

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 accessible*) 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 Deficiencies 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 pseudo 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 in 1974 Massive wage increases mounted up to 17.4% 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 the Cities 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 surgery's In Victoria The Bush Nursing Hospitals :-5 to7 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 Previously 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 bureaucracies.
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 family Doctors 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 to live on .

By 1979 all our trainees in Medicical Practice , including the
business side of our practice and even 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 , expendables 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 Adequate 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 convenient for the locals!

Fifthly Work this out on an hourly basis so that we can
consult One or not more than 4 patients per hour. And Afford to
mount and run 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 RACGP trainees.

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) of 20 % and after hours large additional costs. 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.

My extensive enquiries into **net incomes** bearing in mind the personal responsibilities today, plus the low purchasing power of the Australian Dollar produced a figure around \$150.000 (Tax \$ 56.300) Cost \$102.81 for each *earning hour*!(1459).

Costs Updated infrastructure etc.etc.etc.\$ 274,000 upwards each year. Gives \$ 187.80 to each **Earning hour (1459)**

Total \$290.60 per hour . {quite low}

Bulk billed Rebate \$ 188.70.per hour, for 6 standard consultations .

Gap \$!64.80 per hour, maximum

4.consultations(Rebate\$125.80) per hour or two or even one for mentally ill patients ,always grossing the same \$290.60 per hour!

Canada who helped Bill Hayden set up Medibank etc, are now expecting their citizens to make financial contributions towards their health (Doctor) costs and require their provinces i.e Quebec etc to create insurance facilities to that end, to cover the gaps .

After hours and weekends of course create gigantic increases in costs! To be assessed later!

Again the years of dedicated massive training and life long tremendous personal responsibility to each and every individual At every contact!

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 referred to as General Practitioners) because that is where personal care is to be found.

Know Your Patient eternal watchfulness, Early Diagnosis is the reward.

Reassurance that nothing is wrong to the patients satisfaction, is harder than Treatment and outcomes, and more time consuming. Mental illness is slower to extract and guide but just one more of the myriads of illnesses to watch out for.

And share with our consultant's and teaching hospitals Keeping up to date

Thr RACGP has trained 100's of potential Community 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 broadly 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 quite soon 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 his family, 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 their Learning! To the satisfaction of both parties!

The Health Team

By1972 the major players were Hospital trained Nurses and Medical Graduates filling every niche from G.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 proceed with the solution!

Ain't we Aussies Why should we continue to put up with outsiders known failed ideas that have failed here too?

For the patient's and the Doctor's sake!!! Lets get off our butts
and do it!!!

Dr Bertram S Vanrenen
MB BS Melbourne University 1951
War 2 2/8 Commando Sqn1943-45
R A P Corporal RAAMC
Retired family Doctor 1 Oct 2002

“3 Kingston Mews”
111 wattle Valley Road
Camberwell 3124 Vic
03 9888 4273
24/11/2005

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+)

C.F.P As Problem Solvers

- 3 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 diagnose, confirm, create treatment plan, Implement and follow up within ones learned competence .
d) When beyond our competence and experience to refer to the appropriate “specialist” for diagnosis, management, full feedback (daily) to learn, use and practice on those patients, then transfer that knowledge to other needy patients. Sharing care. & responsibility !

4 Health Surveillance

This is the most important role of the Community Family Physician
We are part of the whole diverse but integrated TEAM of Nurses & Doctors.!

We are so positioned, to 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 patients, of all sexes and at “any” age in their journey through life.!

Human frames do not change but Environmental changes(Political) 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 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

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

8 { Bert Vanrenen 11 June 1999 Re edit 25/11/2005

Fees : -

Proposal for basic hourly rates for consulting fees for:-
“Community Family Physicians “

To Re-legislate the peoples MEDICAL(Doctors) MUTUAL FUNDS

To allow Real Aussie's to share responsibility and costs with the Commonwealth Government(H.I.C.)

