Australian Divisions of General Practice

Submission in response to the Productivity Commission's Issues Paper: The Health Workforce

August 2005

Promoting the health and wellbeing of the community through primary care teams

Executive Summary

Australia's health care arrangements are complex and rapidly changing. The Productivity Commission inquiry into Health Workforce provides a rare opportunity to consider some fundamental and systemic issues around how the health workforce is trained, organised and financed and the planning and systems changes that need to occur to ensure a viable Australian health system into the future with general practice at its centre.

This submission is made on behalf of the Divisions of General Practice Network by the Australian Divisions of General Practice (ADGP). The Divisions Network is funded by the Australian Government to support, better connect individual GPs and link general practice to the wider health system. ADGP is the Network's national peak body.

A number of complex workforce supply and demand issues affect general practice. These command sophisticated policy responses, not 'magic bullets' solutions.

The Australian population is ageing and the burden associated with chronic disease is growing. If we are to take the pressures off the tertiary care sector there is an increasing need to provide for the management of chronic illness, to introduce effective preventive programs and to promote wellness in the primary care setting.

The way the workforce is distributed, the profile/demographics of the workforce, the way care is delivered and the way individual practices operate are driven by a multiplicity of factors. Workforce numbers are a result of the broad funding and organisational environment in which the workforce exists. How the system is financed, organised and supported can make a difference. There have been some attempts to use various policy levers to better distribute general practice, for example, but additional measures are required.

This submission has five major tenets:

- **A viable and vital primary care and general practice sector is the lynchpin to an effective health system**. Systems which rely more on primary health care and general practice than on specialist care can deliver better value to the taxpayer in the form of population health outcomes, improved equity, access, continuity and lower costs.
- **The characteristics of contemporary general practice and support for its viability requires a fresh policy perspective**. General practice in Australia has evolved and changed. The present characteristics of the general practice workforce in Australia are the outcomes of traditions, history and policy settings that reflect a complex range of expectations of the medical profession, of the community and of political decisions and policy interventions that have occurred in an ad hoc way over many years. A more systemic approach is required.
- **A serious investment in primary health care policy and systems reform is needed**. International examples illustrate that different policy aims and settings and different institutional and financing environments can result in a primary care workforce whose characteristics and organisation can enhance the provision of care with general practice at its core.
- **The solution is not just a 'numbers game' or about higher rebates – different modes of working within the primary care setting are needed**. While these are important aspects of the primary health care system, they are not solutions to contemporary health workforce issues in their own right or in isolation. The broader aims of a viable, vital modern health system will only be met if primary care can be effectively supported and integrated with other sectors and disciplines to deliver multidisciplinary care. We increasingly need to see common chronic illnesses such as diabetes and cardiovascular disease managed and coordinated in the primary care setting by GPs supported by a team of practice nurses, pharmacists, diabetes educators, psychologists and other allied health providers responsible for various aspects of the patient's 'package' of care. In an environment of rapidly escalating costs of tertiary care, of new technologies and treatments,

and of an ageing population putting pressure on our aged care system, a robust and well-funded primary health care system delivering community-based prevention, early intervention and chronic disease management is equally paramount.

- **The Divisions of General Practice Network is a uniquely placed infrastructure that can help deliver the solutions**. The Network already plays a major role in workforce recruitment, development, retention and support, and in promoting quality chronic disease management and preventive care. More effective use of the Division's Network could be made in a system developed to allow the primary health care workforce to better adapt to the forces referred to above. Such a system would involve the Divisions in:
    - Assessing and monitoring workforce needs including a common data set
    - Managing, within broad guidelines, a suite of programs that address workforce issues. The delivery of such programs would be informed by a systematic knowledge of local workforce capabilities and deficiencies
    - Acting as a coordinating entity for addressing primary health workforce issues at the local level. Divisions, as locally controlled entities, are ideally placed to hold and administer pooled funds for the delivery of specific programs, to employ health professionals with specific expertise in order to build and support primary health care teams and to overcome one of the most vexing issues in the health sector, dealing with different funding streams from different levels of government.

Prior to the establishment of new workforce planning regimes, a coherent national Primary Health Care Strategy is a foremost need - a strategy that is focused on the dual aims of better consumer health outcomes and supporting and sustaining a viable health workforce. This will only be achieved through system redesign and a workforce planning framework which promotes efficiency and effectiveness of health service delivery through an investment in primary health care teams.

Introduction

The Australian Divisions of General Practice (ADGP) is pleased to provide this submission to the Productivity Commission's study into the health workforce. Given the prime role of Divisions within primary health care and general practice, this submission focuses on the workforce issues currently facing the general practice setting, and ADGP's views on possible policy solutions.

While noting that the Commission is not necessarily interested in the needs of specific workforces, ADGP would argue that general practice is a special case and requires particular consideration. We take this view in light of evidence that suggests that those countries with health systems underpinned by strong, integrated primary health care and general practice sectors deliver better whole of population health outcomes, improved equity, access, continuity and lower costs[1].

The submission is in four parts. Part 1 provides an overview of ADGP and our key policy platforms with regard to primary health care policy. Part 2 provides an overview of contemporary general practice, workforce programs of relevance to general practice, and the role of the Divisions Network in health policy and service delivery, with an emphasis on the role played in supporting and linking the health workforce. Part 3 discusses ADGP's perspectives on health workforce issues with particular reference to the overarching interest of the Commission, that is, a focus on common themes and system-wide problems which governments will need to address to ensure the efficient and effective delivery of health services in coming years, rather than focusing in detail on the needs of each workforce group. The final part includes a concluding statement and summary of recommendations for reforming and better supporting the Australian health workforce.

1 The Divisions of General Practice Network

The Divisions of General Practice Network is funded by the Australian Government Department of Health and Ageing to promote communication between isolated GPs and GPs and other health care providers and to better link general practice and other service systems for better community health outcome. The Network comprises 118 Divisions across Australia as well as the eight State Based Organisations (SBOs) and the Australian Divisions of General Practice Ltd (ADGP).

Divisions are an integral component of the Australian Government's general practice strategy. They play a major part in implementing policy, supporting general practice and managing health programs at a local level and have been responsible for progressing many of the current developments in Australian general practice. The Divisions of General Practice Network provides a key local health infrastructure that enables the planning and delivery of primary care services at the local and regional level. In particular, the Divisions network is focused on supporting high quality, evidence based primary care, integrating health services and engaging the local community.

1.1 About ADGP

ADGP is the peak national body representing the Divisions of General Practice Network, which links around 95 per cent of general practitioners (GPs) across Australia and facilitates and drives change in the primary health care sector. As a result, ADGP, through Divisions, has contact with the majority of grass roots GPs in Australia. This has enhanced communication between the Commonwealth and general practice and has resulted in greater involvement of GPs in various health service initiatives.

The Australian Government funds ADGP to advance the health of the Australian community by acting as the national peak body for the Divisions Network by undertaking:

[1] *WHO HEN (Health Evidence Network) Report January 2004: What are the advantages and disadvantages of restructuring a health care system to be more focused on primary care service?*

- National leadership and governance, for the network to meet the Government's primary care priorities of increased access to services, greater integration, better chronic disease management and a focus on prevention and enhanced service delivery
- Coordination and synthesis of the views of the Divisions Network to contribute to the policy and program development of national programs that relate to Divisions
- Support and assistance to build the capacity of Divisions including the identification and promotion of models of best practice within the Network in co-operation with SBOs
- Support and management of the development and oversight of the practical application of a quality framework aimed at improving the consistency of quality management systems and governance within the Divisions Network
- The support of national research, evaluation and development to expand the evidence base for, and improve the quality of, primary health care through communicating and sharing information and resources with the Divisions Network and relevant organisations

In addition to these 'core' functions ADGP is funded, principally by the Department of Health and Ageing, to provide national leadership and co-ordination in key primary health care priority areas such as aged care, nursing in general practice, information management, and mental health.

At the policy level, there is a strong alignment between the Government's primary care priorities for Australia, the core business of Divisions and the focus taken by ADGP at the national level. Areas include:

- Making care more accessible
- Focusing on prevention and early intervention
- Encouraging better management of chronic disease
- Supporting integration and multidisciplinary care
- Building the evidence base for effective, quality primary care
- Recognising and respecting the variety of practice styles
- Using technology to support best practice
- Supporting equity of access to services across Australia

1.2 The role of Divisions of General Practice

Divisions' prime role is to support local general practice and the health needs of the communities that those practices serve. They do this through:

- Providing continuing professional development for GPs and practice staff in order to encourage the provision of quality, evidence-based care to their communities
- Conducting workforce support programs to help both recruit and retain doctors and other health personnel in their local areas
- Offering community based health promotion and self-management programs which emphasise health prevention and early intervention
- Engaging with health consumers as well as with community groups so that health programs can be adapted to best suit the needs of their local communities
- Promoting multidisciplinary team-based care within general practice and the broader primary health care sector.

