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Understanding the Australian health system: how it works and how to fix it.

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A Definition of Health
This may seem obvious, but health is defined as 'The state of physical, mental and social well-being, not merely the absence of disease or infirmity[1].' This contrasts with the normal definition of the health system, which almost invariably is taken to mean 'paying for the treatment of illness.' As disease patterns increasingly become dominated by lifestyle diseases and problems of ageing, the fostering and maintenance of health must increasingly think beyond the 'disease-treatment' model.

Basic Problem- Diverse Funding Sources Causes Cost-Shifting
There are a number of important elements to understand in the Australian health system. The Australian health system has a number of different funding sources: the Federal government, the State governments, the Private Health Insurance industry (PHI), the Workers Compensation (WC) and Compulsory Third Party (CTP) insurance systems, Medicare and individuals themselves. This leads to a situation where each funding entity attempts to minimise their own costs without any real care for the overall cost of the system.

Compounding this problem, it has been said that no one is in charge of the health system. The doctors think that they are; so do the health administrators and so do both federal and state governments, though these last two have at least defined their areas of responsibility. Private companies are trying to maximise their profits.

The fact that there are so many funding sources leads to a situation where cost-shifting is a major element of the health policies of each of the funding entities[2]. This leads to massive inefficiencies. Private entities such as pathology and radiology also have an interest in providing more services, whether they are needed or not.

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[1] www.publichealth.com.ng/world-health-organizationwho-definition-of-health/

[2] Examples of cost-shifting: The Federal government has let Medicare decline against inflation so that patients either need to pay a gap, use PHI or go to a StAte-funded ED. The State government used to run Hospital outpatient clinics, paying specialists a fee. This was cheaper for the patients, trained registrars and kept continuity with the hospital records. These were largely abolished so patients had to make their own appointments to see specialists for follow up clinics saving the State money. When patients visited EDs, they were given the full course of the drugs that they needed. Now they are given only a few, and a script to take to an outside chemist, creating a whole new set of costs for patient, chemists and the Federal govt's PBS. Workers Compensation and CTP insurers often refuse to approve treatments, forcing doctors to use Medicare, PHI or the patient's resources. The insurers' profits rise commensurately.

The broad division of the health system is that Public hospitals and EDs are State-funded, and non-hospital services are Federally, PHI or self (patient) funded. There is some overlap. The State has some community-based services if it allows them to save on hospital-bed days and private funds paid to State hospital inpatients are eagerly sought by the State.

Two Current Concerns: Emergency Depts and General Practice

There are currently large amounts of criticisms and scandals about elements of the health system. For example Emergency Department (ED) overload results in ambulance ramping and people unable to get Emergency Care in a reasonable period of time. Two items might be noted here:.

Emergency Departments are funded by the state, and a visit there costs on average about 6 times a GP visit, but is free to the patient. General Practice is funded either privately or through Medicare. As GPs increasingly are reluctant to use Medicare this gives a financial incentive for patients to go to the Emergency Department rather than to their GP. The Federal government's saving on Medicare has resulted in a hugely greater impost on the States and the total cost of the system is considerably increased by every ED visit that could have been done by a GP.

The other current related concern is the lack of doctors wanting to go into General Practice. This is the tip of the Medicare iceberg. When Medibank was established the doctors' rebate was set at 85% of the AMA fee. Federal governments of both colours have controlled their costs by allowing the Medicare rebate only to rise at half the inflation rate for the last 37 years. The rebate is now less than half the AMA fee. The AMA[3] fee for a standard GP visit is $90 but the Medicare rebate for a standard consultation is $39.75 (44.12%). This systematic undermining of Medicare is an extraordinary expression of bad faith by the federal government. They should have maintained the rebate relative to inflation, or they should have created a different funding mechanism. It would seem that the federal government is only concerned about its own costs or that the political parties in response to generous donations from the private health insurance industry are willing to starve Medicare to death and allow a US-style medical system to develop. This process has been happening by stealth, is already quite advanced and most Australians are unaware of its extent. The US system has been greatly criticised by public health professionals as it spends large amounts of money on expensive care for some, but leaves about a third of the population with little or no affordable care. It is, however, the most efficient system in the world for turning sickness into money, and it uses its consequent political influence to survive. The same is happening here.

Probably the best way to fix the health system would be to repair general practice, and even the elements of community support before GPs are involved. This is consistent with the general managerial principle that it is better to solve problems early and as low down in the system as can be achieved. GP expertise is currently underutilised. Improving General Practice would take pressure off the hospital system particularly if there was an emphasis on prevention so that cases did not get to the level requiring an emergency department. The simplest way to do this would be to return the Medicare rebate to 85% as it was but this has generally been dismissed as politically impossible. The Federal government does not want

[3] The AMA fee has not risen against the CPI.

this as it would mean it was taking a more expensive role in the health system that it has subtly and systematically abandoned. General Practice suffers from the problem that it is not as politically sensitive as Emergency Departments and Intensive Care units are. GPs who continue to bulk-bill have had to shorten their visits to maintain their income, undermining their patient contact, their ability to diagnose and treat and their skills and job satisfaction. Naturally if GPs got a rise, all other health practitioners would want a similar increase. The private health insurers would be disadvantaged as many patients would go back to Medicare. The specialists would be reluctant to take a pay cut as most charge the AMA rate, some charge more. The rates for the Orthopaedic Association, Workers Comp and CTP are also higher.

Alternate ways of funding general practice with salaried medical centres would be resisted by the corporate sector who have bought many general practices and take a large percentage of the rebates from the doctors who work in them. Alternate ways of funding are usually discussed in a cost context and doctors are rightly sceptical that these discussions are merely ways of avoiding the issue that the Medicare rebate needs to be increased.

On the other hand, if the issue were examined from a health delivery point of view, salaried Medical centres would also allow better integration with other community services such as Community Mental Health, District Nurses, Aged Care Assessment Teams (ACAT's) and many others who are often overlooked in a fee-for-service system. Indeed, strengthening the community support services with schools, district and community nurses, school dental nurses and vaccination nurses and support workers would solve many problems before they even got to the GP level[4]. The use of practice nurses or school nurses occurs in New Zealand with good cost-effectiveness, and in outback Australia nurses do job that are normally done by doctors and work up to their capacity rather than down to their station, which is similarly cost-effective[5]. Strengthening the allied health services is also cheaper than using medical graduates[6].

The emergency departments have problems of their own also. There is probably an absolute shortage of resources but there are a number of other factors that should be considered. Emergency Medicine is a relatively new speciality. Casualty departments, as they were called, were merely seen as a triage function. The need for Early Intervention in accidents, heart attacks and strokes has led to a situation where Casualties changed their name and focus to Emergency Departments to reflect this more rapid intervention model. The nascent College of Emergency Medicine was conscious of its political sensitivity and vulnerability to criticism and has been keen to get the resources to perform its increased task. Compounding this recently, health ministers have demanded that people be processed in 4 hours rather than 6. This has led to a situation where large numbers of Investigations are done very quickly according to protocols, rather than allowing doctors to do investigations sequentially which would lessen the number of investigations ordered. At a lecture in Dunedin Hospital[7] to emergency registrars the Head of the Radiology department

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[4] The author is not an expert on the welfare or community support systems and recommends that further expertise be sought in these areas.
[5] Author's experience in Nyngan and the Pilbara.
[6] Optometrists have replaced many ophthalmologist services, Psychologists psychiatrists, and audiologist ENT surgeons.
[7] The author attended this in 2014

protested that 99% of the scans that he did were normal and that it was a huge waste of resources. The reply from one of the registrars was 'Do you want us not to follow our protocols then?' The effect of plaintiff lawyers in the US has led to a situation where doctors are unable to use their judgement and all diagnosis must be proven by technological evidence. The medical journals have published very large studies from multiple American teaching hospitals which were fully equipped with all technologies. These protocols have assumed almost unlimited resources and a minimal input of medical officers' knowledge. This suits the technology companies that sponsored the equipment in the hospitals involved in the protocol trials- they sell more machines. It is also another example of how research priorities have been hijacked by the private sector, especially since the Wills[8] report.

