Appendix 1. Response to the interim report of the National Health and Hospitals Reform Commission – A healthier future for all Australians.

National Primary Health Care Strategy
CONSULTATION SUBMISSION FORM

Submissions on the Discussion Paper: ‘Towards a National Primary Health Care Strategy’ should be accompanied by this form.

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Send this form and your submission to:

Email: nphcs@health.gov.au

Post: National Primary Health Care Strategy Submissions
GPO Box 9848
CANBERRA ACT 2601

Content of submission - your submission should include:

➢ A completed consultation submission form (as detailed above)
➢ Comment on areas/questions in the Discussion Paper that are of interest to you;
➢ If applicable, any other relevant information (for example, any technical, economic or business information, or research-based evidence) supporting your comments and views; and
➢ If applicable, identification and discussion of any perceived omissions in the Discussion Paper or alternative approaches.

Enquiries regarding submissions should be directed to:

➢ NPHCS Secretariat (02) 6289 5159 or email nphcs@health.gov.au
➢ Further information, including Questions and Answers, is available at: www.health.gov.au/primaryhealthstrategy

Deadline for submissions: 27 February 2009

Unless otherwise indicated in the submission, all submissions will be published on the Department of Health and Ageing website. If you wish any information contained in your submission to be treated as confidential, please explicitly and clearly identify that information, and outline the reasons why you consider it to be confidential. Note that general disclaimers in covering emails will not be interpreted as a specific request or taken as sufficient reason for submissions to be treated confidentially. Any submissions which include personal information identifying specific individuals will be de-identified before submissions are published.

In addition, where submissions focus on issues specifically relevant to state and territory governments, this information may be forwarded to the relevant jurisdiction(s).

Note that submissions or comments will generally be subject to freedom of information provisions under the Commonwealth Freedom of Information Act 1982.
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Response to “Towards a National Primary Health Care Strategy: a Discussion Paper from the Australian Government”

Author – Jan Radford

Background to the author and context of this response:
This has been written as a response to the Australian Federal Government’s discussion paper “Towards a National Primary Health Care Strategy: a discussion Paper from the Australian Government”. I am a General Practitioner and bring to the discussion my experience of 22 years in private, General Practice in a rural regional city (Launceston, Tasmania), 14 years as a medical educator including 2 years as a full-time General Practice academic, and my experience of 26 years of very active involvement in my medical college. The perspective offered is therefore from a primary care medical practitioner, who has managed a small business in co-ownership with other General Practitioners, worked in rural Australian General Practice, and who has practical experience of teaching medical students, General Practice registrars, and peers. The importance of my medical college (the Royal Australian College of General Practitioners) in giving definition to my professional sense of self cannot be under-estimated. My local division of General Practice, General Practice north, offers opportunities to work with peers and committed staff to enhance General Practice capacity to deliver care locally. The University of Tasmania offers an opportunity to add to the teaching and research endeavors required to improve our health systems. My General Practice peers and patients help me to ‘keep it real’. In particular my experience of caring for my patients, for more than 20 years in many cases, is the major reason I enjoy my job so much. Hopefully, in that time I have also offered them the benefit of relational continuity of care and whole person care.

This response is written in 7 sections:
1. The wider health agenda
2. Primary (health) care
3. Australian General Practice and international trends
4. Education and training: General Practitioners and other members of the primary health care team
5. The system of care
6. Supportive government policies
7. Research and its funding

The response starts with 19 recommendations. Evidence based discussion supporting each recommendation makes up the majority of the response. Discussion leads to a recommendation.

Recommendations:
1. A ‘whole of government approach’ aiming for ‘health in all policies’ should be adopted by the Australian Government.
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2. An Equity Gauge strategy, or similar, should be introduced at regional level in Australia to measure and respond to health needs.

3. Primary care should be strengthened as Australia’s foundational keystone to health care.

4. The National Preventative Health Taskforce should increase General Practitioner involvement at the level of the proposed National Prevention Agency, and other levels, to balance an overstated public health perspective to the Taskforce.

5. To improve the sustainability of General Practice the number of General Practitioners in Australia must be increased by improving their pay, hours of work and status. This will increase the attractiveness of the profession to the increasing numbers of graduating medical students.

6. Expert Australian General Practitioners should be financed and trained to become master clinical teachers to General Practitioner Registrars, junior doctors and medical students working and/or learning in General Practice.

7. The Australian government should finance adequate education, training and support programs for General Practice based international medical graduates.

8. Initiatives such as the national rural and remote infrastructure program should be expanded to cover areas of primary health care need in Australia.

9. Any attempt to develop new skill mixes in primary care workers must be based on a foundation of competency based education that describes the holistic/integrative competencies as well as the task-based behavioural competencies.


11. The roles of General Practitioner and Primary Care Nursing professional colleges be supported and boosted in Australia.

12. More resources to be targeted at relieving poverty and enhancing General Practitioner integrated patient self care for those with disabling chronic health problems in Australia.

13. Continuity of care delivered by General Practitioners is integral to providing optimal patient outcomes in primary care. Any future change to the health care system must enhance this vital relationship.

14. To enhance coordination of care, a new form of health care assistant working in General Practice should be financed by the Australian health care system.

15. Delivering General Practice care in the future will require an expanded built environment and funding of a larger team according to context. Areas of greatest health need should be publicly subsidised to deliver this outcome.

16. General practice teams should be the designated team approach to primary care delivery [2, 3]. Processes to improve the quality of teamwork that lead to improved patient outcomes should be supported legislatively and financially by the Australian government.

17. The Australian Government should ensure the provision of universal or near universal financial coverage guaranteed by the publicly accountable body of government.

18. The Australian Government should ensure the provision of low or no co-payments to receive health services for those who are deterred from seeking care due to cost.

19. The Australian Government should ensure payment to General Practitioners commensurate with other specialists

20. The Australian Government should improve funding to General Practice / primary care to answer research questions based in primary care.
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Section 1

The wider health agenda

Before looking at primary health care [4], or other areas being reviewed in health [5] a plea must be made to take a wider view of health. The ten key elements of an enhanced primary health care system identified on page 13 of the discussion paper[4] lack acknowledgment of this wider context. As the research to back up primary care’s claim of its benefits has grown over the past thirty years[2] so too has the evidence for the social determinants of health [6, 7]. The health outcomes we seek are not divorced from other elements of our society. Anderson [8], writing in the context of Aboriginal health offers several social health models developed within the discipline of social epidemiology [6] to aid understanding of this new area of study. These models are applicable to the health of all Australians. Thus international trends (e.g. economic, climate change) affect government policies across all sectors (financial, science & technology, welfare, housing, education, health, environment, the arts, industries and transport) which then impact on poverty, social gradients, employment and working conditions, and access to services. All are couched in cultural processes such as racism, sexism, and the degree of social cohesion. All of these many layers of effects determine the social environments and networks we all live in. These in turn affect health behaviours and influence the development of the whole person. The developing individual has a certain genetic potential but the eventual expression of this potential is heavily influenced by all the preceding factors. The overall effect leads to wellbeing, morbidity and mortality [8].