Divisions support general practice by promoting a team based approach to care and especially encouraging an expanded role for practice nurses through ADGP's practice nurse program. Practice teams provide benefits to professionals working within general practice through, for example, increased collegiate support[2]. Such support helps sustain the general practice workforce

[2] *Watts I, Hutchinson E, Pascoe T, Whitecross L, Snowden T 2004. General Practice Nursing in Australia; RACGP/RCNA.*

– important in a time of workforce shortage. Multidisciplinary practice teams also help improve health outcomes for consumers, particularly with regard to chronic disease[3] [4].

In addition to the support provided directly to practices and communities, Divisions engage in a variety of activities which also contribute to enhancing linkages within the primary care sector and between the acute and primary health care sectors by co-ordinating and engaging with various medical and allied health practitioners and other services at the local, regional and state level. Some examples of the ways in which Divisions achieve these linkages are provided below.

2 Contemporary general practice

2.1 The context of contemporary general practice

General practice plays a central role in the current Australian health system where it fulfils several key functions: It provides the first point of contact for people accessing the health system; It acts as the gateway to the rest of the health system where further referred care is required and; It delivers high quality, wide-ranging, continuous care within the general practice setting as well as coordinating care within the broader primary care sector and between the primary and tertiary sectors as required. These various roles mean that general practice acts as both an independent service provider and manager of health care, as well as acting as a gatekeeper to the wider health system through its linkages to other service providers (many of which, in more recent years, have been mediated by Divisions of General Practice.)

This dual role, together with the fact that over 90 per cent of the population see their GP in any one year makes general practice an ideal setting not only for treating and managing ill health but also for health promotion, opportunistic and early intervention and delivery of health gain. Not surprisingly, evidence indicates that populations that are served by well-coordinated health systems with an emphasis on primary care / general practice receive optimal care and improved health outcomes[1.]

2.2 Statistical overview of contemporary general practice

Approximately 41 percent of Australia's working medical practitioners work as non-specialist, primary-care clinicians. Whilst these are all colloquially referred to as "general practitioners" (or GPs), technically this group comprises three main types: Vocationally Registered[5] (VR) or recognised GPs; GP registrars (or "trainees") undergoing VR training and Other Medical Practitioners (OMPs). This latter group mainly consists of Australian trained, permanent resident doctors who did not obtain VR prior to 1996 and a large proportion of temporary resident overseas trained doctors (TROTD) working in general practice[6] [7].

These primary care practitioners engage in the primary care of patients through general practice. At the end of 2002, there were 21,815 primary care practitioners employed in Australia, comprising 13,888 (64 percent) males and 7,927 (34 percent) females. Of the total, 18,879 were Vocationally Registered GPs (VRGPs), another 1,080 were RACGP trainees and 1,856 were OMPs[8].

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[3] *Wanger E, Austain B and Von Korff M 1996. Organizing Care for Patients with Chronic Illness. The Millbank Quarterly (74) 511-534*
[4] *Sibbald B, Luarant M, Scott T. 2002 Changing task profiles in Saltman A, Rico A & Boerma W (Eds) Primary Care in the Driver's Seat? Organisational reform in European Primary Care.*
[5] *Since 1996, all Australian trained doctors who enter general practice must undergo further post-graduate training to become vocationally registered through the Royal Australian College of General Practitioner's (RACGP) recognised training program.*
[6] *Sims G and Bolton P 2005.The supply and distribution of general practitioners. In: General Practice in Australia: 2004 First edition. Canberra. P98.*
[7] *AIHW (Australian Institute of Health and Welfare) 2003b Health and Community Serviices Labour Force 2001. Canberra. (AIHW Cat. No. HWL 27 and ABS cat. No. 8936.0)*
[8] *AIHW (Australian Institute of Health and Welfare)Labour Force – Medical webpage: http://www.aihw.gov.au/labourforce/medical.cfm Accessed July 2005*

2.3 Contemporary general practice – workforce issues

Reference is frequently made to the critical workforce shortage that is facing general practice and other professionals within the health system. In reality however, the overall number of general practitioners has increased in recent years and there has been a continued (but reduced) positive growth (3 percent over 5 years) of overall primary care non-specialists other than those working in a "casual" capacity. In 2001 – 2002 there were 24,307 non-specialist medical practitioners billing for services provided under Medicare – 16 percent more than in the 1988 – 1989 period[9]. Despite this, access to primary care practitioners / GPs (as well as to other supporting allied health professionals) has declined. Several factors, relating to both supply and demand of the workforce, have contributed to this situation and must be taken into account in approaches to redress this imbalance. These factors include:

- The changing profile of general practice over recent years
- An unequal distribution of the medical and other health workforce across Australia and
- Changes in focus and demography of Australian health consumers

2.3.1 Workforce supply issues: the changing profile of Australian general practice

The profile of general practice in Australia has changed over recent years. There has been a shift away from GPs as solo practitioners providing episodic opportunistic care, one way referral processes and fee-for-service financing to a greater focus on integration and shared care, prevention and early intervention, structured chronic disease management, multidisciplinary primary care teams, and blended payments that remunerate quality care. This has meant change in both the delivery of care and the business side of general practice.

The face of general practice is also changing in other ways. There is a clear and ongoing increase in female GPs with females now comprising most of the graduate and registrar pools. The proportion of female non-specialist primary care practitioners has increased between 0.5 percent and 1 percent per year since 1985 and reached 35 percent in 2001 – 02. This growth is due not only to a greater number of female GPs but also a decline in the number of male GPs. There is also a growing trend towards part-time work. This is only partly explained by the increasing feminisation of the workforce. Younger GPs, both male and female, now seek greater diversity in what they do and increasingly elect to work only part-time in clinical consulting roles, with their remaining time spent in non-consulting as well as non-medical activities (such as academia, public health and family work)[10] [11]. While such alternatives provide greater career options for GPs and help them to achieve a better work-life balance - both important factors in retaining doctors within general practice - the result is that community access to GPs is decreasing, despite an increased total number of GPs within the workforce.

Overall numbers of primary care practitioners practising in traditional procedural special interest areas has also generally declined. For example, 14 percent fewer primary care practitioners reported practising in areas such as internal medicine and surgery in 2000 compared to 1998[12]. The number of GPs practising obstetrics has also decreased in some areas, partly as a result of a more litigious society and the high costs of indemnity cover now required. Decreases in the number of GPs offering such services mean that patients must often look to the acute care setting for these procedures. This can have a serious impact on access for regional, rural and remote communities where additional hospital infrastructure is often lacking. Practice in some special interest areas has, however, increased. For example, since 2000 more primary care practitioners reported special interest practice in the areas of women's health (up by 40 percent) and aboriginal health (up by 15 percent)[12].

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[9] *Sims G and Bolton P 2005.The supply and distribution of general practitioners. In: General Practice in Australia: 2004 First edition. Canberra. P100-01*

[10] *Harding, J. 2000 The supply and Distribution of general practitioners. In: general Practice in Australia:2000. Canberra: Department of Health and Aged Care*

[11] *Sims G and Bolton P 2005.The supply and distribution of general practitioners. In: General Practice in Australia: 2004 First edition. Canberra. P102.*

[12] *ibid P105-06*

2.3.2 Workforce supply issues: unequal GP distribution across Australia

Workforce mal-distribution has been a matter of policy debate for a number of years and although there are indications that rural health workforce capacity is increasing, primary care practitioner workforce remains unequally distributed across the states and territories, as well as across RRMA[13] categories. Although deficits still exist in rural and remote areas, increasingly, outer metropolitan as well as some other areas are undersupplied with primary care practitioners. The variations in primary care practitioner to population ratios between states and territories can be seen in table 1 below. The age distribution of primary care practitioners also displays some variation[14], as does gender breakdown, although this later varies to a lesser extent.

Table 1: Employed primary care practitioners and FTE rate per 100,000 population States and territories 2002[15]

	NSW	***VIC***	***QLD***	***WA***	***SA***	***TAS***	***ACT***	***NT***	***Australia***
Total	7,614	5,670	3,341	2,000	1,893	569	470	257	21,815
FTE rate (per 100,000 pop.)	108	106	82	91	112	103	131	115	101

The distribution of VRGPs and OMPs within the primary practitioner workforce also varies between states and territories and across RRMA categories with Queensland (QLD) and the Northern Territory (NT) having the highest proportion of OMPS billing Medicare at 26 percent and 25 percent respectively. OMPS play an important role in areas where GP to population ratios are low and help to increase accessibility to primary care practitioners especially in areas of workforce undersupply[16].