Specialists

As Medicare has withered, specialists increasingly refuse to use it and charge a copayment. The specialist colleges tend to have exams to exclude people and keep their numbers below what would meet the need. There is now a long wait to see gynaecologists, ENT surgeons, Ophthalmologists and psychiatrists among others. Faced with more work than they can do, it is hardly surprising that specialists are not keen to do Medicare for a reduced amount, however worthy the sufferers. It also has to be faced that having a cartel has allowed some practitioners simply to raise their prices to what the market will bear. It is probable that the government needs to assess the number of specialists required independently and pressure the colleges and registration system to improve the numbers.

Intensive Care Units

Intensive Care units are very expensive per day and very politically sensitive as sometimes they can save lives that would otherwise not be saved. They are also favoured by doctors as they are the technological cutting edge in ward-based struggles against death and are professionally satisfying for the staff involved. They are increasingly used routinely in post-operative situations as the staffing levels in normal wards fall and the staff are increasingly deskilled to save money.

As they have the potential to absorb almost endless resources for minimal increase in the average population lifespan they need to be looked at in terms of their cost per QALY (Quality-Adjusted Life Year) obtained per dollar. Their benefit also needs to be compared with improving ambulance services, as more QALYs are likely to be saved by quick simple actions than prolonged high-tech ones. ICUs need to have admission policies and discharge policies, and these need to be integrated with advanced directives (living wills) and organ donor programs. This requires a meaningful social debate, rather than a heavy-handed political action, which is likely to have a considerable backlash.

Social determinants of health.

One US Surgeon-General[9] was asked at his retirement what was the greatest medical advance in his time. He answered 'Food stamps'. It must be remembered that clean water,

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[8] The Wills report on Medical Research in Australia was an assessment from outside the research community, Wills having a business background. His report was much praised as it advocated more money for research, which suited the research community, but it also advocated cooperating with the private sector and doing research that was more likely to be able to be commercialised. Research which was likely to save costs is unlikely to be funded,.

[9] ? Luther Terry. Food stamps were part of the 'New Deal' from 1939-43, then reintroduced by John F Kennedy in 1961. It is now called SNAP (Supplementary Nutrition Assistance Program).

nutrition and housing are vital, and probably more important to health than the health system itself.

Preventive Health

Preventive health is also far more cost-effective than therapeutics. Social approaches that minimise harm are vital. Governments should intervene to lessen smoking, vaping, alcohol consumption, gambling, unwanted pregnancy and to minimise the harm of hard drugs. Behavioural change in areas such as road and industrial safety, safe sex, and masks and quarantine to reduce infectious diseases need to be supported. The market will advertise whatever is profitable, so the government should both restrict marketing of socially harmful products and practices, and run their own campaigns to maximise social welfare. This should be done transparently and unashamedly. Obesity is a rapidly growing and serious problem, which leads to diabetes, hypertension, and cardiovascular and kidney disease. A major initiative is needed in this area, perhaps combined with a national exercise initiative[10]. Vaccination is generally good, and needs a high level of 'herd immunity' to prevent disease outbreaks in pockets of unvaccinated people, who generally tend to gather together for economic or social reasons.

Mental Health

Mental health services are in disarray. The large institutions that gave long-term accommodation to chronic mental patients were closed by Nick Greiner in NSW, but the replacement by community support services did not happen. As people become socially dysfunctional their most important need is support and accommodation. The Housing Dept, which has to prioritise its dwindling stock does its best to offer support, but this results in public housing being skewed towards the most marginalised and dysfunctional and disrupts these communities. Obviously more affordable housing is needed with graded community support services. This would also help with domestic violence issues as there would be alternative accommodations available.

It might be noted that the Prison system is very closely associated with mental health. As people become mentally deranged they may not pay rent or utilities and very likely to become homeless and can never meet the 'mutual obligation' requirements for Jobseeker, or the major hurdles for a Disability Pension, so they may not get help from Centrelink. They are then involved in petty crime and come to the Court and prison system, which is an expensive and inappropriate service system. A supported accommodation system is expensive, but far less so than the prison system or continuing homelessness which is the default.

There was interest in the effect of child care in the first 12 months of life, with one psychiatrist[11] claiming that the common factor in a number of children who had had very difficult lives but had 'turned out alright' was that their first 12 months were stable and their problems occurred later. This is a reasonable proposition, and if so, it would make a strong case for good ante-natal care and daycare, so that infants would have a stable situation for at least significant periods of time and their nutrition could be checked and supplemented if

[10] ACHPER (Australian Council for Health, Physical Education and Recreation) is the professional body for sports and recreation teachers and has generally good programs and suggestions for inclusive physical activities. www.achper.org.au

[11] Lambie-Dew Oration Sydney University 1969

necessary. The setting of norms in behaviour and early intervention are likely to be very cost-effective in developing good behaviour patterns, yet money is usually only spent when children are physically strong enough to cause significant problems. It is likely to be very cost-effective in mental health and crime prevention to have subsidised day care, kindergartens and after-school care for disadvantaged parents. This should be more thoroughly considered, especially as there is now more money for day care.

Pharmaceuticals

Pharmaceuticals are an increasing percentage of the health budget. Publicly funded research studies need to be done to ascertain the most cost-effective treatments for common problems such as antihypertensives. The dominance of the pharmaceutical industry in drug trials has made a situation where it is almost impossible for doctors to discern optimal treatments. Up until the 1990s all doctors were sent a Prescribers' Journal. This became NPS Medicinewise, a company that produced advice on which medicine to prescribe. NPS Medicinewise is being ceased at the end of the year and the Labor government will introduce a new scheme to inform doctors. (I am not clear on exactly what this will be). A number of aspects are cause for concern:

1. Many drug trials are sponsored by the pharmaceutical industry and involve very large numbers of subjects. The clinicians who front these and who are the credited authors of the papers rely on a great deal of external funding, clerical and database support and 'ghost writers' as they do not have the time to manage such a large project. If they show a negative result, it is possible that they will not be funded again. If their papers show good published results, they are often flown all around the world to strut their expertise. There is also a bias towards publishing positive results, as no one wants to read a paper that says a drug does not work.
2. It is difficult for clinicians to decide which drugs are the best because of the increasing influence of money in what research is produced. Added to this drug marketing has huge resources, and neutral information is hard to find. It is also likely that drug marketing affects the content of medical publications.
3. It is generally assumed that FDA (Federal Drug Agency -USA) accreditation means that a drug is efficacious. This is not so. There was a lot of resistance to the establishment of the FDA, so all the FDA is allowed to do is to certify that there is no nett detriment to society from approving the drug. The company seeking drug registration has to provide all their data to the FDA, but they do not have to release all that data. As one sceptical Professor, David Healy pointed out with regard to the psychometric drugs, a company could have 100 papers, 50 of which showed it worked and 50 that did not, and only publish the positive 50. Since there was a balance of data, the FDA would say that it did not overall do harm. Professor David Healy had a job offer withdrawn from a Toronto university after pharmaceutical company pressure, as that company donated to that university. Naturally all those recommending treatments[12] can only study the published data.
4. Because medical research is done with a view to marketing a product, research that will save money by using less of a certain drug is unlikely to be done. Widespread

[12] The Cochrane Collaboration is generally considered to be the gold standard of assessment of efficacy of treatments, but it relies on published data, which may be skewed if unfavourable data is not available. www.cochrane.org

comparative trials that need many subjects are not done, and trials of non-pharmaceutical initiatives, such as non-drug treatments of depression tend to be neglected.

