Submission to
The Productivity Commission
On
The Health Workforce

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Background

I am a practicing GP as well as an academic GP (part time). Workforce supply in the various fields of the health profession affect my daily work – largely adversely. However many of the suggestions outlined in the Productivity Commission's Issues Paper[1] appear to lack conceptual rigor in so far as they are largely presented as distinct problems out of context and without a clearly defined central focus or organising principles.

This submission will firstly outline the basic principles of effective medical care, before addressing some of the specific issues raised in the issues paper.

Back to First Principles

Some core questions have to precede any meaningful examination of, and solution to, "the workforce" issue.

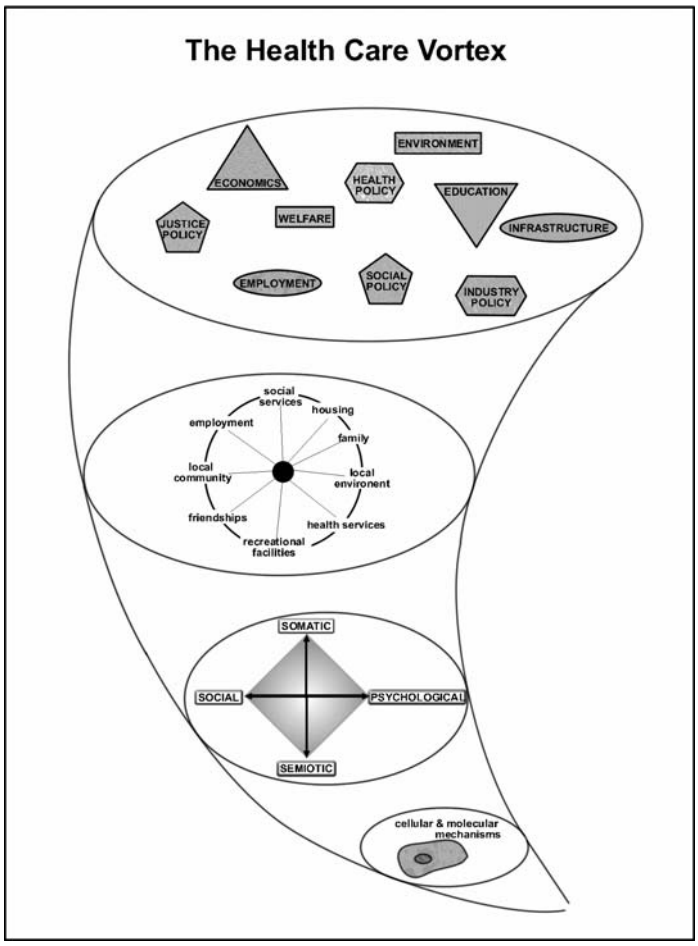
1. What is health?
2. What influences health?
3. How does technology impact on achieving health, and for whom?
4. Why does achieving health depend on achieving trust?

1. What is health?

The WHO definition[2] of health – due to its "negative" notion of health – clearly lacks credibility and applicability. There have been many attempt since Plato's times to define health in a positive fashion.[3-7] All of them stress one common aspect, elaborated on in various ways by peoples from diverse backgrounds – ***health is a deeply personal experience***. This insight is core to shaping health care policy, as well as determining how large a workforce is needed to improve patients' health experiences (in contrast to managing diseases).

2. What does influence health?

Health as a *unique personal experience* is greatly influenced by the person's embededness in his local, regional and global environment. There is a large literature that has demonstrated the influence of specific factors on health behaviour and subsequent development of disease states. Incidentally most so called "health statistics" are concerned with the latter, and the longstanding call for measuring ***"human health"***[8] has been largely ignored.



All societal activity impacts on the personal health experience. In an attempt to capture these complexities we proposed the ***health care vortex*** as a metaphor (see figure).[9] The net

result of the interactions determines as much the ***personal health experience*** as it determines the biological status of the person's cells.

3. How does technology impact on achieving health, and for whom?

The contribution of technology to modern medicine is unquestionable. However it is also unquestionable that a lot of technology is used without contributing to a person's health or health gain, and in many instances in fact is the cause for poorer health. Technology in overall terms has its greatest impact for patients with very well-defined specific health problems. The number is small compared to those with multiple, complex and interrelated problems.[10]