In 2001 - 02, primary care practitioners in capital cities and metropolitan centres were primarily both Australian residents and VRGPs. However, these two characteristics are less prevalent in primary care practitioners working in areas with smaller centre size and increasing remoteness. In fact more than 50 percent of the primary care workforce in remote areas are OMPs and over one third are TROTDs (see table 2 below).

Table 2: Distribution of ARDs and TRDs and recognised GPs and OMPS across RRMA areas
(Source: General Practice in Australia: 2004. Australian Government Department of Health and Ageing)

		Capital city	Other metro centre	Large rural centre	Small rural centre	Other rural areas	Remote areas	Total
Australian Residents	Recognised GPs	82.1	83.7	81.2	78.2	72.3	44.9	79.5
	OMPS	16.4	13.7	12.4	12.5	16.5	33.9	16.4
	Total ARDS	**98.5**	**97.4**	**93.6**	**90.8**	**88.8**	**78.8**	95.9
Temporary residents	Recognised GPs	0.5	1.1	1.6	2.0	1.8	2.6	0.9
	OMPS	1.0	1.6	4.8	7.3	9.4	18.7	3.2
	Total TRDs	**1.5**	**2.6**	**6.4**	**9.2**	**11.2**	**21.2**	4.1

Regional inequalities in workforce distribution also show that, as number of practitioners per 100,000 population decline with increasing remoteness, so too do number of hours worked. For example, the percentage of primary care practitioners working between 50-64 hours per week in

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[13] *RRMA: **R**ural, **R**emote and **M**etropolitan **A**reas Classification is an index of remoteness in Australia with 7 categories where 1 is a capital city and 7 is a remote area with a population <5000. For further information see http://www.ruraldoc.com.au/AboutUs/rrma.asp*

[14] *Victoria and the Northern Territory have the highest proportion of primary care workforce aged under 35 at 18% and 24% respectively, with the Australian Capital Territory and New South Wales the lowest at 8% and 13% respectively. The national average is 15%. AIHW 2003a Labour Force 2000. Canberra (AIHW Cat no AUS 33)*

[15] *AIHW (Australian Institute of Health and Welfare) 2004. Medical labour force 2002. Canberra: (AIHW Cat. No. HWL 30. National Health Labour Force Series No. 30).*

[16] *Sims G and Bolton P 2005.The supply and distribution of general practitioners. In: General Practice in Australia: 2004 First edition. Canberra. P113*

2000 was 28.6 percent in capital cities, 31.2 percent in other metropolitan centres and between 36.8 and 38.7 percent in all other rural and remote regions[17].

The point about these factors (age, gender, hours worked, GP status etc) is that they impact on sustainability and can compound / exacerbate difficulties in regions which already experience difficulties in access to routine as well as to the broader range of services that can be offered within a general practice / primary care setting.

2.3.3 Other health workforce supply and distribution

As with GPs / primary care practitioners, the current supply and distribution of other health workforce across Australia does not match the population distribution. There are less dental workers, registered nurses, pharmacists allied and other health workers employed per 100,000 population in non-urban areas than in capital cities. The geographic distribution of health workers in different occupations also varies[18].

A number of allied health and nursing professions are currently on the national skill shortage list[19]. Once again however, the issue is not simply about numbers. For example, between 1997 and 2003 there has been a 6.3% increase in all nurses employed in the health workforce in Australia[20].

Other factors such as hours worked, age of the workforce, time in clinical roles, changes in population profiles and consumer demand also need to be taken into account. In fact when population growth alone is considered, despite increased numbers of nurses, overall there has been a decrease in the rate of nurses from 1,202 nurses per 100,000 population in 1997 to 1,191 in 2003 [20].

These factors have an impact on the provision of health services and the way they are delivered, particularly to people in areas of undersupply. Different models of working need to be considered to address this situation, not just greater supply. In the general practice setting, there is a clear role for practice nurses to assist in the provision of care in GP led practice teams - to enhance the provision of primary care services and provide valuable support to GPs. General practice nurses are able to undertake a wide range of clinical procedures and care coordination activities, as delegated by the practice doctor/s. The ADGP 2003 national practice nurse survey demonstrated that 45% of surveyed practices employed practice nurses (n=1,485). Of these practices, 40% employed only one nurse, while less than 2% employed five or more[21]. Support for practice nursing is a key role for Divisions of general practice.

The importance of Aboriginal Health Workers (AHWs) to primary care also needs to be considered. Apart from their clinical roles of wound treatment, administration of medicine, chronic disease management, immunisation and other prevention programs, AHWs play a key role in cultural brokerage and translation between Western medical systems and Indigenous communities.

A significant health disadvantage to Indigenous peoples in accessing general practice in Australia is that their health needs require a different style and quality of practice. Compared to mainstream general practice, clinical consultations in Aboriginal Community Controlled Health Services (ACCHS) are generally “more complex, with more young patients, more new patients, more home visits, more problems managed, more new problems and more consultations leading to emergency hospital admission”[22]. AHWs are often utilised in such situations both for consultations in their own right and / or as a means to access GPs and other health professionals[22]. Yet AHW numbers,

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[17] AIHW (Australian Institute of Health and Welfare) 2003a Medical Labour Force 2000. Canberra (AIHW Cat no AUS 33)
[18] Australian Institute of Health and Welfare website. Accessed July 2005 Labour Force – Health webpage http://www.aihw.gov.au/labourforce/health.cfm
[19] NSW Health website. Accessed July 2005. Australian Health Workforce Shortages January 2004 webpage :http://www.health.nsw.gov.au/amwac/pdf/Austhealth_shortages.pdf)
[20] AIHW (Australian Institute of Health and Welfare) 2005. Nursing and midwifery labour force 2003. AIHW cat. no. HWL 31. Canberra: (Health Labour Force Series no. 31).
[21] Australian Divisions of General Practice: National Practice Nurse Workforce Survey 2003
[22] Thomas D, Heller R and Hund J. 1998: Clinical Consultations in an Aboriginal Community-Controlled Health Service: a Comparison with General Practice, Aust NZ J Public Health 22(1): 86-91.

particularly in the NT, are decreasing[23]. More must be done to support the training and provision of this necessary part of the primary care workforce.

2.3.4 Workforce demand issues: changing health consumer / population profiles

While supply issues are an important part of the health workforce situation in Australia, equally important is consideration of workforce demand issues. These have changed over recent years in two main ways: the changing demographic profile of Australia's population and the increasing expectations of Australia's health consumers.

Australia's population is ageing. Not only is the ageing population increasing *numerically* (in that there are more actual numbers of older people in Australia), it is also changing *structurally* in that the proportion of people aged 65 and over in Australia is rising. Between June 1996 and June 2003, the 45 to 65 year age group increased by 2.8 percentage points to 23.8% of the total Australian population whilst the same period, the 65 years and over age group increased by 0.8 percentage points to 12.8 percent of the population. Predictions for the years between 2001 to 2021 suggest that there will be an overall rise of 73% in people aged 65 years and over from 2.4 million in 2001 to 4.2 million in 2021[24] [25].

In terms of practice populations, the proportion of patients new to GP practices is increasing, indicative of increased mobility in the Australian population but also carrying implications for continuity of care. Patients are increasingly making appointments for prescriptions, referrals, tests or investigations and less likely to visit GPs with symptoms and complaints, or specific diseases. This may suggest increasing long-term management of chronic diseases, the rates of which are also currently high. Seven of every 10 general practice consultations is chronic disease related[26]. Rates of obesity, a risk factor for a number of chronic conditions, are also rising in Australia[27]. Hypertension is the most frequently managed chronic problem, followed by depression, then diabetes, lipid disorders and osteoarthritis. Together these account for almost half of all chronic problems managed[28]. There is a growing burden of disease associated with common risk factors, and increasing evidence of the link between mental health and physical health outcomes. It is likely that the ageing population will increase the already high rates of chronic disease experienced in Australia and place further demand on the health workforce.

Coupled with this, consumer expectations are also increasing. Health consumers have become progressively more litigious. There is more public access to scientific and health literature and in some cases, the paternalistic approach to care is decreasing as patients elect to be more actively involved in their health care. Whilst these aspects are in the most part beneficial and assist patients to take more responsibility for their own health, they can also lead to increased demand for services that are already stretched[29].

2.4 General practice workforce programs

A number of programs have been developed to actively assist with and manage the changing general practice and primary health care workforce situation. Such programs include:

- The establishment of Rural Workforce Agencies (RWAs) in 1998 which provide incentives and support for rural practice
- Access to provider numbers for Overseas Trained Doctors (OTD) to enable them to work in areas of need

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[23] NT Primary Health Care Workforce Update, February 2004 of the Top End Aboriginal Health planning Study (2000) and the Central Australian Aboriginal Health Planning Study (1997) undertaken under instruction from the NT Aboriginal Health Forum through their regional planning structures (TERIHPC & CARIHPC).