‘Whole of government approach’ aiming for ‘health in all policies’

The questions posed by the discussion paper[4] need to be answered while looking at Australia as a whole. As health is a shorthand way of measuring wellbeing every policy in other, seemingly non-related areas of government should be considered in this light. As the WHO suggests, a ‘whole-of-government approach’ aiming for ‘health in all policies’ is needed [9](chapter 4). For example Bradley’s 2008 “Review of Australian Higher Education” has set a target by 2020 of 20% of undergraduate enrolments in higher education to be students from lower socioeconomic backgrounds [10]. If this policy is achieved the health benefits could include better health outcomes to those who undertake the education, as we know more highly educated people tend to attain higher socioeconomic status which tends to confer better health outcomes [11]. Consideration of improving the nation’s health may have led to a recommendation to target areas of study for these students such a medicine as we know students from lower socio-economic backgrounds are more likely to enter General Practice after studying medicine and the more General Practitioners we have per head of population the better Australia’s health outcomes [12, 13].

Recommendation 1.

A ‘whole of government approach’ aiming for ‘health in all policies’ should be adopted by the Australian Government.
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**Equity**

Australia is a stratified society with poorer health outcomes for those with less socioeconomic privilege [11, 14] This trend has worsened over the last decade in some areas such as cardiovascular disease [11]. Primary health care reduces social inequality in health [15]. Australian General Practice calls for equity in health care [16-18] as do the Australian public [19] who do not favour a user-pays system.

**Equity Gauge strategy**

Measures of health outcomes should also measure the contexts of the health populations under scrutiny. The social determinants of health are measured in Australia [11, 20] but these findings need to be emphasised in all policy decisions. Nuancing of these measurements with honing of social health models as applied to Australians is needed. Whenever health outcomes show a decline in health status all Australians need to know about this. Community engagement with finding the cause and the solution should be encouraged and made possible. The WHO suggests use of the Equity Gauge strategy to generate trend data and a response to findings [9](chapter 5). Equity Gauges bring together stakeholders relevant to the context and could include parliamentarians, local councillors, the media, ministries and departments of health, academic institutions, churches, community leaders, community-based and nongovernmental organisations, local authority organisations and civic groups. Involvement is designed to lead to social and political investment in the work needed to overcome inequity. The Equity Gauge strategy relies on three pillars of action which are responsive to each other; a) research and monitoring, b) advocacy and public participation to bring about change, and c) community involvement to involve poor and marginalized people as active participants in decision making. This approach can range from national to municipal application[9]. This approach is useful in high income as well as low and middle income countries [21] and consistent with Australian governments’ social inclusion policies [22, 23]. The approach should be adopted in Australia.

**Recommendation 2**

An Equity Gauge strategy, or similar, should be introduced at regional level in Australia to measure and respond to health needs.

**Section 2**

**Primary (Health) Care**

The 14th of October, 2008 was the 30th anniversary of the international signing of the Declaration of Alma-Ata, where the first international call for equity in health care was made under the auspices of the World Health Organisation (WHO). To mark this event the WHO has published a World Health Report, “Primary Health Care – Now More than Ever”[9]. The report critically assesses the way health care is organized, financed, and delivered in rich and poor countries around the world. The report found that when countries at the same level of economic development are compared, those
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in which health care is organised around the tenets of primary care produce better health outcomes for the same resource expenditure. The evidence for this finding is very strong [2]. The decision by the Australian Government to develop a primary health care strategy is therefore most welcome [4]. But better still, just as has been decided in the United States of America [24], primary care should be Australia’s designated approach to health care.

As pointed out by Boerma (2006) the concepts of “primary care” and “primary health care” are often used interchangeably but actually represent different aspects of the first level of health care [25].
The definition of primary care used in this paper is that used by Starfield et al i.e. “the provision of integrated, accessible health care services by clinicians who are accountable for addressing the majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community”[2](p 458). Thus in Australia primary care denotes care delivered by a General Practitioner (Family Practitioner), supported by the team they lead.
Primary health care is care provided in primary care plus the wider network of services that may include e.g. dentistry, optometry, community nursing, and wider health initiatives such as provision of clean water, adequate housing, etc.
These definitions are important to note as the evidence base is considered. Benefits found in a strong national primary care sector [2] may not apply to all of primary health care when one or some elements of the definition is or are missing.
It is worth noting that Australia does not have the strongest primary care sector in comparison to other industrialized countries [26] as measured using 1990s figures. Australia’s ranking as published in 1998 was in seventh place behind the United Kingdom, Denmark, Finland & Netherlands, Spain and Canada (in order of best to worst). Australia was just ahead of Sweden, Belgium & Germany, then United States and finally France [26]
Overall the stronger the primary care approach in a country’s health system the better the health outcomes [2]. As recommended by the World Health Organisation [9] and about to be adopted as health care policy in the United States of America [24], primary care should be Australia’s designated approach to health care.
The National Health and Hospitals Reform Commission (NHHRC) has highlighted twelve key areas for action [5]. The vast majority would be achieved or strengthened by spending most of the health care dollars in primary care and less on services closer to the tertiary end of the spectrum.
Evidence follows to argue that the NHHRC key areas improved by an emphasis on primary care include closing the gap on Indigenous health, investing in preventative care, ensuring a healthy start in life, improving care for those with chronic and complex conditions, delivering whole patient care, improving appropriate hospital access, delivering end of life care, promoting safer and better quality health care, improving access to care, improving access to care based on need and not ability to pay, and continuing to improve the use of better information strategies. The area Australia has truly defaulted on is ensuring enough health care professionals to carry this out. We could also do much better in funding research based in primary care.
As in many international countries, over the last 20 years Australia has, presumably inadvertently, used policy levers to degrade primary care as explained in later sections of this paper. The formulation of the primary health care strategy and the work of the
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NHHRC offer an opportunity to improve Australia’s stance towards primary care and thus primary health care.

Recommendation 3
Primary care should be strengthened as Australia’s foundational keystone to health care.

