7th November 2005

Dear Messers Woods and Fitzgerald,

We congratulate you on the breadth and depth to which the Australia's Health Workforce Productivity Commission Position Paper has analysed the nation's current health industry status and welcome your invitation to comment on the next stage of your deliberations.

As a group of medical (physician) subspecialists we represent a very small part of the medical workforce but believe that some of the suggestions we have would be transferrable to the increasing number of other outpatient (office-based) medical specialties and other allied health groups.

We note your references to the inefficiencies attributable to the dual involvement of both federal and state governments at many levels in our health care system and suggest that, although major, a move to nationalise training, accreditation and service provision in your current draft proposals would be a step towards greater efficiency in our system. It is worth noting that the current Medicare levy was computed so long ago that it bears little relation to current real expenditure and that the Commission could take the lead and make the politically unpopular but fiscally justified suggestion to increase it.

If, as is more likely, overall funding does not change, then changes to the remuneration for certain services would be appropriate. The Medical Benefits Scheme was constructed at a time when the greatest demand was for the treatment of acute illness without technological support. Over time new items have been added to the schedule but few, if any, have been deleted or reviewed to determine if the costs of delivering any particular service may have changed. Treatment of acute illness now represents only a small percentage of patient services and is strongly technologically supported, while treatment of chronic illnesses predominates.

The Pharmaceutical Benefits Scheme has a robust independent process for reviewing and changing rebates in response to new evidence, new indications and change in demand. A similar process for reviewing MBS items and their remuneration would help to maintain their relevance and equity in the ever-changing medical service environment.

Facilitating workplace innovation
As well as an overall MBS review process as mentioned above, specific new activities could add efficiency. For example, in the area of chronic diseases a lot of doctor consultation time is used in patient education. A workshop model comprising a specialist, a general practitioner and a practice nurse conducting an education session with a group of 7-10 patients with the same condition would educate all the participants (patients and professionals) and empower the practice nurses to provide followup sessions with these and other patients. (Patient satisfaction surveys reveal that patients prefer consulations with doctors even though they may acknowledge that the outcome of the consultation is no different or even less beneficial.) In the area of chronic pain, patient group sessions with either a general practitioner or psychologist may prove as effective but a less expensive form of treatment than individual doctor consultations.

More responsive education and training arrangements
The availability of traditional medical training positions in public hospitals is limited by a number of factors. Patient inpatient numbers have fallen as serious illnesses have been increasingly treated by outpatient visits. Limits on the number of hospital outpatient clinics and lengthy waiting lists has resulted in patient followup occurring increasingly in the private sector, shifting the cost to the federal government.

Currently there is no funding for private practice training. The advantages of developing such a system include:

- exposure of the advanced trainee to a diversity of clinical material now not seen in the hospital setting

- the provision to quite quickly increase the number of training positions to match the projected workforce shortfall (and to reduce it again when appropriate)

- improve retention of graduates in the "service" domain of the industry. Currently there are more full time specialists in hospital practice compared to the largely "Visiting Medical Officer" model of the previous generation. Trainees have little exposure to mentors from the private sector and tend to stay in the sector in which they trained. As the public hospitals cannot provide employment in clinical service provision many graduates move into other, currently expanding sectors such as epidemiology and administration.

The Australian Rheumatology Association have already moved towards the development of a private practice training model for final year advanced trainees and consider that the major obstacle to its implementation is remuneration for the trainee and supervisor. Negotiating an MBS fee for an initial and a review consulation for both parties would facilitate the establishment of some pilot positions which could then be evaluated.

A consolidated national accreditation regime
Specialist medical fellowships are already uder the control of a national body, the Royal Australian College of Physicians (RACP), and the Australian Medical Council have been reviewing its accreditation process. Whilst there has been criticism of the process by some trainees and other members of the broader community, we believe that the quality of medical care provided by physicians in Australia and their worldwide acceptance in the job market stands as an independent measure of the robustness of the process. Also the RACP is responding to its critics by reviewing their processes with consultation and transparency. In any event, whatever changes are made to accreditation processes must not compromise on quality.

To ensure that your proposed review groups are more than just another bureaucratic layer and provide balanced and honest decisions, the membership will need to be chosen apolitically, in the broadest sense, and with the greatest of care.

Yours sincerely,

Andrea Bendrups

President
Australian Rheumatology Association (Victorian Branch)