[24] AIHW (Australian Institute of Health and Welfare) 2003. Australia's welfare 2003. Canberra: AIHW.

[25] Australian Government Department of Health and Ageing: The Concise Fact Book November 2004.

[26] Britt H Miller G, Knox S et al. General Practice Activity in Australia 2000-01. AIHW Cat. No. GEP 8. A joint report by the University of Sydney and the AIHW. Canberra: AIHW Dec 2001. (Gen. Prac. Serries no.8)

[27] Catford J and Caterson I. 2003. Snowballing Obesity: Australians will get run over if they just sit there. MJA 179: 557-579

[28] Australian Institute of Health and Welfare website. Last reviewed June 2005. Use of General Practice services webpage http://www.aihw.gov.au/cdarf/data_pages/gp_practice/index.cfm

[29] Larsen R. Inflated consumer expectations erode healthcare quality.2000 Postgrad Med. 107(1):21.

- The 2003 *Strengthening Medicare* OTD initiative which aims to recruit an additional 725 OTDs to Australia by 2007
- the addition of Doctors to the Skilled Migration list to ease entry for OTDs into Australia
- The Bonded Medical Places (BMP) Scheme which supports medical graduates in return for their commitment to work in an area of workforce need
- Additional university places for medical students and the establishment of new medical schools
- The establishment of 10 University Departments of Rural Health across Australia
- Funding for GP registrar rotations to rural areas
- The prevocational General Practice Placement Program which funds 12 week postgraduate placements to general practice in areas of workforce undersupply
- The Rural Australian Medical Undergraduate Scholarship (RAMUS) scheme. An un-bonded program available to students of rural origin
- The John Flynn Scholarship Scheme which supports extracurricular placements for undergraduate medical students in rural and remote areas
- Incentive payments to GPs who work in Areas of Need
- Rural locum relief programs which provide funding to eligible areas for locum doctors
- Funding for procedural up-skilling for rural GPs
- More Allied Health Services (MAHS) which provides funding to increase allied health services and linkages in rural areas
- *Better Outcomes in Mental Health Care* (Better Outcomes) which provides GPs with mental health training and promotes better linkages between GPs and other mental health providers
- Practice nurse programs including:
  - A Practice Incentive Payment (PIP) to encourage eligible practices to employ more nurses,
  - Funding for the provision of ongoing training and support of all nurses working in general practice
  - A Scholarship Scheme to support nurses who wish to re-enter the workforce, and to provide funding for nurses currently employed who wish to refresh their skills.
  - Two new MBS items for services provided by general practice nurses for immunisation and wound care services.
  - Extension of the PIP practice nurse incentive payments to urban areas of workforce shortage.
  - An additional MBS item for Pap Smears taken by practice nurses in regional, rural or remote areas.
- Allied Health MBS items which enable GPs to offer Government subsidised referrals for up to five visits with relevant Allied Health providers
- The introduction of new Chronic Disease Management MBS items which remunerate multidisciplinary team working in managing disease, especially chronic and co-morbid conditions
- Medical Specialists Outreach Assistance Program (MSOAP) which helps to improve access to medical specialist services for rural communities near their homes
- Broadband and e-health initiatives which enable GPs, especially in rural areas, to access health information and records on-line
- Rural Medical Infrastructure Fund (RMIF) which provides funding to small rural councils to help establish 'walk-in walk-out' community medical facilities, making it easier to recruit or retain general practitioners
- After Hours access to primary care services through the "Round the Clock Medicare" initiative announced in September 2004

2.5. Divisions specific role in workforce support and development

Divisions play a major role in workforce support and development. Virtually every activity that Divisions perform has the central aim of supporting their regional workforce. Subsequently, Divisions are highly experienced in workforce support, vacancy information provision, continuing professional development (CPD) and other workforce activities. Workforce support especially is key business for rural, regional and outer metropolitan divisions. Particular workforce programs which have closely involved the Divisions Network include MAHS, Better Outcomes, Practice Nurse Initiatives, a number of GP rural schemes and after hours programs.

95 per cent of Divisions are involved in at least one activity to support the workforce needs of GPs. The most common type of activity is education, training and professional development (76 percent), followed by support for registrars and medical students (73 per cent). Notably, there have been large increases (26 percent) in the number of Divisions supporting registrars and medical students, and similar but smaller increases in support for recruitment and retention programs and support for OTDs[30].

More than 50 percent of Divisions provide locum and after-hours support for their existing workforce, support for OTDs and recruitment and retention programs.

2.5.1 Examples of workforce activities provided by Divisions

Workforce Support for Rural General Practitioners (WSRGP) Program

Many rural divisions are involved in the Workforce Support for Rural General Practitioners (WSRGP) Program[31] which is part of a package of education, training and workforce initiatives designed to address the short, medium and long-term needs of the medical workforce in rural and regional Australia. Funding for the Program is managed by eligible rural Divisions of General Practice. This recognises the important role that Divisions play in improving health outcomes for communities at the local level. Sixty-six Divisions of General Practice, with at least five per cent of their population living in rural areas, are eligible for WSRGP develop funding.

In 2003-04, key activities that Divisions provided as part of the WSRGP Program included:

- Family support activities (such as orientation of family to area, house and school assistance, social activities, assisting spouses with employment, family camps)
- General Practitioner support
- Practice support and
- Education activities

2.5.2 Overseas Trained Doctor (OTD): recruitment, support, orientation

Many rural and remote and outer metropolitan regions,are without sufficient doctors, especially GPs. Although importing a skilled workforce into Australia is by no means the complete solution to this situation, OTDs[32] who migrate to Australia as either temporary or permanent residents play an important role in helping to address the health workforce issues that currently face Australia, particularly in areas of workforce undersupply. In fact, OTDs make a significant contribution to the medical workforce in many rural and regional communities which otherwise would often lack access to any GPs and are generally over-represented in such areas.

In addition to their general workforce support activities, many Divisions also provide assistance to OTDs in the following ways:

- General orientation and support programs for OTDs and their families. Such programs assist these doctors to adapt to the Australian culture and health system and play a key role in retaining doctors in needed areas.
- Working with RWAs to recruit doctors. In this case, Divisions share the national / international and local recruitment and support activities with RWAs according to each agency's expertise with the result that placements are more suitable and sustained.
- Case managing OTDs. The case management starts from the time the vacancy is listed, through to placing and settling the doctor and their family in the practice and in suitable accommodation, and carries on beyond that to orientation, mentoring and where necessary, assistance with training and the like. The case managed approach not only assists in better matching the placement to the practice, but also helps to ensure that appropriate and more individually customised support processes are in place for the new OTD in a timely way.

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[30] Kalucy E, Hann K, and Guy S. 2005. Divisions: the Network evolves. Report of the 2003-2004 Annual Survey of Divisions of General Practice. Adelaide. Primary Health Care and Research Information Service.

[31] The WSRGP program is part of the broader Rural Health Strategy devised by the Commonwealth Government in 2000 to develop long-term measures to increase the rural workforce in Australia, including support for recruitment and retention of GPs in such areas.

[32] OTDs have more recently been referred to as International Medical Graduates (IMGs) but for the purposes of this submission the term OTDs is used.

- In some cases, Divisions also undertake the bulk of the recruitment process as well as the mentoring and follow-up support work in order to find suitable placements who are likely to stay for a reasonable length of time so that the recruitment effort is maximised.

Divisions often provide follow-up work for newly placed doctors in their areas (again, especially for OTDs) such as:

- Finding accommodation, spousal employment, sorting out schooling for children
- Cultural orientation and communication training for OTDs
- Mentorship / supervision / GP peer support for the doctor
- Helping the doctor train toward fellowship / working with Regional Training Providers,
- Facilitating CPD events to promote quality practice.

2.6 Practice capacity and business management programs

Workforce issues and the changing profile of general practice impacts not only on clinical care but also on the business side of general practice. There is more "red-tape" involved. With larger practices, less GPs have experience as practice partners and younger GPs are less willing to be involved in managing practices. These issues must also be addressed in workforce planning so that effective and efficient business processes can be implemented to maximise the clinical time that general practice clinicians have available. Many Divisions work with their practices to develop practice capacity by taking a systems approach that builds on and maximises available resources and increasing technology for example by:

- Providing training and assistance to GPs and their practices on the use of electronic and non-electronic business systems to enhance practice capacity
- Increasing the capacity of GPs and their practice staff to implement chronic disease management initiatives through education and training regarding disease registers, recall systems, clinical management guidelines as well as in improved utilisation and referral to local allied health services etc.
- Providing assistance to practices about the use of Practice Incentive Payments (PIP), Enhanced Primary Care (EPC) Service Incentive Payments (SIP) and other MBS items

3 An ADGP Perspective on the General Practice Workforce

In this part, we have taken relevant headings in Chapter 3 of the Commission's Issues Paper as a general to guide the discussion and points of view on general practice workforce issues and how they might be addressed.

