Submission No. 73
AUTHORISED: 14-9-05

Health Funding. The thoughts of a Western Suburbs GP.

GPs are unlikely to consider the financial implications of their practice of medicine while the Government shows no constraint in it's use of public funds (eg. spending of hundreds of millions , ultimately billions to invade other countries).

Until as recently as 10 years ago a medical consultation consisted of a medical history being taken , a clinical examination , a diagnosis being made and appropriate treatment prescribed. Only a small minority of patients needed further investigation or specialist referral.
Today , because of litigious patients and the ambulance chasers that our government and judicial system effectively support , GPs are forced to practice defensive medicine.
Costs are further increased by the community's unrealistic expectation and demand for often unnecessary investigations and referrals. MRIs are expected for simple tension headaches , and extensive pathology investigations for life-style induced tiredness. Healthcare is seen as an unlimited right , instead of a privilege that needs to be rationed.

The development of Divisions of General Practice has been another ill conceived and expensive exercise. These self-serving bureaucracies spend most of their funds on sustaining themselves and make little if any difference to the GPs and their patients. As an Director , Executive Director and then Chairman of a division of general practice for nearly 10 years , I experienced their evolution from GP run organisations supporting GPs in their provision of primary health care , to impotent arms of the health bureaucracy , carrying out government programs with arguable relevance to the community. The notion of these organisations being given the responsibility of healthcare fund holding is terrifying. The consequences would be bureaucrats (non GP) being paid megabucks to ration essential services , with the health of the community being the ultimate loser.

It is important to ensure a continuity of care in any system that is developed. The simplest way is to have patients register with one GP or Practice , and only receive medicare rebates for services initiated at the Practice (exceptions for emergencies ). This type of registration process would also stop 'doctor shopping' , where patients can see any number of doctors over any period of time with no penalty for over-usage cf. doctors who get crucified for over-servicing.
Provider numbers could also be limited to areas of need to prevent a glut of GPs in any one area , with the associated inefficiency and unnecessary cost to the system.

The medical practitioner should be protected from litigation as is the case in the UK where the courts refuse the excesses of the US system (I worked in London 1983-84) . This would allow the GP to practice the 'art' of medicine again rather than the 'defensive' medicine forced upon them by the present legal system. They could investigate , refer and prescribe as is clinically appropriate , rather than bowing to patient demands 'just in case...'.

If the Government proceeds down the path of fund-holding , they should go straight to the coal face and make arrangements with GPs or Practices. Accredited , fully computerised practices with a minimum of 5 full-time GPs , which employ a practice manager , would have negligible overheads compared with a Division of General Practice. Practices of this size already provide total health-care to their patients , providing preventative health advice while managing complex health needs.

Further savings could be made by bonding female graduates , and having them work on a full-time basis for at least 5 years in areas of need. This would be one way to have them repay the cost to the community for training them. In this way the obscene incentives for doctors in rural and remote areas could be eliminated.

Dr.Vladimir J.Vizec
MB.BS (Monash)