Thirty years on from the Alma-Ata Declaration
There are lessons to learn from the world’s thirty year experience since the signing of the Declaration of Alma-Ata. These include [9]:

- Primary health care should be the designated approach to health care. Primary care should not be seen as ‘the antithesis of the hospital’ but instead as the ‘coordinator of a comprehensive response at all levels’[9](p. XV).
- Action is needed not just rhetoric.
- People with the most means – whose needs for care are often less – consume the most care with public spending benefiting the rich more than the poor.
- Health is limited if health systems are built around hospitals and consultant specialists.
- When health is skewed to consultant specialist care many preventative and protective health care activities are lost.
- Health care is often delivered according to a model that concentrates on diseases, high technology, and consultant specialist care rather than on primary care.
- Health systems built around vertically-orientated disease programs and other priority programs produce poorer outcomes than those built around primary care.
- Unregulated commercialism is toxic to good health outcomes. If health care is treated as a commodity and driven by profitability health care quality and equity is sacrificed.
- Primary care is not cheap but it provides better value for money than its alternative.

The benefits of primary care – the evidence
The evidence for the health benefits of primary care is strong. “Systems that explicitly distribute resources according to population health-needs (rather than demands), that eliminate co-payments, that assume responsibility for the financing of services, and that provide a wide range of services within the primary care sector are more cost effective”[27](p. 1365).

Barbara Starfield and colleagues [2] have pooled data from numerous countries. They have used the definition of primary care as “the provision of integrated, accessible health care services by clinicians who are accountable for addressing the majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community”[2](p 458). Using this definition they have measured the degree of primary care within international health systems and the primary care features influencing health outcomes. They note the four main features of primary care services as “First-contact access for each new need; long-term person- (not disease) focused care; comprehensive care for most health needs;
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and coordinated care when it must be sought elsewhere”[2](p.458). Primary care is best when these four features are fulfilled along with a family and community orientation as relevant.

Primary care physicians in Australia are General Practitioners. Australian General Practice is defined by the Royal Australian College of General Practitioners as “the provision of primary, continuing, comprehensive, whole-patient medical care to individuals, families, and their communities”[28]. Therefore, Starfield et al’s findings are relevant to the Australian context. The findings are that the more primary care physicians per head of population the better the health outcomes; people who receive health care from primary care physicians are healthier, and the characteristics of primary care are associated with better health [2].

The more primary care physicians per head of population [2]:

- The lower are all causes of mortality including death from heart disease, cancer, stroke, cervical cancer, asthma, emphysema and pneumonia.
- The lower are infant deaths and low birth weight babies.
- The less people self-report poor health even after taking into account age, education, income, smoking status etc.
- The lower the number of acute hospital admissions and teenage pregnancies in General Practitioner serviced areas of socioeconomic deprivation.
- The lower the in-hospital mortality rate.
- The more preventative services are delivered such as screening, immunisation, and counselling about adverse health habits.
- The more adolescents were likely to receive preventative care and less likely to seek emergency department care.
- The less people reported feeling depressed.
- The lower the suicide rate.
- The greater the reduction in health disparities due to race and socioeconomic grouping.
- The better the ante-natal care provided, leading to fewer low birth weight infants.
- The better diabetes care, with lower smoking rates, neuropathy and peripheral vascular disease, with less lower limb amputation in this population.
- The lower the rate of hospitalisations for both acute and chronic conditions.

The characteristics of comprehensiveness (the primary medical practitioner provides the service themselves rather than referring) and family orientation (services are provided to all family members by the same practitioner) were key markers for positive outcomes.

Total costs of care are also lower if provided by primary care physicians even as quality of care is enhanced as outlined above. In contrast, the higher the number of consultant specialists per head of population the higher the cost of health care provision and the poorer the health outcomes [29, 30].

It is important to note that the evidence of the benefits of primary care rest with the ability of a child or adult to be cared for by the same medical practitioner at each visit – this definition of continuity of care is important to note. Having the same place of care but differing providers of care decreases the health benefit of primary care significantly [2].
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“If the interest is in patients’ health (rather than disease processes or outcomes) as the proper focus of health services, primary care provides superior care, especially for conditions commonly seen in primary care, by focusing not primarily on the condition but on the condition in the context of the patient’s other health problems or concerns.”[2](p 477). This aspect of care is particularly relevant to providing high quality well-integrated, coordinated, continuous care for people with multiple, ongoing and complex conditions.

Preventative health care

In the area of preventative care Starfield et al [2] found that higher ratios of primary care physicians lead to:

- Lower smoking rates
- Less obesity
- Higher rates of immunisation
- Higher rates of breast-feeding
- Higher rates of physical activity
- Higher rates of good nutrition
- Better secondary and tertiary prevention such as
  - Earlier detection of breast cancer, colon cancer, cervical cancer and melanoma
  - All aspects of diabetes management apart from checking for foot ulcers or infection
  - Hypertension management which also leads to less hospitalisation for complications due to poorly managed hypertension such as stroke or myocardial infarction
  - Management of recent myocardial infarction
  - Depressive disorder management

Van Weel et al [31] suggest that a fundamental missing strategy in the implementation of the 1978 Declaration of Alma Ata in primary health care was the failure to integrate the perspective of personal and public health. Public health leaders define and view primary health care in the context of populations while primary care physicians view the same term within the context of ‘personal care’. The current review of preventative health care called by the Australian Government [32] seems to be unaware of these two perspectives and is assuming a public health view of preventative health should predominate in delivering preventative health care to Australians.

Starfield et al’s collation of the evidence clearly shows the capacity of primary care physicians to deliver excellent preventative health outcomes at a personal, and subsequently, public level [2]. However to attain the best public (population) health outcomes in terms of preventative care, the health system must also provide equity of access to health care and an awareness of the social and physical environmental impacts on health [33].

An ideal time to provide preventative care is at a consultation initiated by the patient for another reason but this takes extra time [34]. For example smoking cessation messages can be more effective if given in the course of a usual consultation with the patient’s usual GP and is more effective still with longer time spent on this
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Preventative activity [35]. The payment systems to General Practitioners in Australia are structured to discourage taking the extra time needed, leading to relatively less time spent on preventative care at each visit than in similar countries [36], i.e. the business case for undertaking such activities in Australia is poor despite the development of good materials and training for GPs [37].

Recommendation 4

The National Preventative Health Taskforce should increase General Practitioner involvement at the level of the proposed National Prevention Agency, and other levels, to balance an overstated public health perspective to the Taskforce.