3.1 Some opening remarks

The Australian general practice workforce is highly motivated and skilled. General practice has evolved within a tradition and history of independent, self-regulated professional bodies. However it is doubtful if Australia's complex and rapidly changing health arrangements can in future rely only on the integrity and traditional professional values of individual, highly motivated general practice professionals to achieve optimal workforce outcomes in terms of fundamental matters such as the scope of work performed by GPs, distribution of practitioners and, especially, orderly interactions with other parts of the health system and other health professionals.

Powell-Davies and Fry describe two conflicting perceptions of general practice. These are "a service that is largely autonomous and stands apart from the wider health system" and "a service that is essentially the 'front end' of the health system and that depends heavily on its relationships with other service providers to carry out its role of providing, coordinating and mediating care"[33].

[33] *Powell-Davies G and Fry D 2005. General Practice in the Health System. in: General Practice in Australia: 2004 First edition. Canberra. P422.*

ADGP accepts international comparative work which finds that health systems with strong, integrated primary health care and general practice sectors deliver better whole of population health outcomes, improved equity, access, continuity and lower costs[34].

Australia's health care arrangements have evolved in a rather haphazard way. ADGP believes strongly that the broader aims of a modern health system will only be met if primary care can be effectively supported and integrated with other sectors and disciplines. ADGP believes that Australia must evolve processes and structures that ensure effective integration in which multidisciplinary care can occur. Whilst important one-to-one professional relationships between practitioners and patients must be preserved, GPs must also be supported to be both deliverers of care for complex, co-morbid issues as well as clinical coordinators of care, through better linkage and access to multidisciplinary support. This activity already occurs to some degree through: shared care with public health services, collaborative care through programs (including MAHS and *Better Outcomes*) and, in the practice setting, through the involvement of practice nurses in health assessment, care planning and care coordination. However, there is scope for the system to feature this mode of care in a much more coordinated and systematic way.

ADGP has not included a large amount of detailed descriptive material in this submission as there is much published work available on the general practice workforce. However, as highlighted in the Productivity Commission's May 2005 Issues Paper, there are some significant barriers which must be dealt with in order to implement the necessary changes required in general practice and the broader health workforce arrangements if sustainable gains are to be achieved. These issues include:

- The need for improved and better co-ordinated general practice health workforce planning. Current workforce planning is done by a combination of government and professional bodies, such as the Australian Medical Workforce Advisory Council (AMWAC), General Practice Education and Training (GPET) and the colleges. Yet none of these entities, AMWAC, GPET or the colleges, are directly accountable for ensuring that workforce aims are met in terms such as patterns of work, distribution of practitioners and interactions with other parts of the health system. More coordination between different parts of the system is need in the planning of workforce activities

- The need to consider workforce objectives in combination with other policy and health financing initiatives. While market forces are a prime influence on the distribution and other features of the primary care workforce government subsidies for medical services provided through Medicare, it is a distorted "market". The workforce consequences of medical care financing in Australia mean that workforce planning is often undertaken in isolation from other policy considerations. MBS underpinning of GP services essentially enables GPs to work where they like, for how long they like. Whilst GPs must be free to chose where they work, improved incentives (financial and non-financial) as well as other means (such as programs at medical undergraduate level etc) must be enhanced in order to attract and retain GPs and other health professionals in areas of undersupply.

  Outside of public hospitals almost all expenditure on medical services in Australia relates to services that are provided by practitioners on a 'fee-for-service' basis. This is reflected in the distribution of funding for medical services. Of the $11.2 billion spent on medical services in 2001–02, 79.9 percent was funded by the Australian Government[35].

  One example of the risks of considering workforce initiatives in isolation from other factors is the recent substantial increases in MBS GP rebates. These may exacerbate GP misdistribution if some GPs had been under pressure to consider relocation to less attractive areas. That is, a major policy (undertaken for good reasons) may well have an adverse effect on the effectiveness of other programs designed to attract doctors to

[34] *Starfield B. 1998. Balancing health needs, services and technology. Revised Edition, Oxford University Press New York.*
[35] *AIHW (Australian Institute of Health and Welfare) 2004: Health Expenditure Australia 2002-2003. (AIHW Cat. No. HWE 2)*

practice in less well serviced locations. It is useful to note that different policy aims and different policy settings can result in a primary medical care workforce with different characteristics, organised in different ways, and which does different things than the current general practice workforce in Australia.

- Consideration of different models of practice in addition to increased workforce numbers. As a way of simply illustrating the broad argument that things could be different and that the primary care workforce could be organised to better meet the emerging needs of a changing health system, ADGP notes that in other institutions and alternative financing environments, there are different health outcomes. Models from other countries, for example, the UK general practice model, the prepaid group practice model that operates in parts of the USA, and the New Zealand experience illustrate this point.

  ADGP is not proposing that Australia adopt such models as there are many contextual differences between Australia and these countries. They are mentioned here simply to illustrate alternative ways of working. Other countries have also struggled with the challenge of better integrating their primary care arrangements with the wider goals of the health system and in some ways have progressed well beyond Australia.

  It is not for the ADGP but for the Commission and ultimately for governments and the broader community to decide whether the contributions of Australia's health workforce can be achieved by a series of relatively minor adjustments to existing arrangements or whether some more radical proposals are required.

  A striking difference between UK and Australian general practice is the difference of GP to population ratios. The UK Royal College of General Practitioners (RGCP) Primary Care Workforce Committee has examined the most recent NHS Census, which counts the number of GPs per 100,000 weighted populations, weighted for age and need. The RCGP data indicates there is a "headcount" of 30,358 GPs in England and a "Whole Time Equivalent" number of 27,624. The average figure of GPs per 100,000 population in England is 56.42 and equates to an adjusted list size of 1772. The variation in GP numbers is much less wide than in Australia ranging from 63.94 per 100,000 people in North Central London to 50.95 in South Yorkshire[36].

  These figures contrast with similar Australian data. The AIHW reported in 2002 that there were a total of 23,243 general practitioners in Australia for approximately one third of the population of England. In the UK general practices (not individual general practitioners) now contract with Primary Care Trusts to achieve defined outcomes. Practices there have greater flexibility and autonomy in how they deliver services. They can choose how they organise the care of their patients, with a view to selecting services that will provide quality outcomes in a more efficient and effective way[37].

  A new allocation formula means that practice income will no longer be based on the number of individual practitioners, but will increasingly reflect the particular health needs of each practice's local community. A new quality and outcomes framework will systematically resource GPs on the basis of how well care is provided for patients rather than simply the number of patients treated.

  The US is yet another scenario worthy of consideration, where Prepaid Group Practices (PGP) offer options for more effective primary health care delivery. Prepaid group practices (PGPs) are highly structured, multi-specialty medical groups that serve the enrollees of a HMO. When founded, PGPs adopted unique strategies, emphasising primary, preventive, and ambulatory care, and were among the first to develop coordinated approaches to care delivery.

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[36] *Royal College of General Practitioners website: Last updated August 2005: (Profile of UK General Practitioners, June 2004, RAGP Information Sheet No 1. http://www.rcgp.org.uk/information/publications/information/infosheettitles_index.asp*

[37] *Fradd S and Cross J. Radcliffe (Eds) 2004. The Insider's Guide to the New GP Contract. P4)*

Work by Winer[38] describes how eight large PGPs have structured their workforces to deliver care to consumers enrolled in several Health Maintenance Organisations HMOs. These groups cover large populations, in total around eight million people. Winer notes that determining whether a given provider-to-patient ratio is too low, too high, or almost right is both technically and conceptually difficult. Over the years, alternative methodological approaches have been used to set medical workforce "requirement" benchmarks.

The total U.S. primary care physician supply is about 93 per 100,000, whereas the adjusted primary care supply in the PGPs ranges from 58 to 80 per 100,000. At one HMO, 10 percent of primary care providers are Nurses or Physician Assistants (PA); at another, the non-medical proportion is 17 percent, and at the third, it is 25 percent. Nationally, about 14 percent of primary care providers are non-physicians.

Winer's study provides evidence that organised PGPs in urban and suburban areas can provide high-quality, cost-effective care to a diverse insured population with considerably fewer physicians than are now available in the nation at large. After adjustments are made to take differences in U.S.-to-PGP enrollee demographics and use of providers not employed by the PGP into consideration, the physician-to population ratios at the three PGPs is approximately 22–37 percent lower than the overall U.S. ratio. When nurses and PAs are added to the mix, the PGPs' total provider supply rate is about 24–36 percent lower than the national rate.

