
Know Your Patient eternal watchfulness,
Diagnosis is the reward,Reassurance that nothing is wrong to the patients satisfaction is harder than Treatment and outcomes, and more time consuming.

Thr RACGP has trained 100's of potential Communit Family Physicians ,they (with their families) will only come forward when the situation is economically and realistically viable again!
They are all there ready to fill those empty niches in:-
high density inner Metropolitan areas,inner and outer suburbs, Country towns of all sizes and remote areas
All. Are broardly based ,but each is an individual with special interests used to fill every niche in the total team in the past .
All generalists ,but each will find their special niche in the TEAM .
!Remember ;they are still adaptable and adventurous ,and learn every day of their life through their patients ,consultants and teaching hospital reports.
All new information is sorted at that level and sooner or later passed on to us via our patients, in time to help our other patients.
Most new information is only finesse and tidying up!

My Senior Partner told me never to be the first to start something new or the last to cease it's use!
Very wise advise and never forgotten !!!!

Definitions

A Community Family Physician is one who choses a district to take hisfamily,settle into and grow with that community. Understanding the ethos ;knowing the individuals and the family kinetics ;always watching for early changes of remedial

illness at ever consultation , whatever their presenting problems,,and training them to bring their problem lists. The 4'th or the5'th problems are the important ones ,. my FMP Trainees learned to their surprise and pleasure! As they were able to maximise theirLearning! To the satisfaction of both parties!

The Health Team

By1972 the major players were Hospital trained Nurses and Medical Graduates every niche fromG.P.'s to Administrators And Matrons . And run **frugally**
Australia today and all other countries altruistically offering free health services went in blindly to the economics and administration ,and that fact was known by the end of the 1960's to all Aussies ,Commo's and Socialists were still blind!.

It is time we Aussies,the worlds greatest Innovators, Got our heads together to procede with the solution! Ain't we Aussies Why should we continue to put up With outsiders known failed ideas that have failed here to! Lets get off our butts and do it!!!

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" JOB DESCRIPTION "

General Practitioners for the New Millennium become

"Community Family Physicians"

ROLE

1 To Allay Anxiety in respect to physical, mental and social well being!

2 To hear, to see, to sense with all our learned experience why they came. To numerically list each and every problem (4 to 6+).

3 C.F.P As Problem Solvers

a) To ascertain firstly if there is a problem.

b) If not, to reassure the person to that persons satisfaction.

c) If there is a problem to treat and follow up within ones learned competence.

d) When beyond our competence and experience to refer to the appropriate "specialist" for diagnosis, management, full feedbacks daily; to learn with our patient, use , sharing care & responsibility. And then pass on to others

4 Health Surveillance

This should be the most important role of the Community Family Physician

We should be the first ones to recognise any changes within that human being our patient. C F P's are all trained to know and look for early signs of illnesses in our patients, of all sexes and at "each and every" age in their journey through life.!

We are part of the whole diverse but integrated team of Nurses & Doctors.

Human frames do not change, but Environmental changes (Political etc.)do have marked effects for good or bad Viz:- pre 1972 and now !!!

5 To medical,surgical,gynaecological,psychiatric specialists and consultants:; to paramedics ,healthcarers, to Private Hospitals ,public hospitals, and Tertiary Teaching hospitals:

We as C.F P's are responsible to every discipline. To find problems beyond our competence, at such an early stage,that our supberb specialist technicians can be of greatest help to our patients!!!

6 Then with kindness and full explanation to smooth their way through all the hurdles into the frightening unknown of specialist and hospital care and to always be available to them to clarify each and any stage of their Treatment { Bert Vanrenen 22/4/2004}

7 To allay Anxiety and help in every way to ease our friends fears