5. Australia had a world-leading scheme of assessing not only the effectiveness of drugs, but also their cost-effectiveness. The question was, 'How many QALYs (Quality-Adjusted Life Years) were there for every dollar spent?' This was assessed by a specialist committee who worked out how much better a new drug was than the one it replaced, as a basis for a negotiating team that generally then offered to put drugs on the subsidised PBS (Pharmaceutical Benefits Scheme) if the company would meet a certain price. As the PBS guaranteed a much higher level of sales there was considerable pressure for the companies to get this market and Australia had some of the cheapest drugs in the world. Many countries came to Australia to see how this worked, and there was danger to the pharmaceutical industry that this model would spread with governments with large buying power negotiating price, rather than consumers paying what was required. After heavy lobbying of the Howard government by Pfizer, a pharmaceutical industry representative was put on the central committee of the PBS, which effectively meant that the Industry knew and could influence what negotiations would take place. The architect and Chairman of the scheme, Prof David Henry of Newcastle resigned. The issue became politicised and now new drug availability is announced by the Health Minister in a Santa Claus role with no clear connection to cost-effectiveness. Ideally this could be reversed at a Federal Parliamentary level.
6. Senator Rex Patrick has complained that Australian research grants are awarded by a very opaque process[13]. Some years ago there was a scandal as there was a collusive system where a number of researchers from a laboratory would apply for grants which together would fund the research laboratory of the Profesor who was awarding the grants.

Medical Devices

Medical devices such as artificial joints, stents and pacemakers are extremely expensive, and generally involve sales reps targeting doctors, who then merely pass the costs on to the patients. It would be good if the TGA also evaluated and approved these to use the same cost controls that should be used on pharmaceuticals. It might be noted that the prices of these vary across countries without apparent reason apart from profit maximisation[14].

Workers Compensation, CTP (Green Slips) and Sports Injury insurance

These are separate State Government insurance schemes, which fund medicine at generally higher than private rates for the workplace injury, car injuries or sports injuries. They are usually, however, seen by governments as a cost on employers or motorists, so governments tend to side with insurers to minimise costs and payouts, and not to worry if treatment denials result in cost-shifting elsewhere in the Health funding system. The effect of this is that the insurers, both iCare and the CTP insurers, spend large sums trying to avoid liability and the schemes are very inefficient in terms of the percentage of money collected relative to the amount paid out as treatment. Workers Comp schemes are sometimes

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[13] https://michaelwest.com.au/mrff-medical-fund-secrecy-is-a-corruption-incubator/

[14] www.smh.com.au/politics/federal/global-health-giants-getting-more-subsidies-from-australia-than-what-they-are-paying-in-tax-government-told-20220929-p5blze.html

government monopolies (as in NSW- iCare), and CTP may be a government monopoly as in Victorian Transport Accident Commission. Government insurers are probably marginally better than private ones, but not much. These schemes are very inefficient in terms of their overheads, as they waste time and resources determining liability, disputing liability, churning 'customers' , and then seek to have large profits. In NSW CTP some of the supernormal profits were taken back to the NSW government as 'dividend' and handed to motorists as a 'rebate' just before the 2018 State election. (My own experience is that many patients have treatment denied and suffer very much as doctors do not want to operate on them for Medicare or even private rates, as they feel that they are being asked to work for less because of insurer refusals and may later be involved in legal disputes).

Legal Aspects

Quality control of medical practice is by education, a complaints system and by tort law, the ability to sue for an adverse outcome. The right to sue for damages is a major driver of change, but works only retrospectively and is very slow. Any deficiencies identified by tort law or by coroners are quite a long time after the event, so their ability to affect common practice is correspondingly limited. The insurance system and the paradigm of finding someone at fault in order to get compensation has the effect that mistakes are covered up, rather than creating opportunities for discussion and ongoing improvements, which might prevent problems by identifying systemic issues or personnel with knowledge or practice deficiencies. The Health system has been extremely reluctant to address this issue.

A paper in the Medical Journal of Australia by Fiona Tito (later Fiona Tito-Wheatland) in 1994 looked at adverse events in Australian hospitals. She estimated that there were adverse events in 1 in 16 hospital admissions, which nationally was 470,000. Of these 250,000 were preventable and 18,000 deaths were caused. She was forced out of her position as Chair of the Professional Indemnity Review in 1996[15] when she was about to produce a report relating to this paper. As a non-medical person, she had used the methodology from other industries to estimate the likely number of errors. (The oil and airline industries have been at the forefront of the analysis of adverse events because of the significant consequences of adverse events in their areas). The key point is that medical errors are common, but because they are all swept under the carpet, systemic change does not occur. Both the legal system and the insurers benefit from the current system. But there are significant downsides:

1. Adverse events or practices are not identified or examined and so will continue until one occurs that demands attention and
2. Defensive practice occurs where every possible technology is used which generates a tremendous amount of extra costs, inconvenience and in the case of radiology, large increases in the total population radiation dose.

An alternative is to indemnify doctors and all other medical staff as long as any adverse event was reported within a time frame, say 48 hours, of a person becoming aware of it. It would be accepted that there are suboptimal practices, events and outcomes, and each report would be discussed in terms of its ability for improvement in the quality of services and the lessening of suboptimal outcomes. Obviously if there are only 18,000 deaths from

[15] www.parliament.nsw.gov.au/lcdocs/transcripts/1091/Transcript 23 March 2004 - Inquiry into Complaints handling within NSW Health.pdf pages 22-30 (termination p 28). The Health Care Complaints Commissioner, Amanda Adrian, was also sacked as part of the 2004 whistleblower event.

470,000 adverse events 'suboptimal' can be a relatively neutral term. Medical staff would have the safety that if they had reported within the prescribed period they would not be prosecuted There would have to be some method to compensate those who were adversely affected by the errors discovered and elaborated on, but if such a system were to replace the costs of expensive tort litigation there is also considerable public benefit to be had from this also.

What needs to be done to fix health in Australia?

Ideally there should be a single administration for health care with universal eligibility. This removes all inefficiencies associated with cost-shifting, and stops the distortion of services to those that are more lucrative. In a 'market' those with more money get the resources and those who lack them do not. There is also no mechanism for prioritising related to need, so trivial problems of the rich get priority over serious problems for the poor. This is already happening with the Medicare waiting lists that are over a year for many procedures that are not immediately life-threatening.