New Zealand general practice offers some useful parallels to Australia in that they provide services within a fee-for-service environment with co-payments from patients as well as some targeted fundholding. In addition, there are many similarities between Divisions and the New Zealand based Independent Practitioner Associations (IPA) and Primary Health Organisations (PHO)[39].

Equitable access to health care services is also an issue in New Zealand. To assist in dealing with this, the policy context of health in New Zealand is now fostering co-operative rather than competitive models of service provision with an increased focus on primary care as the key to overall improvements in service delivery and health[40]. New Zealand's recent Primary Health Care Strategy proposes to utilise PHOs to address problems of access to services and the lack of co-ordination between providers. Within Australia, the Divisions Network offers a similar mechanism and infrastructure through which to address these issues within the primary health care sector[41].

ADGP wishes to stress again that it is not proposing some radical change to the funding of health care based on the UK or USA managed care models. These examples are raised simply to illustrate the extent to which outcomes such as workforce numbers are a result of the broad funding and organisational environment in which the workforce exists.

ADGP suggests that it is futile to consider the general practice workforce as an isolated issue to do with numbers of doctors and training requirements. Any useful consideration of GP workforce issues must occur in the context of organisational, financing and distribution issues. Such an approach needs also to incorporate consideration of issues around how GPs operate within the context of health care teams.

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[38] *Winer JP. 2004. Prepaid Group Practice Staffing and US Physician Supply: Lessons For Workforce Policy. Health Affairs: Web Exclusive. Posted Feb. 2004 http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.43*

[39] *Barnett R and Barnett P.2004: Primary Health Care In New Zealand: Problems And Policy Approaches: Social Policy Journal of New Zealand. Issue 21.http://www.msd.govt.nz/publications/journal/21-march-2004/21-pages49-66.html*

[40] *Moon G. and North N. 2000. Policy and Place: General Medical Practice in the United Kingdom, Macmillan, Basingstoke.*

[41] *Independent practitioner Association Council (IPAC) conference 2005. Australian Divisions and others http://www.ipac.org.nz/conference2005/whoshouldattend.htm*

3.2 Meeting equity and access objectives in a fiscally responsible manner.

Access to general practitioners is a key community and public policy issue. Issues around general practice are more likely to attract media attention and political reaction than issues associated with other primary health care providers. The media has regular reports about long waiting times for appointments in many areas, shortages of doctors in rural towns and outer metropolitan areas, the lack of GP services after hours and on weekends, and of doctors leaving small towns because of closure of supporting facilities.

In the early 1970s, Julian Hart, a United Kingdom general practitioner, described the "inverse care law", which essentially states "the availability of good medical care tends to vary inversely with the need for it in the population served". In 2002, 30 years later a report by Furler and colleagues in the Medical Journal of Australia show that the inverse care law is still alive and well in general practice consultations in Australia. They showed that there is an inverse relationship between the need for longer consultations and the provision of them[42].

ADGP believes that the Commission must take a whole-of-health-system perspective in its consideration of the health workforce but cannot do this without some serious consideration of some details of the general practice workforce. Australia does not have an overarching framework and vision for primary health care or any widely endorsed program, beyond regularly some broad "in-principle" concepts, to move towards such arrangements.

The ADGP supports the National Health Workforce Strategic Framework developed over the last few years (Australian Health Ministers Conference April 2004). That framework lists various "guiding principles" including Principle 2: Distribution of the health workforce should optimize access to health care for all Australians, and recognize the specific requirements of people and communities with greatest need.

The framework goes on to list several very broadly defined strategies to realize the aims in the principle including incentives and disincentives to practice in areas and sectors of greatest need and workforce shortage, targeting training and education where the need is greatest and using innovative models of service delivery to improve access to areas of need

ADGP believes that such a strategy is needed in order to respond to emerging challenges that our health system faces including growing levels of chronic disease, the ageing population, ever rising health costs and the pressures emerging across the health workforce. A national, coherent and cohesive framework is needed to drive primary health care forward in an orderly way.

ADGP wishes to stress that it is not proposing some impractical, unworkable, politically unachievable, top-down bureaucratic control mechanism. ADGP is suggesting that much more thought must go into the 'manipulation' of all the policy instruments or levers available to achieve primary care and GP workforce outcomes more equitable than the present situation. A guiding principle should be that control and administration of policy be devolved as far as possible.

In summary, ADGP believes it should be an urgent priority to develop a National Primary Health Care Strategy to provide a policy framework to guide decision-making at all levels of primary health care, with consistent goals and strategies, policy which is focused on enabling integration of care between the various parts of the health system.

The Divisions of General Practice Network cannot develop such policy alone. Such development requires input from all primary health care service providers and stakeholders.

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[42] *Furler J, Harris E, Chondros P, Powell-Davies G, Harris M and Young D 2002. The Inverse Care Law Revisited: Impact of Disadvantaged Location on Accessing Longer GP Consultation Times. MJA; 177(2) 80-83.*

3.3 Shortcomings in workforce planning

> *"On the surface, workforce planning and forecasting appears to be largely a statistical undertaking—fuelled by data, shrouded by minutiae, and confounded by countervailing assumptions. But at its heart, the process is not a technical enterprise. Rather, determining what a nation's workforce should, could, or would look like ten to twenty years hence is fraught with conceptual, political, and even moral challenges and choices."* [38]

In the 1970s and 1980s, opinion swung between the notion that we had too few medical practitioners, and then too many. In the mid-1990s, AMWAC determined that an oversupply was emerging. In 1996 the Commonwealth, on advice from AMWAC, limited the total number of doctors entering general practice training to 400. In 2000 AMWAC recommended an increase to 450 places. In 2003 this was raised to 600 places by the federal government. The recent AMWAC study into Australia's need for general practice training suggests a large expansion in GP training places, maybe to around 1000 per annum[43] [44].

By the mid-1990s, government favoured a restriction on provider numbers and on the entry of overseas-trained doctors. Also, it was no longer assumed that distributional issues could be left to resolve themselves. In the 1992–93 financial year, the Federal Government started spending money on the rural medical workforce problem, introducing the Rural Incentives Program (later constituted as the Rural and Remote General Practice Program, or RRGPP). More recently, in the second half of the 1990s — reinforced by successive Australian Medical Workforce Advisory Committee (AMWAC) reports — it was the orthodox view that Australia had too many GPs overall, but too few in rural and remote areas, and too few medical specialists. By 1998, AMWAC had undertaken studies covering 50 percent of the specialist workforce, had reported shortages in most of them, and had recommended increases in training numbers. This was despite increasing anecdotal evidence of shortages across the board in the availability of general practice locums and the availability of GPs in outer metropolitan areas[45].

In the past few years general practice has attracted insufficient applicants to fill 600 training places. At the same time as the number of GP training places was increased, training places in other disciplines were greatly increased. The reality is that because of long time-lags there is now a major gap, with medical school output far short of the number of training places in all medical disciplines. It will be difficult to achieve the revised recommended GP training intakes, at least until the total number of medical graduates begins to increase later this decade following recent increases in numbers of medical students and medical schools.

Effective delivery of primary health care needs an adequate and sustainable workforce. The Division's network is ideally placed to initiate and develop recruitment and retention strategies for all levels of the primary health care team and to work with existing agencies to support and advance primary health care workforce capacity. The division's network recognises that comprehensive primary health care requires collaboration between general practice and other health care providers. Efforts to develop the primary health care workforce must therefore target GPs and other members of the primary health care team (e.g. allied health professionals, practice nurses, pharmacists, psychologists, carers etc).

The upcoming AMWAC report analyses likely influences on the demand for GP services factors such as demographic trends in the Australian population. The report will provide much useful data on the composition of the existing GP workforce. There was much concern about the benchmark adopted by AMWAC for its August 2000 GP report. ADGP is not certain how AMWAC is

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[43] *Australian Medical Workforce Advisory Committee (2000), The General Practice Workforce In Australia, AMWAC Report 2000.2, Sydney*

[44] *AIHW (Australian Institute of Health and Welfare) Jan. 1996: A report for the Australian Medical Workforce Advisory Committee (AMWAC Report 1996.1)*

[45] *O'Dea J, Kilham R. 2002. The inverse care law is alive and well in general practice. Med J Aust; 177 (2): 78-79.*

approaching this issue in the forthcoming report and is not sure that a national benchmark supply has much meaning given the many factors affecting demand for GP services. ADGP would have concerns about AMWAC's upcoming report if it recommends large increases in GP training input without some analysis of whether this would actually lead to increased access to GPs in under-serviced areas. ADGP would be wary of an outcome from the AMWAC report that resulted in just adding numbers without any regard for how more GPs may be distributed. More importantly, ADGP would wish to assess whether any recommendations of AMWAC have taken account of the workforce implications of changing work patterns within general practice, particularly factors such as the emergence of multidisciplinary teams. ADGP would also be concerned about recommendations that are unachievable. It is no point recommending substantial increases in training numbers if there simply are not the numbers of new graduates to fill the positions. In this case there should be more emphasis on other sources of GPs such as re-training and use of OTDs.