Possible reasons why primary care physicians deliver better health outcomes

Surmising why the health outcomes from receiving care from primary care physicians are superior to that provided by other medical practitioners Starfield et al [2] offer the following reasons:

- A focus on the person rather than managing a particular disease; the overall aspects of the patient’s health rather than a specific disease.
- Being a first point of contact protects from over-treatment.
- Continuity of care or a relationship over time (the individual uses their primary care physician, over time, as their primary source of care) generates more accurate diagnoses, greater satisfaction with care, better compliance with management plans, and lower emergency and hospitalisation rates.
- Previous knowledge of a patient increases the odds of recognizing psychosocial aspects of care.
- Continuity of care and first point of access leads to greater efficiency in using less consultation time, fewer laboratory or other tests, and fewer prescriptions all leading to cost savings.
- People with no source of primary care delay seeking help for longer, and do not receive timely preventative care.
- Consultant specialists are likely to over-estimate the likelihood of illness in patients they see leading to inappropriate diagnostic and management modalities leading to adverse events and medical errors [38].

Also noted is that

- At least two years of a relationship and as many as five are generally needed for patients and medical practitioners to get to know each other well enough to provide the best care [26].
- Choice of practitioner is important to ensuring the relationship is sustainable over time.
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Section 3

Australian General Practice & international trends

Australian General Practice trends: BEACH

The internationally unique Bettering the Evaluation and Care of Health (BEACH) study gives a comprehensive view of current General Practice and its trends [39]: Britt et al, in their latest study of 2006-07, found the following when compared to 1998-99:

- More GPs are working fewer hours.
- Fewer GPs do after hours work, visit homes or aged care facilities
- More GPs work in larger group practices
- The usual consultation length is still about 15 minutes but more consultations are longer ones.
- Patients are significantly older with a 30% increase in patients over 75 and a 15% increase in those aged 45-65 years of age
- Patients were also very much more likely to be overweight or obese though fewer smoked. Just as many drank alcohol at a risky level
- More chronic disease is managed – it now makes up 1/3 of the workload.
- Practices nurses are being increasingly used to deliver health services such as immunisation and wound management.

Australian General Practitioners and consultant specialists: trends & international comparisons

Despite strong evidence of the superior health benefits likely to result from the strengthening of Australian General Practice, Australian society has been deaf to or unaware of the message. This is even though Australians favour a collective, socially responsive health care system with equity of access as a major concern [19] and the need for good quality primary care will be greater than ever as the population ages [39].

From 2000 to 2005, the number of General Practitioners (GPs) decreased from 192/100,000 head of population to 179/100,000; a drop of 1% [11]. The full-time equivalent workforce of GPs dropped by 9% in the period from 2000 until 2005 [11] and was not related to age or gender of the GP [39, 40]. Noting the number of GPs per head of population does not measure GP activity; a mistake assumed by some commentators [41]. GPs are also aging with 40% over the age of 45 in 2000 versus 43% in 2005.

The international evidence notes the need to train more General Practitioners operating in the framework of a primary health care team [15] but notes an international tendency for medical, and other health, graduates to prefer consultant specialty training [42]. It has been postulated that health care students may be more attracted to consultant specialisation as it is seen as a “safer environment” than the comprehensive generalist approach of primary care [15].

In member countries of the OECD (Organisation for Economic Co-operation and Development) there has been a 50% increase in the number of medical consultant specialists over 15 years compared to a 20% increase in GPs [43]. In Australia consultant specialists over the last decade have increased from 84 to 116/100, 000 head of population, an increase of 47% [11]. In the last decade the number of
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Consultant specialists per head of population in training has grown much faster than the number of General Practitioner trainees [44-46]. This runs counter to the evidence of how to improve Australia’s health outcomes because we know this produces poor value for money [26]. Government agencies or health care commentators ponder how to change models of care as if no particular model is of benefit [46-49]. This is not just an Australian tendency [9, 43, 50]. The reasons for this are multiple and likely relate to a perception that money spent on drugs, technology and disease oriented medicine must be inherently ‘better’. This erroneous belief is held by the general population, health professionals and political decision makers [9, 15]. It is time for a campaign to correct this misunderstanding directed at all levels.

In recent decades government policy has actively worked against the growth of the General Practitioner population by limiting medical school intakes, limiting intakes into General Practitioner training [44], degrading the conditions of work for General Practice by, for example, allowing the income for consultant specialists to outstrip that of General Practitioners, and increasing the amount of administrative ‘red tape’ GPs must comply with [51]. Administrative overload is not unique to Australian GPs with 70% of European GPs reporting the same concern [52]. Some external commentators suggest General Practice as a career may be less challenging [45] and thus less appealing, while others suggest vocational training should be increased from 3 to 5 years to cope with the complexity of the work [53]. Those GPs actually doing the job are most happy with their level of autonomy, teamwork, variety of the job, level of responsibility, and their opportunity to use their abilities, and least happy with their hours of work, their income, and the level of recognition for the work they do [54].

Wage disparity is not unique to Australia [52]. It is worth noting the strong correlation between parity of pay between General Practitioners and consultant specialists and the ranking of primary care within a country; those countries with the higher primary care rankings have pay parity [26]. Some countries with a similar OECD ranking to Australia, such as Norway [55], have responded by improving payment for the work of their General Practitioners to assist in reversing this trend. Australian attempts to redistribute the workforce budget aiming for pay parity, via the Relative Values Study [56, 57], has failed. The leadership of government will be needed to overcome the resistance of entrenched attitudes to this issue [9].

These negative factors have contributed to a fall in GP numbers [58] as they make a career in General Practice less possible or appealing. General Practice registrars have a low rate of attrition from training as do other discipline registrars [59] suggesting the problem in attracting General Practice trainees to the profession may be one of piquing their interest to enter. The outsider perception of General Practice being less challenging has no evidence to support it [54].

To attract doctors to train for General Practice pay parity with other specialist colleagues, shorter work hours and a better, general appreciation for the work done is needed. Workload per GP can be decreased by increasing GP numbers and increasing the numbers of other members of a co-located GP team such as practice nurses. Student numbers are now increasing [44] as are the number of training places for General Practice [60] though not fast enough. The peak body for General Practice in Australia, United General Practice Australia, has called for an increase of one hundred training places per year [61] to meet current shortfalls and projected need.
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**Recommendation 5**
To increase the number of General Practitioners in Australia their pay, hours of work and status must be improved. This will increase the attractiveness of the profession to the increasing numbers of medical students due to graduate soon.

**Section 4**

**Education and training: General Practitioners and other members of the primary health care team**

*Expert General Practitioners as teachers*
Standards for education and training for Australian General Practice are determined by the professional colleges and this should not change. The Royal Australian College of General Practitioners (RACGP) published an online curriculum for Australian General Practice in 2007 covering the vertical extent of General Practice from undergraduate through to junior doctor, then vocational training, and finally continuing professional development phases in the General Practitioner’s career [62]. The RACGP’s curriculum and assessment to Fellowship is competency based [62, 63].
Expertise is best developed by expert clinicians training learners in the authentic context of General Practice [64, 65]. This can be complemented by teaching practices such as the use of simulation [66]. Expert General Practitioners need to be supported financially and in terms of training to become expert teachers within their practices while Registrar and Junior Doctors and medical students benefit from expert GP teachers taking on a consultancy role. Registrars need to be paid to teach more junior team members as outlined below.