The Case for Medicare

Medicare has overheads of less than 5%, PHI about 12.5%, Workers' Comp about 30% and CTP was over 40%. That is to say, Medicare delivers over 95% of money invested to people who are actually delivering health care, whereas CTP is only a little over half. The US health funds have overheads from about 16% to 36%, most in the mid 20s. The more profitable ones are often the least efficient as the way to make more money is to have staff supervising and lessening payouts. This reduction in payouts is not evident to the consumers. It is interesting that the Productivity Commission in its report in 2015 did not mention any of these figures[16], and they are rarely quoted. One might reflect that those who want private medicine do not want these figures widely known. The figures on Medicare have not been updated for some years, which suggests that the Morrison government did not want them known. The inefficiency in WC and CTP are because of the concentration of resources on determining or denying liability or eligibility, and a very high profit level which was achieved because insurers locked in their premiums and were more successful in denying claims than their wildest dreams. The delays caused by the administrative processes and disputes also result in huge amounts of extra costs that do not show in the health figures. It might be said that all monies spent on determining liability are unnecessary waste, when compared to a universal system. Profits are also waste, and adding a financial incentive makes the system have two objectives, money and health, instead of merely health. The assumption that making money is necessary to motivate people and render the system efficient is a very dubious proposition if one considers how hard people work on salaries in public hospitals.

Medicare Rorts

Medicare Rorts have had a lot of recent publicity. Despite the fact that the Medicare rebate to doctors has practically halved, the stories were about doctors ripping off the system, rather than the system failing because of the government ripping off doctors. When Medicare started there was a lot more emphasis on stopping doctors ripping off the system, but this was not pursued[17]. Given that General Practices cannot survive on bulk billing, it would be

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[16] This may be because the round table was merely a selection of the stakeholders in the system. Efficiency in Health Productivity Commission Report April 2015 ISBN 978-1-74037-545-0

[17] The Health Insurance Commission (HIC) was tasked with policing Medicare so that doctors did not abuse it. When Medicare was established it had a state of the art system, which was even before

remarkable if doctors had not made some adjustment. As stated, GPs have let rooms in their practices to pathology companies at above market rents to keep the practices viable. The pathology companies are keen to recover these rents from the surgeries that they are paying the high rents to. This alone probably costs the government more than it saves on the GP rebate. The commonest GP response, however, is to work within the system and shorten visits so that more can be done, making the patient attend more frequently if necessary, which obviously inconveniences the patient. Corporate practices also take a high percentage of the total income, again squeezing the GPs, who are pressured by both Medicare and their new 'employers' to increase their throughput or bill more expensive items. It is likely that these are significant factors in overservicing. The idea that making money is necessary for good medicine is simplistic and wrong.

Specialists have also rorted the schemes as many item numbers were set up so that a whole operation was covered by a single item number. Some specialists then add an extra item number. There are also add-ons, such that if an extra cut into another structure is required, it was assumed that the operation was more extensive so a higher rebate was obtained. A tiny unnecessary cut could then be made to get the extra rebate, and when the operation was over there was no way of telling what was necessary. I am unsure if this has been addressed in the Medicare Rebates Review, or if it can be. Medicare is now in a position that it is lucky if the specialists use it at all in that they have the option not to. Pursuing a few high profile obvious fraud cases is unlikely to fix the systemic problems.

How Much Money Should be Spent on Health?

Australia spends 9.4% of GDP on health, which is little above the OECD average of 8.8%. The effectiveness of this spend is what is questionable. Some years ago, research by AIHW (Australian Institute of Health and Welfare) compared GDP per capita, health spending and the number of doctors with the two most basic health outcomes, life expectancy and neonatal death rate across all countries. The interesting conclusion was that the two indices improved with income up to a national per capita income of $5000, but after that the improvement related to the equity of access to health care. There was also no correlation between the number of doctors and the two indices.

A international by the study by the Commonwealth Fund comparing[18] 11 countries health systems concluded:

Four features distinguish top performing countries from the United States:

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google started using algorithms. Neural networks were used and the HIC got a Prime Minister's Award. When Brian Howe was Health Minister (1991-93), there were 20 GPs, 20 Specialists, 30 Pharmacists, 30 Police full time as well as cooperation with ANOA (Aust. National Audit Office). Doctors were given feedback as to how their practice patterns compared with the national average, which both helped them and also told them that they were being observed. A single letter reduced pathology services by tens of millions of dollars. De-identified data on rip-offs was shown to the AMA who then also supported action to stop doctors ripping off the system. Patients had to be given a summary of their treatments with the item numbers that they had been charged for. This made it harder to charge for services that had not been given. A review of the HIC in 1995 recommended that the HIC be strengthened and Medicare get a new computer. John Howard stopped the new computer and abolished the HIC. Source: John Nearhos

[18] https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly

1) they provide for universal coverage and remove cost barriers;
2) they invest in primary care systems to ensure that high-value services are equitably available in all communities to all people;
3) they reduce administrative burdens that divert time, efforts, and spending from health improvement efforts; and
4) they invest in social services, especially for children and working-age adults.

These are very important conclusions and Australian legislators would do well to remember them!

The high-tech areas of health, which are the most politically sensitive and of most interest to doctors professionally and the technology industry also, are often the least cost-effective. Less expensive initiatives like school dental nurses, community nurses, and good ante-natal and post-natal care are far more cost-effective than technology-intensive late interventions in terms of the number of QALYs per dollar.

In terms of a framework to think about health objectives for politicians, these differ very much from the standard political considerations. Intelligent management of the health of the population would have minimising the need for medical interventions as its key objective, and then trying to make these interventions as cost-effective as possible. So the hierarchy should start at the social and preventive end of interventions.

Objectives

1. Improve basic determinants of health, clean water, sanitation, good food and housing.
2. Improve community support for people in need due to any disadvantage.
3. Educate the population in how to achieve good health in terms of their food and lifestyle choices, and actively intervene against unhealthy promotions of food, drugs, alcohol and gambling which are likely to have adverse health consequences. ;
4. Make maximum use of community and school interventions and support services such as District and Community nurses and School nurses, mental health support networks, Aged Care Assessment Teams, Hospitals in the Home etc.
5. Keep high levels of swimming lessons, first aid and CPR training in the community.
6. Keep vaccination rates high.
7. Create a registration and insurance system for home and community support services, so that individuals can offer and pay for standardised services from other individuals. This will increase the participation rate and lessen the oligopoly situations where the organisations providing services make far more money than those doing the work and grossly increase the costs.
8. Create a meaningful regulatory, inspection and enforcement system for support services, both community and residential, and for workplaces and recreational facilities.
9. Maintain fixed staff-patient ratios related to the disability classification of residents.
10. Enable better communications between different disciplines within the welfare and health systems.
11. Solve all problems as early and as low down the treatment hierarchy as possible.