ADGP understands the desire of AMWAC and of its consultants to ensure the estimates of demand and the projections are not misused. ADGP is simply stressing that it believes a more robust, devolved and on-going system is required for decision making regarding GP workforce issues. ADGP believes that the current AMWAC methodology cannot meet this need and believes that great care must be taken before important decisions are based on the new AMWAC work.

In this context ADGP notes comments in the introduction to the Australian Health Ministers recent document "National health Workforce: Strategic Framework" (April 2004) that coordination is needed "across jurisdictions, service settings, professional groups and the health and education and training sectors" (p6).

3.4 Insufficient coordination between governments, planners, educators and service providers

Direct Commonwealth involvement in Australian general practice began in the 1950s with a system of support for pensioners medical bills. This involvement was expanded in 1971 with a scheme of subsidies for those with private insurance, and was extended to "universal" cover through the Government managed schemes Medibank and Medicare, established in 1984.

In 1991 the Commonwealth, the AMA and the RACGP jointly published "General Practice: A Strategy for the Nineties and Beyond". This publication heralded more focused attempts by the Commonwealth to influence aspects of general practice. Many initiatives have been implemented including the establishment and funding of divisions of general practice, a system of accreditation of practices (as opposed to individual doctors) and attempts to use the Medicare Benefits Schedule to influence the activities of GPs, for example, by creating subsidies for activities associated with specific illnesses or specific groups such as the elderly.

Of particular relevance to this submission are government workforce policies. Many programs are aimed at controlling the number and distribution of general practitioners and successive Commonwealth governments have implemented workforce policies through the training arrangements.

Divisions offer an existing, well established national infrastructure which assists in integrating and linking national initiatives with state systems and through which a range of health and community initiatives can be introduced. Through their multiple linkages with relevant agencies at all levels, Divisions bring together the necessary components of primary health care whilst retaining contact with grass roots general practice. As such, Divisions are the lynchpin of the primary health care sector, bridging health and social goals by bringing together health and community services on the ground.

The strength of Divisions is that they are simultaneously unified as a network, yet can act independently in order to provide local solutions to key local health issues. By working to build and promote primary care teams, and to link Commonwealth, State and local government health

services, Divisions offer a local means of overcoming the Commonwealth-State issues that recurrently plague the health system at a broader level. The Divisions Network supports processes, such as the quality framework, Performance Indicators and accreditation, which ensure that Divisions are accountable and mature agencies through which primary health care can be delivered.

Multidisciplinary teams are fundamental to primary health care and have been shown to improve health outcomes, particularly for those with chronic disease[46] [47]. Divisions have a major role in coordinating and facilitating effective, multidisciplinary service provider teams involving GPs, practice nurses, allied health, psychologists, pharmacists, carers and consumers that are built and maintained at the service delivery level. Preparation for multidisciplinary team work must begin at the undergraduate stage of training and continue through the whole professional life-cycle.

Examples of initiatives of divisions aimed at overcoming lack of coordination include: supporting practice nurse and practice team approaches to care; promoting and implementing shared care and allied health programs; developing and implementing robust referral services; assisting the vertical and horizontal integration of health workforce education and training to establish a consistent approach and a sharing of resources, promoting multidisciplinary palliative care teams in rural areas.

The main thrust of this submission from the ADGP is to support the view that better coordination and collaboration is needed across the health sector. At the primary care level divisions have much experience in achieving such aims. ADGP believes a more systematic approach against an agreed strategy is necessary to progress this further.

3.5. Distortionary funding mechanisms

ADGP and the Divisions Network further support funding models that allow general practice to operate as part of primary health care teams and that enable regionalised population health service planning and delivery. This issue is discussed in more detail above in the section titled “An ADGP Perspective on the General Practice Workforce”.

3.6 Piecemeal approaches

[46] *Wanger E, Austain B and Von Korff M. 1996. Organizing Care for Patients with Chronic Illness. The Millbank Quarterly (74) 511-534*
[47] *Sibbald B, Luarant M, Scott T. 2002.Changing task profiles in Saltman A, Rico A & Boerma W (Eds) Primary Care in the Driver’s Seat? Organisational reform in European Primary Care.*

"US leaders in the development and evaluation of integrated models of care for people with chronic illness, such as Kaiser Permanente, and Group Health Cooperative of Puget Sound, have shown that the burden of chronic disorders can be reduced by informed primary care practitioners and patients working together, supported by evidence from modern information technology. Yet in 2003, when other nations have moved beyond talk into detailed proposals for reforming the prevention and management of chronic conditions, Australian governments still debate…..We now need larger injections of political will. The early prevention and better coordinated management of chronic conditions will require changes in the methods of financing and paying for healthcare, inspired and supported by strong leadership from our politicians." [49]

At present, patients with complex chronic health issues are usually assessed and cared for in the same way as patients who present with acute problems – by an uncoordinated sequence of individuals assessing and advising on discrete problems. Such a model is not well suited to a situation in which Australia's ageing population means that the demand for care of multiple or complex conditions will increase. With chronic conditions patients are often better managed by someone who is able to determine an on-going care plan and is responsible for ensuring it is delivered and who can seek input from any of a team of providers.

Australia faces a pronounced ageing of its population over the next forty years. One-quarter of Australians will be 65 years or more by 2045, roughly double the present proportion. The proportion of 'oldest old' will increase even more[50]. ADGP believes that in the broadest sense a more efficient and effective health system will evolve if there is more explicit recognition that new models of care are necessary to meet emerging trends. There will then be some basis on which to make decisions around the mix of health workforce necessary and what training arrangements are therefore required to ensure the workforce is appropriate skilled for the new environment.

Box 1: Barriers to integration[48]

Political:
- *Dual state / Commonwealth funding.*
- *Multiple funding structures (resulting in lack of integration or even motivation to integrate).*
- *Role and territory disputes resulting from multiple funding and administration of services by different authorities.*
- *Other political factors, such as three year elections, makes systems change difficult.*

Financial:
- *Separate funding sources and approaches. Planning barriers arise from different levels of government being responsible for ambulatory and in-patient care while medical, nursing and allied health care are funded separately.*
- *Cost shifting from one organisation to another whose funding source is different.*
- *Lack of remuneration: collaboration between different providers and different levels of health care is not rewarded*[i]*.*
- *Inadequately resourced health services, particular examples are allied health and psychiatric services.*

Organisational:
- *Little contact between separate funding sources in strategic or operational planning.*
- *Different accountabilities and responsibilities.*
- *Poor communication and poorly integrated information management systems, eg lack of feedback about patients from other services; GPs have difficulty in identifying whom their patients will see when referred to another community-based organisation.*

Professional:
- *Differences between service providers in organisational culture, professional background and values.*
- *Different training methods, particularly when there is separation of training and care delivery.*
- *Lack of understanding among health professionals of the roles and skills of other professionals.*
- *Fear of loss of autonomy, territory, income and employment opportunities.*

[i] *Note: This research was conducted in 1996 prior to the introduction of Extended Primary Care items for general practitioners in 1999*

[48] *Raupach J, Kalucy L, Magarey A,Hurley C. 2001. Primary Health Care and General Practice: The Way Ahead. Adelaide. Primary Health Care and Research Information Service. http://www.phcris.org.au/publications/pdfs/WayAhead2003.pdf*
[49] *Gross P, Leeder S, Lewis M 2003. Australia confronts the challenge of chronic disease. MJA 179 233-234.*
[50] *Australian Government. 2005. The Health Workforce Productivity Commission issues paper 2005. http://www.pc.gov.au/*

ADGP believes that a more holistic view needs to be taken of workforce planning if the aims referred to here are to be met. In the framework provided by multidisciplinary traditional general practitioners will play a central role and be able to more effectively apply their skills.