The recommended hourly rate of \$ 290.60 (based on my present requirements, and subject to A.M.A. annual reviews etc.) **at todays wages**, seems an appropriate charge for a ¼ hour ,Standard consultation at \$ 72.65 with a 90% rebate, for workers (Employees and Employers)and their families.(see below)

This has to cover:- all of our Commercial costs

Infrastructure, Expendibles, wages, Two ,Two week family holidays, Locum tenens etc; 20% of our time non earning (ref RACGP) ;

For a standrd 38 hour working week.

(After hours services add penalty rates to be calculated to cover extended consulting hours with wages at time and a half and double time etc.)

Then ,our nett returns to slightly better than a middle class for family living, sick leave and family holidays.(see below)

That financial security is needed, to always remain fully focused on our patients well being . Ours is **a vocation**, not just a job 9 to 5 !!!
A vast difference, Ask our families ! at call 24 hours a day !!

“Community Family Physicians“ Is the New Job Description for this New Millenium ,

Much more space and staff , larger consultation rooms with “ island” examination tables .All diagnostic equipment close at hand and visible or in wide shallow draws under the examination table (couch : 1940mm long by600mm wide, 1000mm high for 6 footers less when shorter ,for comfort).

We are now the only primary diagnosticians, much of which we are able to handle ourselves.

However we are responsible, to all our brilliant (technicians)) Young Specialists fresh from overseas, Older consultants and our World renowned Teaching Hospitals, to forward work to them at the earliest stage of illness , while it is still remedial.

In this way is our work is checked , critically and reported back helpfully .

Through our referred patients to specialists, their full and meaningful reports allow us to keep up with new investigatory methods, all new medical, surgical, gynaecological & obstetrical, psychiatric and social new knowledge is in those reports that land on our desks every day(4-5) These are read, and soon discussed with our patients, as soon as possible, treatment followed up, and added to our fund of knowledge for passing on to other patients.

Continuing education occurs every day of our working lives!

The basic tenet of MUTUAL FUNDS is that 10% of costs for services will be met by the Members. People seem to be more comfortable making a contribution, it also reduces the weekly premiums.

Taking a figure of \$290.60 per hour, for Standard ¼ hour Consultation (\$ 72.65) the rebate to be covered will be \$ 65.39 to be shared firstly \$ 31.45 by H I C for the Commonwealth, plus New Legislation to Reinstate the Medical(doctor) Mutual Funds moiety, to pick up the rest of the rebate(\$33.44) to 90% for the patients.

Historically that was the model of 1950 created by our new Liberal Government and worked excellently till 1973, when the socialist (labor) Whitlam Cwlth Govt took over; Bill Hayden was ordered to destroy the Liberal's Aussie World renowned, fully funded easily available, excellent quality Health service (a free enterprise health system) to provide us with the chaotic Socialist free Health Service we have today!

To quote Michel Grattan' s recent Sunday Age Opinions "our present Health Chaos is now on par with the rest of the worlds Free Health Services."

Australians today are accepting responsibility by picking up their large extra costs above the present very low "shedule fees" for available, proper, full medical consulting services, which take a lot more time and thoroughness, only available from "G P's" charging higher but obviously acceptable fees !

It is up to the Government to once more allow Australians to insure for the necessary increase in real fees and resultant gaps

**Dissecting the daily hourly rate of \$ 290.60 on a 38 hour week .
 (After hours penalty rates later) Viz:-**

RATE LESS REBATE HIC\ FU ND PATIENT NONFUNDED

1/4 Hour 10%

Standard

\$ 72.65 \$7.27 \$ 65.39 \$ 31.45 \$ 33.44 \$7.27 \$ 41.20

1/2 Hour
Long

\$ 145.30 \$ 14..53 \$130.77 \$ 59.70 \$ 71.70 \$14.53 \$85.60

3/4 Hour
Prolonged

\$ 217.95 \$21.80 \$ 196.16 \$87.90 \$108.26 \$21.80 \$130.05

One Hour

\$290.60 \$29.06 \$261.54 \$124.96 \$137.58 \$29.06 \$202.70

“When Needed “

"Standard" will still be in the majority as most Doctors will have to cast aside their Economically Enforced bad habits (quick turnover) and relearn how to maximize Long & Prolonged Consultations for the benefit of their patients :- early illness detection and treatment and follow up !!!