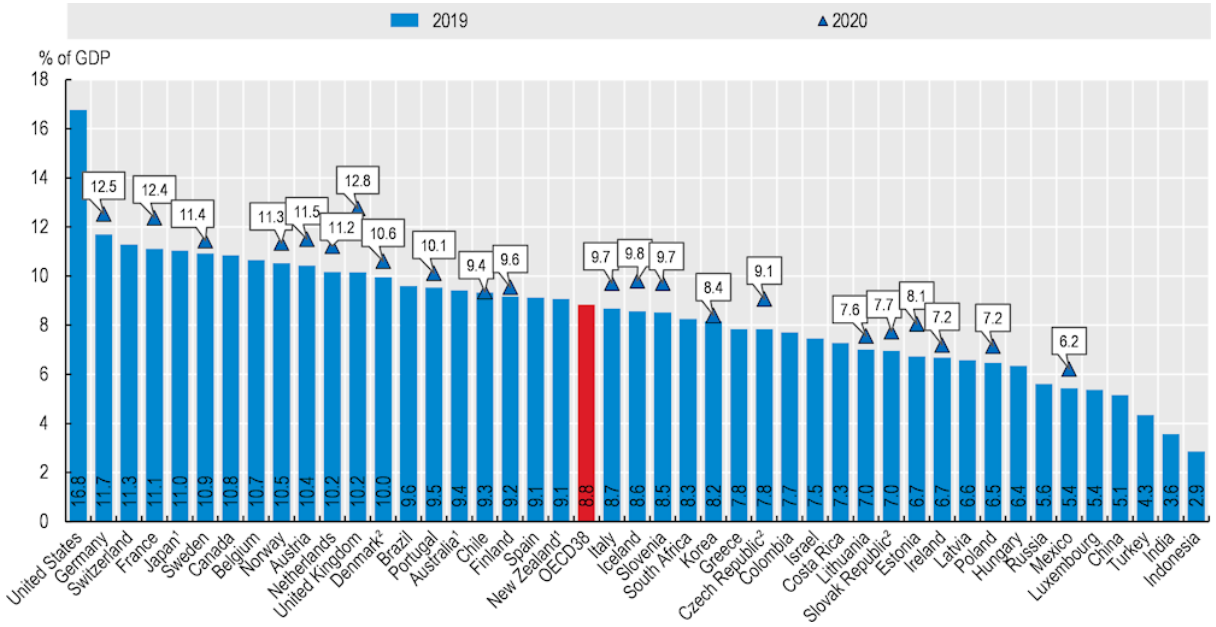
12. Support General Practice and try to increase their ability to solve problems without referral. Have GPs work in health Centres with community support workers as far as possible to improve communication.
13. Have independent evaluation of the numbers needed in the specialties and pressure the colleges to provide these numbers. Use waiting times as an initial index.
14. Initiate either university-based or college-based continuing medical or professional education with mandatory refresher exams every decade.
15. Have universal professional indemnity insurance with doctors and other health professionals unable to be sued if they reported all incidents of suboptimal outcomes within 48 hours of their becoming aware of them, and participate in regular quality control meetings. Have systematic discussions of suboptimal outcomes as part of quality control.
16. Maintain a good quality ambulance and air-ambulance service, the latter unconstrained by State borders.
17. Make medical data collection a by-product of normal work, not an additional imposition. This will require far more user input to the information management systems.
18. Abolish time frames and allow Emergency Doctors more professional scope in the work[19]. The use of protocols that require large amounts of investigations must be discouraged.
19. Publicise organ donation, wills, end of life plans and enduring powers of attorney as sensible steps in life management.
20. Evaluate Intensive Care interventions in QALY terms, researching their outcomes and comparing them to earlier intervention initiatives.

Financial Initiatives

1. Work towards a single, universal taxpayer-funded health system that is free at the point of delivery.
2. Return the Medicare rebate to 85% of the AMA fee, and create multidisciplinary Health/Medical centres with salaried staff .
3. Increase rebates for optometrists, physiotherapists and psychologists also.
4. Stop subsidising inequality in the health system such as Private Health Insurance.
5. Change the Pharmaceutical Benefits Advisory Committee such that it has no pharmaceutical industry representative on it, and remove ministerial discretion from its decisions.
6. Work towards replacing Workers Compensation and CTP insurance schemes with income guarantee schemes. (This will only be possible when Medicare allows rapid treatment- which is in no way the case at present).

[19] The current need to report all cases that took longer than a certain time to Ministers is an appalling waste of time. Many cases exceed the times and each report is written as if it is an exceptional case, which it is not. Thousands of reports are written and very few used- only the ones where a complaint gets to a ministerial level. The current system is just to protect the Minister.

Appendix 1: Health Spending by Countries



Submission to Special Inquiry into Healthcare Funding

Part B- Specific points on the Terms of Reference

Dr Arthur Chesterfield-Evans

This submission makes some general comments about the terms of reference, the expertise of the committee and the need for the committee to seek submissions, not merely to see what turns up. The author then tries to make broad comments related to the functioning of the health system within the terms of reference of which he has some knowledge. The author did not train as a GP and did not take the opportunity to be grandfathered in when the RACGP was set up. Later the differential Medicare rebate for RACGP vocational registration was introduced, so the GP patients that the author sees are remunerated at the non -vocationally registered rate. The author is thus acutely aware of the dereliction of the Federal government in its lack of support for Medicare and its endeavours to shift costs elsewhere. He minimises his GP work accordingly.

The management and structure of the NSW health administration system is not an area of his expertise except as it impinges on aspects of general practice, workers comp or CTP.

General Concerns

The author is concerned that even before the terms of reference, the title of this inquiry is 'Healthcare Funding'. The political concentration on the financial aspects of healthcare have been the main factor in the dysfunction of the Australian healthcare system, a point that was made in part A of this submission. To put it simply, it is better to do the right thing badly than the wrong thing well. Because the unstated policy of each part of the health system is to shift costs elsewhere many procedures are much more expensive and complicated than they need be[1].

The lack of either simple prevention or simple cooperation with relatively simple treatments will create the need for expensive late ICU interventions. Administrative cost-shifting which distorts optimal initial resource allocation cannot be overcome by optimal financial management in one sector. It is vital that the committee look at what is actually done, and not merely how well it is financed.

The author notes that the committee has many lawyers and only one doctor who has worked in a specialty and has had minimal recent patient contact. The legal system has a model that it assesses the evidence brought before it. It is necessary that the committee gets evidence as to how to do good medical management, but also how to minimise the need for costly medical care. The legal model which just asks for submissions and evidence and then questions those who turn up is simply inadequate.

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[1] E.g. The Federal government starves Medicare so patients go to the ED. The State government abolishes outpatient clinics to force patients to go to a specialist on Medicare or privately. The EDs and hospital discharge gives patients only a few tablets and a script to minimise the State drug costs. The patient then has to visit the chemist with the script to transfer the costs onto themselves and the PBS.
All of these activities increase the total cost of the system.

A recent example was an inquiry into the Motor Vehicles Act 2017 which was conducted by Clayton Utz and Deloittes and completed in 2021[2]. The purpose of this Act is to treat people injured in Motor Vehicle Accidents, though the most recent amendments also added some income-guarantee provisions. The CTP system is dysfunctional in the sense that it delivers very poor medical outcomes at very high cost. One might have thought that this was a problem of poor medical management of the injuries and that an examination of the same should be carried out by a medical administrator with a track record of competence. In fact the review was carried out by lawyers and accountants. It received minimal attention in the medical press. There was minimal medical input and none from any medical administrative body[3]. There were a number of 'injured person' confidential submissions which were likely to be from patients who had been dudded by the system, but were too scared of the insurers to give their names. The author's submission was the only one from a practising treating doctor. The author felt that his submission was taken into account in the final report, but insurers retained the ability to make their 'management plans', which usually merely state the roles of doctor, patient and insurer as they would like them. There is also no penalty for treatment denials, so these remain very cost-effective for insurers and of course are catastrophic for both the patients and the effectiveness of treatment within the scheme. Had there been more input from treating practitioners this aspect may have had more attention and the key problem of the scheme would have featured higher in the recommendations.

The author notes that society is structured into subcultures or silos. What is well-known in one group as axiomatic may not be recognised by another. Deficiencies in the breadth of submissions are likely to result in suboptimal reports and the closer to the coal face the information comes from the greater its authenticity, even as its scope narrows. Those involved in management or dispute resolution may not be the best people to get to the root of problems. If strenuous efforts are not made to get input from clinicians and preventive and social health practitioners the report is unlikely to save money. It is not enough merely to call for submissions and then evaluate what turns up. Information must be sought.