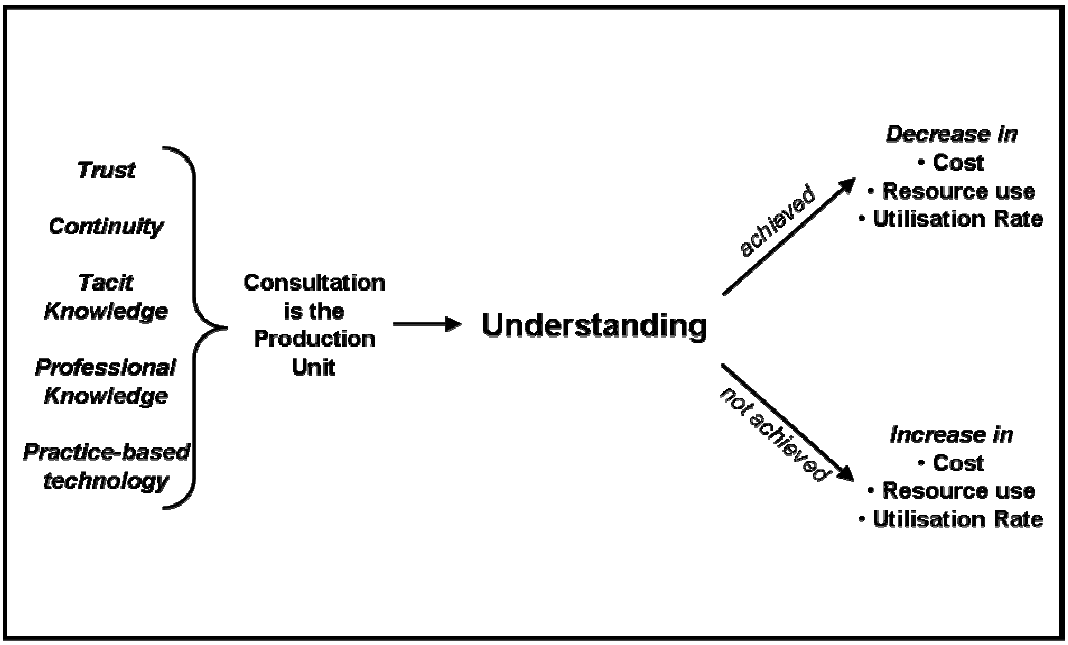
The drive to technology-dependent activities reflects a variety of societal forces: the belief in technology as a means to achieve certainty and cure; our inability to cope with "not being able to offer cure"; the legal interpretation of reasonable doubt in an uncertainty environment; and the uncritical sensationalisation of technology in the media and so forth.

4. Why does achieving health depend on achieving trust?

The GP – based on his medical knowledge, his ability to deal with undifferentiated health problems and his understanding of the illness experience – is the principle health care provider in the community. He is the generally trusted person in the system,[11] and trust is the building block to achieving health.[12-14] Trust depends on knowledge about each other and builds over time between a provider and a patient – the sense of achieving knowledge may take up to 5 years.[15 16]

A continuing and trusting relationship is of particular importance to both doctors and patients when dealing with chronic, complex and psychosocial health problems.[17]

The ***personalised nature of health care*** cannot be underestimated – in terms of quality of care as well as health care cost (see figure).



Recently some have questioned the value of the personal provider-patient relationship, and proposed that information sharing within teams is the all important aspect.[18] This view stands in stark contrast to the large literature that has shown the benefits of personal care (or provider stability) in relation to health care processes,[16 19-23] resource use[22-24] and patient satisfaction,[22 23 25] and may indeed reflect the *shared sense of responsibility* between provider and patient.[26]

In economic terms, Tudor Hart showed that the consultation is the production unit in medical care – that is were the decisions about the further consumption of health care resources are made.[14]

Guidelines and evidence-based medicine due to their de-contextualisation lead to rigidity and are a threat to the trusting relationship and the personalised nature of health care to individuals. Patients quite rightly want tailored care, not population-based care, i.e. they may want and need to have approaches contrary to the "current best evidence", or they may wish to have no intervention despite "good current best evidence". In effect guidelines and evidence-based medicine are based on an efficiency model (i.e. population based) rather than what works for the ***health of an individual*.**[27]

Workforce Demands – a Complexity Problem

It is beyond the scope of this paper to outline a complete picture of the complex system underlying the workforce crisis. The most important decision to be made is what constitutes the ***overarching value of providing health services***. These values must be consistently applied to all domains and levels of the system. These values need to translate in a set of simple rules as these ultimately determine the systems' behaviour.[28-30]

In that regard a few simple relationships exist between the achievements of medical care and the workforce:

1. the amount of time spent in the consultation equates to the **level of understanding** achieved;

2. the level of understanding achieved during consultations determines the achievement of ***personal health*** and the ***use of resources***;

3. the achievement of ***personal health*** is dependent on time and other required resources, the sum of which equates to the required workforce size.

Implications for the Workforce – What Types, What Numbers

Initially it has to be recognised that the majority of illness occurs in the community, and that within any month less than 1.5% of the community requires either a consultation with a specialist or admission to hospital.[31] This means that the ***majority of perceived health problems*** – *acute and chronic* – are dealt with in the community setting.