The Divisions Network endorses the development of a workforce that can adequately deliver effective, high quality and sustainable primary health care. The Divisions Network supports:

- Maintenance and expansion of programs such as the Prevocational General Practice Placement Program and John Flynn scholarship scheme etc. which promote general practice as a fulfilling career
- The development of compulsory general practice placements / rotations for interns
- Practice team models of care to increase professional support and morale
- Employment and support of appropriately qualified and placed International Medical Graduates (IMGs) in areas of workforce need
- Consistent national criteria to identify areas of workforce need, including relevant data collection and monitoring to inform community and government of local needs
- Fundholding models to direct health services where they are most needed within the community
- Fast tracked medical training to accelerate placement of capable GPs into the community
- Modular health professional training schemes that offer more flexible and attractive career structures to encourage people to join and remain in the health workforce.
- Bonded GP placements to supply adequate doctors to areas of workforce need
- The development of a national medical workforce policy which includes systematic, structured and integrated workforce planning and support for the provision of multidisciplinary care

Effective delivery of primary health care needs an adequate and sustainable workforce. The Division's network is ideally placed to initiate and develop recruitment and retention strategies for all levels of the primary health care team and to work with existing agencies to support and advance primary health care workforce capacity. The divisions network also recognises that comprehensive primary health care requires collaboration between general practice and other health care providers. Efforts to develop the primary health care workforce must therefore target GPs and other members of the primary health care team (eg. allied health professionals, practice nurses, pharmacists, psychologists, carers etc).

3.7 After hours primary care and GP clinics in or near hospital emergency departments

The drivers of reform in after hours primary care policy are numerous. Workforce demographics have changed: There are greater numbers of female GPs. Younger GPs restrict their working hours. There is a lack of after hours MBS items for long or prolonged consultations and poor business viability due to higher fixed costs for staff time. All these have contributed to fewer GPs being willing to provide services out of normal hours. Public hospitals under ongoing budget pressures are looking for alternatives to the high costs of providing GP-type services from within emergency departments, and most State governments have shown an interest in co-locating GP after hours clinics with hospitals where emergency department demand is high.

The *Round the Clock Medicare* initiative announced by the Government in September 2004 builds on the groundwork established by the After Hours Primary Medical Care (AHPMC) program announced in the 2001-02 Federal Budget in seeking to develop new and/or improved after hours primary care services, which better utilise existing resources including workforce, and improve the links for after hours care allowing for better continuity of care for patients and improved communication between providers, and between providers and consumers.

Key enablers of the AHPMC program to date have been the effective use of the Divisions network to address the systemic issues to make substantial, sustainable and equitable changes to after hours primary care in Australia. Divisions can support the development of locally appropriate models that incorporate GP and non-medical service provision in team-based solutions to after hours care such as:

- Nurse triage, call centres, integration of services with local hospitals, use of nurses, Aboriginal health workers or mental health workers
- Obtaining local stakeholder input into the development and evolution of service provision Negotiating service agreements and contracts with other service providers including hospital/area Health service, pharmacy, and ambulance
- Supporting information management that underpins continuity of care with patient's regular GP and Supporting quality through providing training for the after hours workforce (including IMGs) as well as consumer information and education on appropriate usage of after hours services

A number of issues however need to be considered regarding the implementation of GP clinics in or near emergency departments as a way of offering after hours services. Steps must be taken to avoid patients continuing to seek care from an acute setting for problems that can best be managed within the primary care setting. In particular, these services must not be seen as a replacement for establishing an ongoing relationship with a GP. The following set of principles is offered as a guide to the establishment of an acute primary care service provided in an acute hospital setting:

- The initiative must provide improved pathways for patients between acute health and general practice and for improved responsiveness to patient needs.
- Any substitution of acute health services with primary health services needs to funded and not represent a cost shifting exercise.
- Any general practice provision in acute hospital settings should not threaten the viability and sustainability of an existing general practice, including training practices.
- Any general practice provision, including services provided within an acute hospital setting, need to meet the appropriate standards for general practices.
- Any general practice provision in acute hospital settings should not result in an unfunded shift of activity to general practice (including follow-up care).
- Any general practice provision in acute hospital settings should not encourage patients to hospital emergency departments for chronic disease management.
- There is a range of innovative solutions that are possible to meet the above principles that will be influenced by the local context.

4 Conclusion and Recommendations: The Way Forward

> *"Despite our best endeavours….the report conducted by me and my colleagues in 1997 was almost certainly incorrect within a very short time. I am inclined to think that GPs have a better sense of what is happening on the ground than do the sifters of data. The biggest challenge to workforce analyses, and therefore to patient access to GP care, may be the societal changes in work patterns, not in raw numbers, and these issues need to be better understood if we are to make progress in managing workforce issues".*
> *Hays, Richard: "Medical Workforce Data; Who Do We Believe?" MJA Vol 177 15 July 2002*

To deal with these supply and demand challenges outlined in Part 2 of this submission, what is required is not just more workforce numbers, and more equitable distribution - although these are important - but system change. Different modes of working within general practice and the primary care sector are required with better coordination of multidisciplinary care teams both within general practice and between the primary and acute sectors.

Chronic disease in particular requires different models of care, such as longer, as well as ongoing, proactive review consultations for patient education and self management rather than episodic "reactive" consultations. There is also good evidence that chronic disease outcomes in particular are enhanced by well coordinated, multidisciplinary team are in which GPs and other non-doctor personnel work together. Team approaches also enhance care in areas such as mental health and palliative care and can assist in health promotion activities.

An ageing Australia requires an increased focus on illness prevention, health promotion and improved health self-management to embrace not just the workforce supply issues but also the workforce demand issues.

Different utilisation of the existing workforce for skill maximisation can assist as can organising and financing a system in such a way that those best equipped to deliver a service do so. For example using practice nurses for routine but time consuming screening and preventive care processes can help to "free-up" GPs for more complex and acute diagnostic and management issues.

Practice managers can enhance the business side of general practice and the appropriate utilisation of e-health offers efficiencies through, increased on-line access to information, recall-reminder structures, and networked health record systems to allow patient-approved access for all health providers in the multidisciplinary team to the relevant components of a patient's history.

ADGP has referred in this submission to factors that need to be accommodated in any new approach that seeks to address workforce issues at the primary care level.

ADGP suggests that Australia's health workforce planning, certainly in respect of general practice, has been inadequate. In particular there is poor articulation between the AMWAC 'top down' national approach and the particular circumstances and needs of different regions.

There is wide diversity of need across different regions of Australia driven by factors such as the geography of the area, the age structure of the population, other demographic factors and the pattern of morbidity. From this ADGP argues that whatever policy levers do exist they should operate in a way that allows for local flexibility in influencing workforce numbers and composition.

There is an increasing need to provide for the management of chronic illness and to introduce effective preventive programs. Therefore funding arrangements that influence workforce numbers and composition should support the evolution of arrangements that will facilitate the emergence of multidisciplinary primary care teams, structured to reflect local needs and circumstances.

ADGP would like to stress that divisions are already involved in a wide range of programs that, individually, reflect efforts to respond to challenges and opportunities arising from the issues mentioned above. Some relevant division programs were mentioned in Section 2.5 above. However to date such efforts have been piecemeal and are not operating under the umbrella of any broad national strategic plan.

ADGP believes that it would be unfortunate if the focus remains on "getting the workforce numbers right". ADGP suggests that it may be fallacious to think in terms of "solving" workforce issues by just responding to abstract estimates of demand and that what is needed are established processes and structures that facilitate on-going management.

The community, through the Commonwealth, underwrites the division's network and ADGP believes that much more effective use of the division's network could be made in a system developed to allow the primary health care workforce to better able to adapt to the forces referred to above.

In broad terms ADGP believes that the division's network can much more systematically be involved, in an on-going systematic way, in assessing and influencing the primary care workforce

at the local and regional level. It would a critical requirement that involvement of divisions be such that local benefits were obvious and that some local control was inherent.

The divisions are not interested in having some centrally controlled data collection requirement imposed on them. They are interested in being involved in data collection as part of processes that empower them to use information to address local issues. The aggregation of data to say national levels should be seen as a useful “spin off” not the prime purpose of the broad “in-principle” initiatives ADGP is suggesting.

The components of such involvement would include:

1. Assessing and monitoring workforce needs. This would be done within in some agreed framework including a common data set with divisions having processes for monitoring changing workforce requirements as needs develop and as individuals move into or leave and area, retire etc.

2. Managing, within broad guidelines, programs that address workforce issues. Such programs would be informed by systematic knowledge of local workforce capabilities and deficiencies.

3. Acting as coordinating entity for addressing primary health workforce issues at the local level. The divisions are locally controlled entities that provide a mechanism for addressing one of the most vexing issues that frustrates those involved in the health sector, dealing with the different funding streams from different levels of government. Divisions are ideally placed to hold and administer pooled funds for specific programs or for the employment of specific expertise.

ADGP is available to discuss with the Commission the broad concepts behind the above recommendation and possible ways processes reflecting these concepts might be introduced. As mentioned earlier many divisions already have some experience of implementing programs reflecting the above principles. ADGP believes there are now opportunities to more systematically use the network.