**Recommendation 6**
Expert Australian General Practitioners should be financed and trained to become expert clinical teachers of General Practitioner Registrars, junior doctors and medical students in General Practice.

*International medical graduates*
Reduction in undergraduate student numbers and a continuing increase in the need for doctors has led to a large number of international medical graduates providing care in Australian General Practice over the past ten years [67]. The invaluable services provided by international medical graduates have not always been matched by adequate resources to ensure their integration into the Australian medical workforce [68]. International medical graduates, without Australian post-graduate training in General Practice, practise differently to holders of the Fellowship of the Royal Australian College of General Practitioners [69]. Financing vastly improved education and training support programs for international medical graduates is required [68].
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**Recommendation 7**
The Australian government should finance adequate education; training and support programs for General Practice based international medical graduates.

**Educational infrastructure**
With the need to increase General Practitioner numbers and numbers of the other members of the primary team workforce, financial assistance to provide infrastructure to accommodate learners will be needed. Initiatives such as the national rural and remote infrastructure program [70] should be expanded to cover areas of need in Australia wider than just rural areas.

**Recommendation 8**
Initiatives such as the national rural and remote infrastructure program should be expanded to cover other areas of need in Australia.

**Competency Based Education**
As noted above the RACGP’s curriculum and assessment to Fellowship is competency based [62, 63]. The implication of the concept of competency based education can be that a health professional’s training might be shorter or longer than in a time based system of training. However the imperative of enough time to train the global competencies of a health professional cannot be under-estimated [65]; some competencies cannot be attained without time spent practicing skills with feedback from a teacher. General Practice training cannot be delivered by on-line modules with completion of written knowledge tests implying overall competence.

The health professions and other professional groups are part of a debate about the appropriateness of a competency based approach to education and training [71, 72]. Eynon and Wall (2002) summarise the debate as being about the definition of competence, the way competencies are defined, the disregard for the underlying attributes of the professional, the relationship between performance and competence, the difficulty of assessment, and the focus on achieving competence and not on how it is achieved. They note that the main literature models are ‘task based /behavioural’, ‘generic’, and ‘holistic/integrative’, and that the majority of the debate concentrates on the ‘task based/behaviourist’ approach.

Also noted is that writing learning-outcomes-based statements as part of the competency-based approach has proved difficult as educators grapple with conceptualising outcomes from the behavioural to the holistic, design teaching methods and learning strategies to achieve them, and design assessment strategies to determine that they have been achieved [71, 73]. However progress is being made in the sophistication of using outcome-based education in the health professions as conceptual frameworks for progression through undergraduate degrees [74] and vocational training [75] evolve. Reliable assessment methods for individual performance across most competencies are available[76].

**Recommendation 9**
Any attempt to develop new skill mixes in primary care workers must be based on a foundation of competency based education that describes the holistic/integrative competencies as well as the task based behavioural competencies.
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General Practice Education Summit recommendations

In July 2007, General Practice Education and Training sponsored a meeting of stakeholders interested in General Practice education and training – the General Practice Education Summit [77]. Recommendations from that summit were:

i. That the Commonwealth establishes a funding program to support Community Clinical Schools in each medical school based on the successful Rural Clinical Schools model.

ii. That the Commonwealth establishes a funding program to support community based undergraduate teaching based at each medical school on the successful RUSC model. Recommended establishment parameters were provided.

iii. That the current clinical service focus of the Health Insurance Commission General Practice Training Pool should be reviewed to allow an enhanced role for Registrars as teachers within General Practice.

iv. That a public–private collaborative infrastructure development scheme should be established to allow individual General Practices to remodel their facilities to deliver integrated education. Several successful Australian models for this currently exist.

v. That Commonwealth/State Health Agreements must define and clarify jurisdictional roles for the support of Community Clinical Schools and community based prevocational and vocational training.

The summit did not have stakeholders from the other members of the General Practice team present – nursing and allied health. Training the future General Practice team together is common sense and likely to produce positive patient outcomes though this is far from proven [78, 79]. The development of interprofessional practice via interprofessional education will need time and resources to achieve as a review of the evidence shows.

Interprofessional education

“Interprofessional education is those occasions when members (or students) of two or more professions learn with, from and about one another to improve collaboration and the quality of care”[80].

International and national policy makers have proposed that health care delivery will be improved if various health care disciplines participate in interprofessional education (IPE) [79]. However evidence to support this argument is thin and only just starting to accumulate[78]. The Cochrane review published by Reeves et al [78] uses the strict empirical approach of the Cochrane Collaboration such as reviewing randomised controlled trials (RCTs) or controlled before and after studies (CBAs) methodologies only. The instruments used to measure outcomes of learning were objective or self-reported and validated measures of healthcare outcomes. They found only four RCTs and two CBAs that satisfied inclusion criteria. Undergraduate and postgraduate interventions were included. Reeves et al [78] called for more rigorous studies of IPE. The main results from this review were that four of the six studies showed that IPE produced positive outcomes in the areas of emergency department culture and patient satisfaction; collaborative team behaviour and reduction of clinical error rates for emergency department teams; management of care delivered to domestic violence victims; and mental health practitioner competencies related to the
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delivery of patient care. In addition, two of the six studies reported mixed outcomes (positive and neutral) and two studies reported that the IPE interventions had no impact on either professional practice or patient care [78]. Hammick et al’s [79] recent systematic review of interprofessional education found that “Staff development is a key influence in the effectiveness of IPE for learners who all have unique values about themselves and others. Authenticity and customisation of IPE are important mechanisms for positive outcomes of IPE. Interprofessional education is generally well received, enabling knowledge and skills necessary for collaborative working to be learnt; it is less able to positively influence attitudes and perceptions towards others in the service delivery team.” [79] (p 735)

Attracting trainees to primary care and areas of greatest health care need

The most pressing need is for trainees to be willing to work in primary care. After that, many areas of specific need have been identified such as rural practice, practice in low socioeconomic status areas, Aboriginal health care etc. We know that practitioners who have been raised in rural areas (at least had their primary schooling there), have a preference for General Practice, and have a life partner who grew up in a rural area [81-83] are more likely to take up rural practice.