The author is not able to comment on the workings of medical administration in NSW, except to comment that this is almost invisible in general practice, which may be part of the problem. A relevant tome is 'The Political Economy of Health Care' by Dr Julian Tudor Hart, which traced the history of the British NHS from its idealistic beginning when it was largely managed by those doing the job through a long series of 'reforms', each of which increased the percentage of money going to managers with no real improvement in medical outcomes, even when about 35% of the budget went on management. The privatisation of the NHS has further worsened this as its functions and budget were stipulated by contract and it was hampered in being unable to have a stronger and more flexible response to the Covid epidemic.

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[2]www.sira.nsw.gov.au/__data/assets/pdf_file/0017/1031390/Statutory-Review-of-the-Motor-Accidents-Injuries-Act-2017-Report.pdf
[3]ibid. Page 124

Discussion in relation to the terms of reference:

The terms are in Times Roman font, the submission in Arial font

The funding of health services provided in NSW and how the funding can most effectively support the safe delivery of high quality, timely, equitable and accessible patient-centred care and health services to the people of NSW, now and into the future;

There needs to be a major shift in emphasis towards preventive health. The funding of healthcare at first depends on the maintenance of health, so that the disease burden and load on both the home support system and the health system is minimised.

The extent to which this is State as opposed to a Federal responsibility needs to be addressed. Medicare, the NDIS, Disability services and Jobseeker are Federal. But if Centrelink refuses payments because of issues like non-compliance in Mental Health cases the problem immediately becomes a State one and often ends up in the Prison system at great expense. The increasing gap between rich and poor and the inadequacy of Federal welfare payments needs to be addressed by all State ministers who end up picking up the pieces.

There is also a question as to what extent problems are in the Health portfolio. If there is insufficient housing, there is a problem of homelessness and domestic violence as people have nowhere to go. Children who have to move often are more likely to have problems later, which may spill into the Health portfolio, even if they do not start there. The health system may be a shining light, but at times it is the garbage bin of society's problems and similarly the ICUs may be expensive garbage bins of unsuccessful or inappropriate medical care.

The State must build more housing and try to de-commodify housing. Negative gearing and the cuts to the Capital gains tax have made housing a relatively stress-free way of making easy money and this has been the major driver of high property prices and rents. The capital gains tax must be returned to its previous level and negative gearing only allowed on new properties. This must be urged on the Federal government by a concerted effort of State ministers.

Another example is the increasing problem of children drowning. It is not in the health portfolio, though it is a health issue. The problem is that there is not a willingness to teach all children to swim and the expensive private swim classes exclude disadvantaged children. The health portfolio needs to address this with the Education Dept.

Because the systems are complex and interact and there are now universal databases such as the electronic medical record, it would be possible to do research and monitor the effectiveness of services, both Federal and State. This could be given to a Social Issues Research site on a long-term contract. Universities or the Australian Institute of Health and Welfare might be willing to do this. It is likely to discover some embarrassing things, like the quantification of inadequacies in the welfare systems, or the high incidence of State wards and mental health patients ending up in prison, but it would allow a more evidence-based approach to social support which is likely to save money and improve society and its health in the medium term.

The need to support people in the community is an imperative as the population ages and people with disabilities try to become more integrated into society. What is needed is a 'graded response model' where initially only a little support is needed, but this can grow should the situation worsen. The question is 'How is the communication made between the health system and the citizen, and between elements within support services?' It should be noted that GPs use a relatively small number of software programs to run their practices and the electronic medical record harvests a great deal of data from this which could be used much more intelligently. Community nurses cover geographical areas and there are other teams active, such as the Older Person's Mental Health Network, Mental Health Community nurses, Aged Care Assessment Teams (ACAT), and volunteer services such as Meals on Wheels. It is suggested that Community Nurses and GPs be the basic groups to link people to the health system but both of these will require extra help and resources to take this role. The electronic medical record software may need to be adapted and augmented, and integrated into the routine work of the practitioners. This process would need to be developed by its GP and nurse users, not imposed from a central IT department. The electronic medical record in its current form is useless to this GP. (The track record of government internet-based medical programs is frankly dismal; they are complex, unfriendly and unhelpful to the user, overbearing in tone, and have to be accessed separately from the normal run of work[4]).

B. The existing governance and accountability structure of NSW Health, including:

i. the balance between central oversight and locally devolved decision making (including the current operating model of Local Health Districts);
ii. the engagement and involvement of local communities in health service development and delivery;
iii. how governance structures can support efficient implementation of state-wide reform programs and a balance of system and local level needs and priorities;
iv. the impact of privatisation and outsourcing on the delivery of health services and health outcomes to the people of NSW;

The privatisation and corporatisation of GP medical practices has meant that doctors simply gave a large proportion of their incomes to the corporations that own the practices. This is at times as high as 55%[5]. This has also been the case in dentistry where corporatisation has greatly increased the price to patients. If health centres were set up by the government it would have the advantage that there could be an integrated services model with use of allied health professionals and better community liaison. GPs could be on salaries. Obviously the question of State v. Federal funding would be critical, but it would be possible to have different disciplines funded by different levels of government in the same premises. These could be trialled in disadvantaged areas initially where there was demonstrated need and inadequate services existing.

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[4] The registration of a drug-dependent patient is a good example of this. Although GPs have to get permission from Canberra to prescribe drugs of addiction, there is also a duplicate requirement for a State registration system with an 8 page form to be filled out and the threat of deregistration if this is not done. It becomes totally uneconomic under Medicare to have any drug-addicted patients.
[5] Personal experience

   v. how governance structures can support a sustainable workforce and delivery of high quality, timely, equitable and accessible patient-centered care to improve the health of the NSW population;

B. The way NSW Health funds health services delivered in public hospitals and community settings, and the extent to which this allocation of resources supports or obstructs access to preventative and community health initiatives and overall optimal health outcomes for all people across NSW;
C. Strategies available to NSW Health to address escalating costs, limit wastage, minimise overservicing and identify gaps or areas of improvement in financial management and proposed recommendations to enhance accountability and efficiency;

The author has no insights into minimising overservicing, but would comment that there is huge amount of underservicing, which is a far greater problem. It seems that more money is spent trying to stop overservicing than there is to be saved from overservicing, and those who 'police' supposed overservicing should have their activities closely monitored as they waste money on a frequently non-existent problem.

D. Opportunities to improve NSW Health procurement process and practice, to enhance support for operational decision-making, service planning and delivery of quality and timely health care, including consideration of supply chain disruptions;

The cost of prostheses is much higher in Australia than elsewhere. Ideally the TGA would call for tenders, select some prostheses and subside them as happens with the NHS. This should happen at a Federal level, but if all State ministers were to demand it it would be likely to happen. This could be done for joint prostheses, hearing aids, cardiac pacemakers, glucose monitors etc. A really radical idea would be to hold a design competition for an item, such as a hip prosthesis or cardiac pacemaker, then put the design out to tender for enough to supply NSW hospitals. With a critical mass of relatively cheap product, a new benchmark could be set in the market. Obviously the people who would install them would have to be in the selection process. Currently the practitioners who select them do not care about the cost as they merely pass it on, but the cost is limiting to the number of operations done in public hospitals. The marketers have a big incentive to exaggerate the benefits of minor differences between products.