Pensioners

In 1972 the 10% of the population (Aged, Invalid's ,Indigenous and Seasonal Workers were looked after by the State, by State Public Hospitals for all procedures, and by all the G P's of the last Century ,for day to day consultations , treatment and follow up! .

It is time we got rid of all those phoney (V R's , P.I.P'S , accreditation, etc) political divisions of the 70's and 80's.

So divisive and so politically obvious and did not, nor now ,does anything for the people or their Doctors

They are time wasting and to the economic disadvantage of all participating Community Family Physicians as they detract from the absolute time to focus aurally

And Visually ;and to participate orally and manually diagnostically.

Communication is our major instrument and more time is needed with the aged and the sick.:- physically ,mentally and socially !!

Every (G P) Registered Community Family Physician is required to exhibit equal Personal Responsibility at every patient contact. There is only one level ; -maximum Potential and responsibility by every doctor is expected and fulfilled !!!!!!!

With present funding , this is the impossible dream ; yet the trained dedicated potential is everywhere, but mostly in the wrong niches; until Aussie common sense actuates sensible costing principles, they will stay there scratching an unsatisfactory and unsatisfying living.

Only proper funding will return family doctors and their families ,long term , back Into county communities and towns as well back to inner high density inner suburbs and sprawling outer suburbs ,where they grow with and into those communities.

The Commonwealth has for the last fifty years funded family doctor Pensioner consultations with reasonably discounted AMA fees till 1973 for 10% of the population of 16 million, but grossly under funded since then till now with H.C.C.HOLDERS up to 1/3 of the population of 20 million . Family doctors know the REAL POOR and will always be available as in the past.

Community Family Physicians today are the only Primary Diagnostic and treating Doctors ,

Infra structure and commercial running costs: staff ,paper work etc are very expensive . After hours more so !!

There is NO ancillary income now for GP's as in the past, with busy Procedure rooms, G P hospital Surgery , Midwifery , Medical inpatients; that ,provided that half Of the income that went to the family needs. For everything !!

The proposal of a (12.5%) twelve and a half percent discount on \$290.60 is I feel on Australian wages today ,with taxation, a very reasonable platform.

Dailey rates for "Pensioners", Discount 12.5% of \$290.60 is \$36.33 leaves \$254.27per Hour

| | RATES | H.I.C.Payment |
|----------|-----------|---------------|
| STANDARD | | |
| 1/4 HOUR | \$63.57 | \$ 63.57 |
| LONG | | |
| 1/2HOUR | \$ 127.14 | \$ 127.14 |

PROLONGED
3/4HOUR \$ 190.71 \$ 190.71

OFTEN NEEDED

ONE HOUR \$254.27 \$254.27

The raise in costing is due to **factoring** requirements for the large numbers of H.C.C.Holders And 20% time non earning , but time related to patient care !

Again The majority of consultations will be standard consultations but will be longer with 4 as a Maximum per hour!! (6 the minimum today must stop!)

When necessary (mental illness ,especially etc) and longer consultations are needed ,there will be no hesitation from Doctors ,because there will be no reduction in hourly income to distract and worry them !.

Automatically Quality will improve , both parties will be less frustrated and more satisfied, More efficient outcomes and less frequent visits to the doctor ! **another saving**

I am horrified at the tremendous decay in the purchasing power of the “dollar unit “ over the last 32 years following 1974 ‘s monstrous wage Explosion f And its massive unemployment fallout .

My figures may still be too low on Present Wages and other multitudinous costs so I would like additional expertise to double check ! this is a start !!

Reasonable Frugality with what is Necessary and Sufficient at many levels, with a cohesive team, can slowly return our Community Doctors to where they are needed all over Australia!!!

I submit this as a working platform based on historical knowledge and 60 years of working experience 3 as a medical NCO etc. WW2 and 50 as a Family Aussie GP till 1973, there after an indeterminate Community Family Physician !

Documented to open discussion !

16 July 2005. Edited 25/11/2005 .

Bertram S Vanrenen
“3 Kingston Mews”
111 Wattle Valley Road
Camberwell 3124 Vi

phone 03 9888 42 73
fax 03 9830 4935
E-Mail
bertvanrenen@bigpond.com