The international evidence

The factors contributing to medical graduates choosing to become General Practitioners are outlined in the Bland-Meurer framework [13][figure 1 as cited in Lawson and Hoban’s work [12] page 71]. This work is based mainly on North American studies. This framework has been assessed as the most comprehensive available though weightings for each factor have not been identified [12]. Factors that have been cited to increase the chance of choosing General or Family Practice as a career include:

At the time of intake into medical school-

- A rural background
- Older age
- A stated preference for General or Family Practice.
- A belief that primary medicine is more important than consultation specialty medicine.
- Community or volunteer work.
- Married
- Female
- Having parents with a low income
- Lower physical science based entrance scores

Evident at any time from intake into medical school onwards-

- A positive student experience of General Practice
- The positive influence of mentors, role models
- Having lower income expectations
- Favouring helping people over leadership roles
- Less interest in research and academic work

Factors that have been cited to decrease the chance of choosing General or Family Practice as a career include:

- High levels of student generated debt.
- Those in medicine for the prestige.
- An interest in technology and procedural medicine versus people orientated medicine.
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Neutral factors
  - Tertiary entry scores or their equivalent.
  - Personality testing such as Myers-Briggs typology testing.

Recommendations for Australia
Thistlethwaite et al’s (2007) review[1] is the most recent Australian based review to comprehensively address the issue of attracting health professionals to primary care and offered up several policy options [84] that address the Bland-Meurer model with regard to General Practice. Their recommendations are based on the best available evidence to date though lack of research in this area must be noted (see recommendation 19).

Their recommendations follow including support for the recommendations of the General Practice Education Summit [77]:

1. “Consideration should be given to providing additional incentives to those medical schools that choose to ensure an agreed percentage of their graduates enter general practice and/or practise in rural communities. We
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acknowledge that not all schools have similar objectives in respect of their graduates and that negotiations will be necessary with the Deans of faculties to discuss their commitment and action in respect of workforce needs.

i. Because students from rural backgrounds are more likely to practise there, consideration could also be given to funding more support for entry by students from rural backgrounds to all health professional programs. This is likely to increase numbers of health professionals choosing to work in rural areas following graduation. This support could take the form of scholarships.”[1](p43)

“University processes through nurture

iii. Policy makers should make additional targeted funds available at the time of reaccreditation of all medical schools through the Australian Medical Council, so that medical schools provide counselling on career choices including in general practice and other aspects of community and rural medical practice.

iv. Medical schools should be encouraged to increase the number of GP teachers/academics involved in teaching their medical students. Such people act as positive role models and should be encouraged to mentor students and junior doctors during training.”[1](p44)

“Funding models for clinical placements

v. Enhanced government funding is required to provide longer and better supported placements in general practice and rural practice for all medical students.

vi. Increased funding resources and supports should be provided to develop teaching general practices. This will attract more GP role models and recruit more practices to train students.

vii. Additional resources should be provided to encourage GPs to host junior doctors through the prevocational general practice placement program (PGPPP) – a general practice attachment should be mandatory and available for all junior doctors in either PGY1 or PGY2.

viii. Australian government funding of new community clinical schools in each medical school, as recommended by the Australian General Practice summit and along similar lines to funding provided for rural clinical schools, would provide a substantial increase in the quality and quantity of general practice exposure provided to medical students and junior doctors and will have an impact on their ability to make informed choices about their future careers.”[1](p44-45)

“General Practice as a career choice – Enhancing the factors that make General Practice attractive

ix. General Practice as a career should offer flexible training opportunities and flexible working hours.

x. The Medicare payment structure should be altered to allow properly educated and supported general practice nurses greater autonomy to see and treat patients, with a general practice nurse career development pathway and a national payment structure.”[1](p 46)

xi. “Teamwork, primary care and inter-professional practice
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a. More research is required into the effects of teamwork in general practice/primary care in Australia. Teamwork enhances the attractions of work in general practice/primary care for many health professionals.”[1](p 47)

**Recommendation 10**
The recommendations of Thistlethwaite et al (2007) in relation to attracting health professionals into primary care be adopted [1].

**The role of professions**
Boerm and Rico, in the European context, note “Medical professions are suited to making cooperative mechanisms work, given their common process of socialization (through medical education), the high salience of reputation, and their shared value system. After graduation professional colleges and associations are valuable for maintaining this process by setting internal norms and defending the interests of the profession vis-à-vis other professions, the government, health insurers or other actors in health care.”[85] (p. 53). They also note that “Professional bodies also have an important role to play in health politics. …Cooperation between the state and primary care professional organisations is critical to guarantee that adequate mechanisms are in play. For primary care professionals to gain leverage over hospital colleagues, powerful, politically mobilized primary care professional associations are essential. In countries in which primary care associations are strong, their participation in policy-making is more active, contributing to policies which further strengthen primary care.” [85] (P. 54). Further comment notes that “Self regulation by professional bodies has become an increasingly important instrument in realising health policy goals. It can only become important, however, to the extent that these bodies are able to take up this role. This differs between countries as well as professions. The stronger the autonomy of a profession (and higher its status and recognition) the more significant the instrument of self regulation may be (at the expense of hierarchical control). The degree of recognition of general practice by other medical specialties in a country is usually reflected in its position in academia and education. Where GPs have a weak position, their professional identity and professional organisation is weak, and their education relatively poor. Recognition follows the following steps: firstly, its specific field of knowledge is accepted; secondly, an academic body is established to develop this field of knowledge; thirdly, those who practice produce literature that describes that knowledge; finally, there is external recognition by other medical disciplines, as well as by the state and society as a whole. A strong role of general practice in health care is related to advanced stages of recognition. Thus, professional development, not only in general practice, but also in other professions, is a requirement for strong primary care.” [85](p. 62-63). This description of the development of the profession of General Practice is relevant to Australia; however the last step of external recognition by other medical disciplines, the state and society could be strengthened to produce a true appreciation of the profession as we seek to strengthen primary care.

A special edition of the Australian journal ‘Contemporary Nurse’ [86] in August 2007 expressed a range of views regarding practice nursing. Practice nursing as an area of specialisation was questioned due to a lack of an empirical base for unique knowledge
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in the area, a lack of specific standards of practice, and a lack of tertiary courses and specific texts in the area[87]. Keleher et al (2009) concluded in their recent systematic review of primary care nursing that “Although an increasing number of clinical and organizational activities are carried out by nurses in primary care, there is no systematic gathering of data that measures what they do and what outcomes they achieve for patients and the settings or practices within which they work.”[88]

Therefore the development of primary care nursing as a profession needs a boost in Australia.