E. The current capacity and capability of the NSW Health workforce to meet the current needs of patients and staff, and its sustainability to meet future demands and deliver efficient, equitable and effective health services, including:
   i. the distribution of health workers in NSW;

The distribution of services in a private system is largely determined by economic factors, whether there is a sufficient number of patients to support an activity. The fact that Medicare rebates are at such a derisory level means that in poorer areas, it is simply impossible to run a practice on Medicare rebates. In the city, GPs shorten their visits and do more of them to try to compensate for this, but in the country where people often present later and with more complicated problems there are huge economic disincentives for doctors to go there. An obvious solution is for all State health ministers to demand that the Commonwealth put the Medicare rebates at a reasonable level to stop the massive cost shift onto the State and private funders. The Federal government is starving Medicare to please the private health

interests and party donors when a free universal health scheme would be to the benefit of all Australians, as was originally envisaged when Medibank was created, then revived as Medicare. State health ministries also suffer under this cost-shift model and should band together to get a functional Medicare. Obviously taxes would rise, but subsidies to private health insurers could be stopped and people informed that they could save on PHI, so it would be politically saleable. The Medicare rebate was increased to fund the NDIS (which is currently being systematically scammed to the tune of billions of dollars), so people will accept tax increases if they think that they would not need PHI.

The distribution of health workers is also modified by factors such as isolation, as practitioners do not want to work alone, or may not want to raise their families in isolated environments with perceived poor schooling. Governments can improve the situation by having medical centres with salaried staff and rotations that allow more flexibility of employment. Isolated practitioners have trouble getting time off as they feel that they have to help. This is both a problem at nights and weekends and for taking holidays. Staff in isolated locations tend to work up to their capacity, whereas in the hierarchical system of teaching hospitals they work down to their stations.

ii. evaluating financial and non-financial factors impacting on the retention and attraction of staff;

Job satisfaction and a feeling of being supported in clinical decisions is very important for the morale of staff. Because teaching hospitals are highly competitive with a hierarchical system with annual contacts and fewer jobs as residents progress, they can be quite a toxic environment. In smaller or more remote hospitals staff are aware of the difficulties and tend to support each other far better. The level of competence of some of the older nursing staff is also impressive as they have frequently had to deal with situations that medical staff would have dealt with in larger facilities. Some of them are very pleased to have a doctor at all and willing to support the younger staff. The problem is to have this support available. The younger doctors relish the challenge, but fear making errors, so a balance must be reached. Ideally there would be key competent staff available onsite, but a good telehealth system that could help young residents rotated to country centres might allow experience of younger doctors in smaller hospitals. The communities are also often very welcoming so mechanisms should be created to make even doctors working on rotations to meet local people socially. This is the case for allied health professionals also. The idea of a better professional indemnity scheme was mentioned elsewhere in this submission- (Objective 15 in Part A). It is important that management supports and is seen to support staff and that rules and KPIs do not impair work[6].

[6] The author had experience of one busy ED where management decided that doctors were not working hard enough and they would keep a KPI register of how many patients each doctor saw. The result of this was that doctors looked at the triage sister's provisional diagnosis and took the easiest cases, leaving the more difficult ones. No doctor would help anyone else with difficult cases so cooperation, sharing and learning experience was lost. Towards the end of shift, no one wanted to take a case that would take a long time. Coming on duty, no one wanted to take over a case as each case was only counted once and this would impair the relieving doctor's tally. So doctors were pressured to work unpaid overtime to 'finish' their cases, which is why they did not want to take them on near the end of a shift. The ED department became almost totally dysfunctional and a very unpleasant place to work. Management seemed blissfully unaware.

iii. the role and scope of workforce accreditation and registration; the skill mix, distribution and scope of practice of the health workforce;

APHRA maintains registration. It also monitors CPD points and supposedly maintains standards by a quasi-judicial process and striking people off. It does all of these functions badly. It is very expensive with minimal benefit to the average practitioner, so one is left wondering if it is a very cumbersome bureaucracy or a revenue-generator for the government. It monitors the CDP points but the College cartels and the AMA keep the registers of these points, again as a tidy little earner. The points are merely a list of accredited activities. APHRA should keep the CPD register as part of the registration process. Apart from demanding proof of CPD and deregistering people, APHRA does precious little to improve medical standards in Australia. It has been a complete farce for non-accredited GPs who are ripped off by Medicare and have not even had a place to register their CPD points. APHRA has just fixed this problem in their usual way- pushing the problem back to someone else, in this case the non-accredited GPs, who can now be ripped off by the RACGP that excludes them, or the AMA, which has done nothing for them and mainly helps specialists in private practice. CPD points themselves are often something of a farce. Drug companies fund talks about the superiority of their products, private hospitals have specialists talk to GPs to get their referrals, colleges have their own meetings which act to maintain their cartels, and a few others run 'for profit' seminars. Universities seem to have bowed out for some reason. GPs can choose their CPD points on any subject, useful to their practice or not. Continuing medical education should be put into a proper framework with lists of skills for doctors in different roles and CPD tailored appropriately. AHPRA collects the scope of practice already and should have guidelines worked out and delivered at reasonable cost by colleges and the universities. APHRA's disciplinary actions are similarly farcical. When there is a complaint it takes years to resolve, putting immense strain on practitioners and their practices. So they give little guidance or help, muck people around and use deregistration as the sanction that supposedly proves their worth. State ministers should demand that APHRA does a better job of maintaining standards, as they should not have to duplicate its function. State administrations could set up their own training systems and requirements by negotiations with the colleges and universities and it would improve health care in their states which may be cost-effective, but ideally this should not have to be duplicated by each state, though it might be noted in passing that NSW has duplicated the Federal system in keeping track of patients on high doses of narcotics and monitoring prescribing doctors (as mentioned above in another context). If the State wants to monitor doctor standards and behaviours, it would be useful for it to create a register of CPD points. This would be useful for doctors in training, and other doctors would then merely be an extension of that system. Hopefully doctors in training are already attending as many training sessions as they can and their progress can be measured by the colleges as they pass their exams.

From a GPs point of view it is also hard to find out who does what surgery or which specialists do certain areas. There is an increasing amount of marketing and a reluctance of practitioners and private hospitals to share their fee structure with the GPs. Older specialist practitioners with good reputations have long waiting lists while younger ones who are quite competent tend to languish until they can build up a reputation. A register of which specialists do what and at what fee would be very helpful, even if it were voluntary. Currently patients have to 'ring around' to see what specialists cost and what extra fees will

be incurred. Some patients ask for a generic referral for a service and then research it themselves, others ask the GP for some names and try to find out the cost, returning to the GP for a definitive referral once they have made a choice. Others simply go to the one chosen by the GP and pay what they charge. Hence a register to inform the GP would be an improvement. Obviously the best solution would be to have a functional Medicare, but this seems impossible at present- we are going the US way by stealth.

iv. the use of locums, Visiting Medical Officers, agency staff and other temporary staff arrangements;
v. the relationship between NSW Health agencies and medical practitioners;
vi. opportunities for an expanded scope of practice for paramedics, community and allied health workers, nurses and/or midwives;

Locums and temporary arrangements are merely an indication of failure of normal staffing arrangements. The fact that the market fills a gap at vastly greater cost shows that a fair, balanced and workable bureaucratic system is much cheaper than a market one. The use of FIFO (Fly In Fly Out) specialists in areas where there is not enough population to support full time specialist work is defensible on equity grounds.