In terms of workforce, Starfield and co-workers demonstrated that the ***composition of the workforce*** impacts greatly on the ***health status of the community*** – the more generalists compared to specialists practice in an area the better the care and the better the outcomes of care.[10 32-35]

Three aspects follow:

1. health service providers should be trained in ***holistic medicine***,[36]

2. the majority of health service providers should be ***generalists***,[10 37 38] and

3. the majority of education and training thus should occur in and deal with the provision of ***health service in the community***.

Community-based and community-oriented teaching in medical schools has been shown to be successful in both achieving high knowledge level and patient/community-centred capabilities.[39-42] It needs to be stressed that health care providers need to be **educated** to gain the necessary broad appreciation of the ***human condition called illness***, which stands in stark contrast to the **instrumental nature of training** (e.g. of technicians who can perform mechanical or technical tasks).

The central question however remains – what does/should a health care provider do in the encounter?

Several points are of importance:

1. Knowledge about the patient and the patient's knowledge about the provider are critical to the outcomes of the consultation,[15 19 22-24] and the resulting level of trust paramount to the effectiveness of the consultation.[12]
    a. Stability of the provider-patient relationship with the primary care provider is essential to develop a bilateral knowledge base.
    b. Provider substitution for "apparently trivial acute" or routine follow-up of stable chronic disease imposes a disruption in continuity of care and the development of the all important tacit knowledge base, and differs from the notion of extended team-based care.
    c. Knowledge and trust are the essential ingredients to clinical decision making in the absence of "textbook symptoms and signs".

2. What happens in the encounter determines resource use, but also utilisation in the future.[14]
    a. More providers seeing fewer patients longer is likely to achieve more efficient and more cost-effective care.
    b. Co-ordinated team-based care at the patient's usual place of practice is likely to enhance these benefits.[43]

3. Continuous up-skilling will enhance the effectiveness and efficiency of care in the primary health care setting.
    a. Examples include the use of Dopplers in community-based ulcer clinics.
    b. Near patient pathology will expedite diagnostic and monitoring of disease.
    c. Introduction of new technologies like ultrasonography into primary care will expedite diagnostic accuracy for common and/or serious conditions like gall stones or miscarriage.

4. Achievements of care must be measured in terms of ***personal health***,[8] not separation rates, disease-specific indicators or mortality rates.

5. Achievement of ***personal health*** must be remunerated appropriately. It is unsustainable to the future of health care and the patients'/communities' health to over-reward technology driven interventions benefiting few in favour of simple and holistic co-ordinated care in local communities benefiting many.

The future workforce

The most effective and efficient form of providing primary care in the future will be to **build on the strength** of the community dispersed, community based model known as general practice. GPs are the well-established and trusted core primary care providers in the Australian health system. The system can be dramatically strengthened by

1. enhancing the strength of personalised care by advancing GPs' clinical and technological skills required for effective and efficient chronic and complex disease care;

2. having timely access to the specific skills offered by the wide range of primary care focused allied health professionals;

3. enhancing care by hosting multi-disciplinary community outreach teams – i.e. doctors and allied health professionals specialised in dealing with specific aspects of patients with chronic and complex diseases simultaneously provide input in the long-term management of these patients; and

4. being an integral component of an extended local network of health services (in a hub and spoke arrangement) that diffuses the separation of primary and secondary care so that patients can benefit form specific treatments in their local environment (e.g. building on the “hospital in the home” approach).

In this scenario the emerging **stable primary care centre** will consist of a **stable team** of 3-5 GPs, supported by a number of practice nurses with additional advanced skills in the assessment and managemenrt of patients with chronic diseases, in basic skills of instructing in home monitoring and basic advice on healthy living (nutrition and exercise). This core team is supported by a full-time physiotherapist, and part-time dieticians, psychologists, occupational therapists and social workers.

The team works interactively, i.e. the treatment goals agreed upon between the patient and the doctor are documented, and a care plan is established with the input of the relevant team members. The primary care team – working side by side and knowing each us well – expands and extents the trusting environment from the current doctor-patient to a team-patient relationship.

Summary

Workforce is not simply an issue of numbers. The overriding concern must be a value driven approach to medical care and the health care system. The checklist against which to evaluate proposed initiatives must contain these questions:

1. does this initiative increase the ***personalised health experience*** of patients, i.e. is there ***positive health gain***?

2. does this initiative foster ***education*** of ***holistic*** health care providers?

3. does this initiative increase the number of ***generalists*** in the community?

4. does this initiative strengthen the ***provider-patient relationship*** and at the same time extend it towards a stable extended care team?

5. is this initiative adequately rewarding the achievement of a ***personalised health experience?***

I am happy to provide further comments or clarifications at any stage.

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