**Recommendation 11**
The role of the General Practitioner and Primary Care Nursing professional colleges needs support and boosting in Australia

**Section 5**

**The system of care**

*The patient & chronic ill health*
All people with health problems described as multiple, ongoing and complex conditions have chronic ill health. It is worth noting that Australians with chronic disease rate General Practitioner care highly in terms of patient-centeredness and accessibility [89, 90]. Many interventions to enhance the management of chronic disease have been developed and just about all work [91]. Many are already used in Australian General Practice as markers of quality practice, such as General Practitioner participation in continuing professional development, use of patient reminders, and information for patients about their condition. The development of self management skills for patients has been the focus of recent research in Australia with mixed results [92]. Many showed some improvement in self management but sustaining improvement remains the challenge. Many did not engage General Practitioners effectively. More work is needed in this area to further assess and develop programs that are sustainable over time. Chronic ill health exposes people to poverty and financial stress and should lead to wider government policy change to alleviate their suffering [93]. Households who care for people with chronic illnesses can have decisions to make, such as whether to pay for food or medicines, and many carers must forego work to care for ill household members thus exacerbating household poverty [93].

**Recommendation 12**
More resources need to be targeted at relieving poverty and enhancing General Practitioner integrated, patient self care for those with disabling chronic health problems in Australia.
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Integration, coordination and multidisciplinary primary team care

Integration

A clear, shared understanding of the meaning, reasons, and dimensions of integration is needed as it is possible to describe at least ten dimensions of integration in primary care [94]. Simoens & Scott [94] note that integration in health, including primary health care, is complex because the focus is on the patient’s journey, with each person’s journey being unique, characterised by uncertainty and involving various care providers over time. Those with chronic and or complex health care needs have more to integrate than other Australians. Simeons & Scott [94] note that integration may refer to the comprehensiveness of services provided by a health care service (the breadth and degree of integration); the governance structure of a health care service (the form of integration); the nature of decision making responsibility (mode of control); the purpose of collaboration within a health care service (the type of partnership); clinical integration (holistic management of a person’s health problems taking into account their unique personal circumstance); the degree of fund holding undertaken by the health service (financial integration); the physical co-location or not of health service providers (location integration); and the types of stakeholders involved in managing a health service (organisational structure).

The extent of integration of services is influenced by several factors including external ones like competitive or regulatory pressures to minimise costs, with larger organisations expected to have lower average costs. Internal factors such as the motivation of individual health care providers are also important catalysts of integration, such as an enhanced ability to care for patients, intellectual satisfaction, improved workload distribution, etc [94]. In the United Kingdom efforts to form Integrated Primary Care Organisations have been made since 1992. Factors influencing integration in these Integrated Primary Care Organisations included the transaction costs with only a small body of evidence available for consideration and no benefit found in terms of cost savings. Thus larger organisations may not perform better. Other reasons to integrate included the assurance of a wide range of services and to attract new resources. The evidence for a benefit to patient outcomes is so far lacking [94, 95].

Writing in Australia, Jackson et al [96] have described creating a physically co-located organisation to develop a culture of integration of services across three health organisations. The process took ten years and involved linking general practitioner, hospital integration liaison, education and research services, a domiciliary allied health acute care, and rehabilitation team, and the local division of general practice, all co-located on an acute care hospital campus. Physical co-location began after 2003 and was assessed as the most important factor in delivering enhanced health care provider communication and knowledge about other providers involved in the initiative, along with more opportunities for collaboration and partnerships. Improved workspaces were also noted as a benefit. The benefits were found greatest for organisations sharing clinical initiatives and strategic health service objectives. Other Australian initiatives have not been as successful [97] with lessons learnt including poor outcomes related to a lack of a shared vision, autocratic leadership and poor resource allocation.
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If one leaves the unsettled issue of the general effect of integration of services to one side but instead concentrates on the patient’s journey then some evidence exists of patient benefit from enhancing the individual patient’s care facilitation [98]. Noting a shortage of General Practice care access by a certain population of Victorian, elderly patients, and as a consequence many of them presenting recurrently to hospital accident and emergency departments with acute exacerbations of illness, the Hospitals Admission Risk Program funded the Complex Needs Project [98]. The project employed individual care facilitators to assist patients to access required services and promote self management. The ability of General Practices to employ members of their team with this skill set could enhance primary care delivery in Australia. Powell Davies et al’s Australian review supports this approach [99]. However the evidence that integration, coordination and multidisciplinary approaches in primary health care settings improve patient outcomes is thin [100]. Overall more research is needed.

Continuity of care and coordination of care.

Continuity in the primary care literature is defined as “the relationship between a single practitioner and a patient that extends beyond a specific episode of illness or disease”[101](p.1219). Such a relationship has been proven to deliver improved health outcomes in primary care. It may take from 2 to 8 years to form [2]. The relationship is described as longitudinal, relational, or personal, and fosters a sense of responsibility, trust, and improves communication. Continuity differs from coordination, but fosters improved coordination. This definition of continuity is the one found to produce improved primary care outcomes [2] and used in the Royal Australian College of General Practitioners definition of General Practice [28].

The definition of continuity varies from that used e.g. in mental health services, where it tends to refer to a team process; nursing, where it tends to refer to information transfer over time using patient notes; and disease management in disease specific contexts, where it refers to service delivery in a coherent, logical and timely fashion with the content of care protocols emphasised.[101]. Hence the context within which the term ‘continuity’ is used changes its definition such that clear meanings are needed in discussion of the concept.

Haggerty et al (2003) have gleaned three aspects to continuity from the health care literature- informational, management and relational – and summarise the situation by noting “For continuity to exist care must be experienced as connected and coherent. For patients and their families, the experience of continuity is the perception that providers know what has happened before, that different providers agree on a management plan, and that a provider who knows them will care for them in the future.”[101](p.1221)

Information management systems are especially important to aid team communication and integration of clinical care bringing obvious quality benefits[102]
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**Recommendation 13**
Continuity of care delivered by General Practitioners is integral to providing optimal patient outcomes in primary care. Any future change to the health care system must enhance this vital relationship.

**Recommendation 14**
To enhance coordination of care, a new form of health care assistant working in General Practice should be financed by the Australian health care system.

**The practice environment**
Financial assistance or incentives to build or provide the optimal environment to deliver primary care is needed to cater for the recognised need to enlarge and train the team providing primary care. GPs, nurses, practice management and administrative staff tend to be staple members of the current Australian team. The standards for General Practice developed by the RACGP provide a sound base on which to add criteria. Further criteria could vary in relation to the practice patient profile with a need for the practice to work with their local Division of General Practice and other relevant community stakeholders to measure the practice patient profile and subsequent care need. For example, predominantly aboriginal health care provision may require cultural awareness training by all staff and the employment of an aboriginal health worker. Co-location of services of importance to the practice population e.g. mental health workers, dentists, physiotherapists, dieticians, exercise physiologists, could then be subsidised via Medicare.