Ideally everyone in the health system should work up to their capacity rather than down to the station, though this is difficult to achieve. Cooperation is better when everyone is salaried as there are no financial incentives distorting priorities. Older people with multiple medical problems and mental health are examples of GP cases that take longer. If there is a good relationship with allied health staff, management can be optimised, especially if allied health is well integrated into community service delivery. Under the current Medicare arrangements GPs have to minimise the time spent, confine themselves to the immediate problem and have no time to get to know community-based services.

vii. the role of multi-disciplinary community health services in meeting current and future demand and reducing pressure on the hospital system;

The key problem is that hospital-centred management have little idea of medicine outside the hospitals and see the outsiders' role as somehow magically reducing demand for their institutions. Perhaps if they were forced to manage a few community medical centres in their management training they might do better. Obviously the different structures and funding limit the scope of community centres and GPs to limit ED demand There is now a copayment for MRIs and many diagnostic tests in the community as well as delays. The EDs do these for free and often when they are needless because the patients have to be discharged within a short time frame and the ED doctors follow protocols to minimise their potential legal liabilities should they miss something. Until these distortions are addressed, the abilities of community-based facilities to replace EDs will be limited.

viii. opportunities and quality of care outcomes in maintaining direct employment arrangements with health workers;

The phrasing of this term of reference suggests there are intentions to define outcomes and reward them in KPI (Key Performance Indicators). These tend to distort priorities towards what management think will be best, and usually give priority to money saving or throughput. It is better that medical staff set the priorities based on what is best for the patients than

have external factors impinge on their decisions. Salaried medical staff have the advantage that their clinical decisions are not influenced by pecuniary considerations, but there is always a reluctance of governments to provide salaries. One would have thought that doctors would abandon the derisory Medicare payment system if a decent salary were offered, but the Federal v.State funding problem would need to be addressed. There is also now a residual distrust of government as they have abused their monopoly power to lower the Medicare rebates as well as salaries of nurses, teachers and public servants generally.

F. Current education and training programs for specialist clinicians and their sustainability to meet future needs, including:
    i. Placements;

As stated above trainees, probably including later years medical students should have placements in smaller or country hospitals to gain experience of the life and challenges there. See above for more detailed comment.

    ii. the way training is offered and overseen (including for internationally trained specialists);

The limited training positions were used by colleges in a cartel way to control the number of practitioners in their specialty. A certain number of registrars were ‘accredited’ to fit into those jobs. The story was that they could only supervise and train a certain number, but in the author’s experience there were some jobs in the hospitals that were on the same roster and had accredited and non-accredited registrars doing the same jobs. Clearly the accreditation of the individuals rather than the jobs was cartel behaviour, as those registrars in ‘non-accredited’ jobs were not progressing towards being able to sit the examination.

In the UK NHS consultants on salaries were reluctant to come into hospitals after hours so there was more reliance on junior registrars. The jests that it was a ‘See one, do one, teach one’ system, and that ‘You are the most incompetent fool in the daytime, but at night you can handle anything’ had quite a lot of truth in them. But there is a middle road and the author’s experience was that registrars’ expertise was underutilised in Australia. The transfer of surgery from the public sector to the private has made registrar training more difficult, but the author does not have recent experience in this area.

In the author’s experience, the clinical placements of foreign graduates were an exploitative disgrace. They were attached to hospitals for no pay in the hope that they would be noticed and supported when they later applied for a job in the health service. There were staff without them, so they had little to do and it seemed that few of them were actually employed later, though the author has no knowledge of the success rates of this scheme. If they had work to do, it was presumably because the system was short-staffed and then they would be working unpaid and without anyone having certified their skill level. The author is unsure if this scheme still exists. The issue of the quality control of foreign graduates needs to be tackled at a national level and should be addressed by the Health Ministers COAG meetings. The colleges have to be recognised as cartels who are often interested in excluding competition and controlling specialist numbers. It might be a good idea for a task force to be set up to evaluate either foreign medical colleges or individual practitioners and produce usable guidelines for specialist doctors by the bedside.

iii. how colleges support and respond to escalating community demand for services;

As stated above the colleges act as cartels and restrict the number of graduates. They have traditionally done this by limited accredited training positions. There are now shortages in many specialist areas, (though it is significant that the RACGP cannot even fill its training positions). Governments should get a specialist body, such as the AIHW to assess the number of specialists needed in each area and to insist that these either be trained or imported within a reasonable time frame. If there were a decent register of waiting times, this would help the assessment of current skills shortages. Many jobs done by specialists could be done by GPs and some other professionals can replace specialist functions. Examples of this are optometrists taking some of the work of ophthalmologists, audiologists ENT specialists and midwives obstetricians. Skills older GP have are being lost by younger graduates because of lack of time and training so specialists are taking over simple tasks at higher cost. This could not be corrected overnight and there are both economic and structural impediments to this, but there is potential for savings with a lot of minor procedures. The current shortages could be assessed, but the provision for future needs, such as more geriatricians for an ageing population needs to go beyond this. The market or laissez-faire model which appears to be extant is not satisfactory.

iv. the engagement between medical colleges and local health districts and speciality health networks;

The author is not a member of any college and suffers discrimination because of this with the differential medicare rebate. The AMA fee is $89 for a standard visit. The Medicare rebate is $37.50 for vocationally registered GPs and $21 for non-vocationally registered GPs, who mostly do GP work anyway. As stated above the RACGP and AMA want to charge a large fee merely to record the CPD points which the AHPRA now insists be kept on a register. Colleges only look after their members and generally behave like cartels and do not want people outside their specialty to have their knowledge. Specialists run GP training principally to get referrals. Colleges should have it made clear that they have a more universal obligation to share their knowledge generally in the medical profession at reasonable cost.

Local health districts are mostly invisible in normal GP practice. The author is not able to state what they do. In some specialist areas, such as mental health, pain management and dental health they act to refuse patients from outside their geographical areas and the GP phones around for someone who will help their patient.

Specialty community health networks are valuable in support for mental health, support for post-operative patients, breast and cervical screening and in aged care assessments. Specialist services like hospital outpatient clinics are difficult to access with long waiting times. The wait to see a neurosurgical outpatient service anywhere was 7 months with a further 13 months until surgery that was obviously necessary at the first visit was carried out. The waits for Sleep clinics, pain clinics, gynaecology services, ophthalmology, ENT, balance assessment and dental care are similarly poor.

v. how barriers to workforce expansion can be addressed to increase the supply, accessibility and affordability of specialist clinical services in healthcare workers in NSW;

Hospitals used to have outpatient clinics where patients could be referred to specialists.They were largely abolished so that patients would go to specialists' rooms under Medicare or for a private fee, a State to Federal or private cost-shift. This meant that there were less patients for training medical students or registrars and registrars also could not use their expertise fully. In that clinics are cheaper per patient than private rooms, the federal government may be willing to help fund these clinics, though presumably they will also be keen to have this as a cost-shift to the PHIs. From a GP point of view many patients cannot afford to see specialists who currently will not see Medicare patients or who have a large gap fee that the patients cannot afford. There are also quite a lot of people who are recent migrants or on student or work visas who do not have Medicare at all and simply cannot access medical services except at EDs. When they are injured in MVAs or work accidents (as they are doing the least safe jobs for often subaward wages) they have huge difficulty accessing medical services and are forming a new underclass. Functioning outpatients departments would take pressure off EDs as well as helping social equity and providing timely treatment. Obviously waiting times would have to be realistic.

G. New models of care and technical and clinical innovations to improve health outcomes for the people of NSW, including but not limited to technical and clinical innovation, changes to scope of practice, workforce innovation, and funding innovation; and

This sounds like a catch-all term for any other ideas. See above for the author's efforts.

H. Any other matter reasonably incidental to a matter referred to in paragraphs A to H, or which the Commissioner believes is reasonably relevant to the inquiry.

No further comment, but the author does again urge the Committee to seek information from treating practitioners and not merely those who submit.