**Recommendation 15**
Delivering General Practice care in the future will require an expanded built environment and funding of a larger team according to context. Areas of greatest health need should be publicly subsidised to deliver this outcome.

**Team work**
Co-located or not, members of a patient’s team of health care providers will need to develop better ways of working together
The filtering role (less accurately described as a gate-keeping role) of the GP must never be given up as this has been shown to deliver more cost-effective, higher quality health care. The effect is large and the evidence strong. This will take some effort to ensure as other providers seek direct access to Medicare funding. Activity of the team that enhances patient care should receive support. E.g. Consultations by electronic means should be remunerated for both clinicians in the encounter. Time spent to pursue interprofessional learning should be planned and paid for as each professional learns with, about and from each other. The scope of practice of each professional should be reviewed and agreed by all team members. Responsibility for professional decisions with defined boundaries will be needed.

**Skill mix/scope of practice/role substitution**
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As shortages of General Practitioners loom, discussion has turned to the skill mix of health care workers in primary care. Other countries have developed various responses to this scenario with the dominant trend being towards a more complex skill mix reflected in larger and multiprofessional teams, and increased role differentiation within teams [106].

Sibbald et al [106] note that “skill mix change may be brought about through enhancement – extending the role or skills of a professional group; substitution – exchanging one type of professional for another; delegation – shifting care provision from a senior/higher grade to a junior/lower grade person within a profession; and innovation – introducing a wholly new type of worker” (p.152).

Research evidence comes from overseas. Substituting nurses to undertake primary care tasks does not save money in terms of total care costs (salary, investigations ordered and referrals made) [107, 108]. The quality of care offered by nurses depends on disease specific training [109] with a need for further advanced training to attain the level of independent nurse practitioner in the USA and UK [107]. Surveys of nurses working in extended roles have suggested many nurses feel insufficiently well trained [110].

The effect on patient health outcomes of loss of relational continuity of care by allocating part of the General Practitioner role to others e.g. nurses delivering care for minor illness, providing pap smears or immunising patients has not been assessed. Small studies in other countries suggest skills can be delivered by nurses [111] but the effect of pursuing this policy is to fracture the known benefit of relational continuity of care. This is an experiment that is driven by previous poor policy decisions leading to a reduction in General Practitioner numbers and not evidence. Poor funding of primary care research is likely to prohibit finding the answer to this research question as well – see recommendation 20.

United Kingdom GPs initially welcomed extended roles for nurses in the 1990s as policy makers increased contractual commitments for General Practice. However, during this time nurses developed a desire to be autonomous and not subservient to the medical profession, roles became more overlapped, and GPs became unhappy with the erosion of their roles [112]. For the sake of developing a united primary care team in Australia respect for General Practitioner opinion in this matter is recommended.

Some Australian nurses working in General Practice have noted the more collaborative attitude of General Practitioners versus hospital-setting doctors and the rewarding and challenging nature of nursing in General Practice [113]. Australian academic nursing seem to lack an appreciation for the relatively weak research culture in everyday General Practice [114]. This weak culture needs strengthening as noted below. In fact research trained practice nurses could play a vital role in reversing this [115].

Wariness has been expressed about policy-makers and General Practitioners forming the future shape of nursing in General Practice [116].

In Western Australia nurse practitioner clinics have been launched contrary to the evidence on how to provide good quality primary care i.e. fracturing potential continuity of care. Cresswell [105] reports “Under West Australian law, its nurses are allowed to treat patients for a defined list of minor conditions, ranging from colds, coughs and flu to bronchitis, ear infections, skin infections and bladder infections as well as nausea, vomiting and diarrhoea. They can prescribe drugs for these conditions that are classified S4.” (p.5). A Western Australian chain of clinics called Revive is
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already lobbying the government to be given access to Medicare, without involvement of a GP, including access to health prevention checks and the development of care plans [105]. This development is counter to the pattern of primary care that we know leads to optimal health outcomes in that it fractures the filtering effect of GPs and continuity of care, while standards of clinical care are totally unknown. Quality care requires coherent and integrated care that encourages personal continuity of care [2]. Launching independent nurse practitioners into the primary care arena without proper negotiation of roles and responsibilities with their medical colleagues is likely to undermine this aspect of quality. Australian General Practitioners would prefer that nurses work with them in General Practice to deliver primary care taking on responsibilities delegated in negotiation with their GP colleague in well negotiated extended roles for which they have been trained [3, 117].

Australia has an effective system to deliver high quality care via well-trained GPs. General Practitioner numbers can be increased. Nurses can assist with the delivery of care to play a part in a larger multiprofessional team. Dialogue between all the professions and policy makers to progress this is needed. Other newer roles will need (further) evolution such as multi-skilled support workers who cater, clean, distribute food or perform clerical tasks or act as care assistants.

Recommendation 16

General practice teams should be the designated team approach to primary care delivery [2, 3]. Processes to improve the quality of teamwork that lead to improved patient outcomes should be supported legislatively and financially by the Australian government.

Section 6

Supportive government policy

Starfield et al also found that adequate delivery of primary care services is associated with supportive government policies [2] delivering:

- The provision of universal or near universal financial coverage guaranteed by the publicly accountable body of government.
- The provision of low or no co-payments to receive health services, and
- Payment to General Practitioners commensurate with other specialists

These 3 characteristics are inter-twined as it is likely payment to GPs commensurate with other specialists would lead to low or no co-payments i.e. bulk-billing would increase.

Recommendation 17

The Australian Government should ensure the provision of universal or near universal financial coverage guaranteed by the publicly accountable body of government.
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**Recommendation 18**
The Australian Government should ensure the provision of low or no co-payments to receive health services for those who are deterred from seeking care due to cost.

**Recommendation 19**
The Australian Government should ensure payment to General Practitioners commensurate with other specialists.

## Section 7

**Research and its funding**
More research funding is needed for Australian General Practice. Designing and evaluating complex interventions to improve health care is time and resource consuming [118]. Funding for research is needed in Australian General Practice/Primary care to answer the questions such as:

i. “What sorts of integration lead to better patient health outcomes?”

ii. “What integrating services co-located in a General Practitioner led team could enhance patient outcomes for those in most need?”

iii. “What chronic disease management programs based in Australian General Practice are effective in improving health outcomes for patients with chronic and or complex health care needs?”

The opportunity presents to perform research involving more than just one health care discipline paradigm[114]. Funding could be targeted at interdisciplinary efforts.

**Recommendation 20**
The Australian Government should improve funding to General Practice / Primary care to answer research questions based in primary care.

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