The Royal Australian College of
General Practitioners

Submission to the Productivity Commission

Review of the Health Workforce in Australia

August 2005

Summary of the submission

The Royal Australian College of General Practitioners (the RACGP) is pleased to have the opportunity to make this submission to the Productivity Commission Review of the Health Workforce in Australia.

The RACGP has a membership in excess of 11,000 General Practitioners (GPs). It is the national leader in setting and maintaining the standards for quality practice, education and research in Australian General Practice. Amongst its other aims, the RACGP seeks to work with other organisations to advance key concerns for GPs, their patients and society. As a result, the RACGP has a keen interest in, and a responsibility for ensuring access to affordable high quality general practice and primary health care. Because of its work, the RACGP plays a central role in ensuring an effective and efficient primary health workforce in Australia.

Ensuring a strong general practice foundation for the health workforce – The RACGP asserts that an effective and efficient health system is one that has at its centre a strong general practice base. This position is founded upon sound empirical evidence, both internationally and from Australia, demonstrating the national health and economic benefits of a strong primary health sector.

The RACGP contends, therefore, that a central consideration in health workforce planning is ensuring a sufficient, capable and motivated general practice workforce.

Each year over 80% of people in Australia consult a general practitioner: the average number of visits per patient is just over 5 visits each year. These encounters provide a unique opportunity to improve the efficiency and effectiveness of the health system not only from the nature of the consultation itself, but via initiatives directed through this key interface.

Supporting the general practice workforce – A sufficiently large general practice workforce needs to be supported by policies, systems and structures that assist in optimising effectiveness, efficiency and equitable access. Equitable distribution is of particular importance in areas of socioeconomic disadvantage, geographical isolation and for Aboriginal and Torres Strait Islander communities.

Rewarding quality care – The system of patient subsidies paid through the Medicare Benefits Scheme (MBS) needs to provide appropriate incentives for high quality patient care. Currently, the structure of the MBS provides a number of disincentives to this.

Valuing general practice – The relative value of general practice services need to be appropriately recognised, to provide a positive signal to patients about the value of general practice in their health care. Changes to the financing of health care in Australia could have a positive impact on the effective and efficient use of the health workforce.

Optimising the care for people with chronic and complex needs – Apart from the valuable role in preventive health care provided by general practice, the RACGP argues that there needs to be further and substantial investment in chronic disease management, especially chronic disease self-management. These strategies have been shown to reduce demand for health services, and thus would have a positive impact on the demand for the health workforce.

Enhancing information management and new technologies – an appropriate and sustained investment in information technology and management, and other technologies (e.g. point of care testing) that increase the quality of care will be central to structures to underpin optimal use of the health workforce. Electronic information management is crucial to improving patient care and enabling timely shared access to patient information. The RACGP argues that health workforce planning needs to take account of such factors.

Encouraging teamwork – leading research in the area of general practice roles and workforce design demonstrates that significant benefits in efficiency and effectiveness can be achieved through utilisation of practice nurses and allied health providers to support the role of GPs. Equity of access can be assisted through the use of appropriately skilled and positioned health workers such as community nurses and Aboriginal Health Workers within these communities – provided these roles are properly supported. The careful development of new roles within the general practice team should be trialled with appropriately rigorous evaluation processes.

Where other health providers have been utilised to undertake the role of GPs empirical evidence has shown this to be inefficient and ineffective with no corresponding reduction in GP workload or cost or improvement in health outcomes.

Supporting GP-led primary care – Given the available research and medico-legal environment in Australia, the RACGP asserts that workforce design and role considerations in the area of a strengthened primary care model within general practice be based on a GP-led team model where primary coordination and care continues to be provided by GPs. Such a model has also been shown to be accepted and supported by consumers; such support is critical if changes are to be effective. The NSW Health Department has undertaken work in this area and notes the valuable position of GPs as advocates and coordinators or care and as contributors to population health outcomes.

Exploring new models of care – It is important to continue to examine new models of care delivery such as those that bring together GPs, general practice and community health services.

Ensuring general practice is an attractive career option – Given the crucial role of general practice in delivering the most effective use of the health workforce, general practice itself must be an attractive option for medical students – and the same logic applies to all primary health care disciplines. The health system needs to be re-shaped to ensure this is the case. Additionally, general practice vocational training needs to be underpinned by appropriate incentives to ensure that the brightest and best medical students choose this discipline.

Taken together, the RACGP considers that addressing the above factors within a strategic framework oriented to create a strong integrated primary care system, is likely to provide a health care environment that has been demonstrably shown in research to be efficient and effective in terms of both health and financial outcomes.

To achieve these benefits it is essential that appropriate levels of funding are provided to enable the realisation of the benefits to their full extent as demonstrated conclusively in research.

The RACGP supports examination of opportunities to increase the general practice workforce and create improved outcomes for patients and the community.

Introduction

The Productivity Commission is undertaking a review of the health workforce in Australia. This review will take into consideration and have regard for the National Health Workforce Strategic Framework endorsed at the Australian Health Ministers' Conference in April 2004. The objective of the review is to report on the issues impacting on the health workforce and propose solutions to ensure the continued delivery of quality health care over the next 10 years.

The Royal Australian College of General Practitioners (the RACGP) is pleased to have the opportunity to make this submission to the Productivity Commission.

Background to the RACGP

The RACGP was established in 1958 to maintain high standards of learning and conduct in general practice, and currently has a membership in excess of 11,000 general practitioners.

The RACGP is committed to ensuring that general practice remains the centre of high quality health care in Australia and that general practice remains a satisfying and rewarding vocation for all general practitioners.

The mission of the RACGP is to improve the health and wellbeing of all people in Australia by supporting both current and future general practitioners and general practices in their pursuit of clinical excellence and by ensuring high quality clinical practice, education and research for Australian general practice. The RACGP advocates on any issue which affects the ability of general practitioners to deliver a high quality service to the people who trust them for their medical care and advice.

Amongst its aims, the RACGP seeks to work with other organisations to advance key concerns of general practitioners, their patients and society. The RACGP, through Australian general practice, works to improve the standard of health care for all Australians, especially for groups of people with special health care needs. To ensure that its work, and the work of general practitioners, continues to be relevant to the Australian community, the RACGP also aims to increase its capacity to accurately forecast what the future holds for Australian general practice.

As a result, the RACGP has a keen interest in the review of the Australian Health Workforce by the Productivity Commission.

The RACGP is Australia's largest medical college. As at 30th June 2005, the RACGP had 11,689 financial members. The RACGP National Rural Faculty (NRF) has over 3,600 members throughout Australia, and the RACGP has the largest rural membership of any medical college in Australia. Nearly 100% of all general practice registrars are members of the RACGP.

The RACGP is responsible for Australia's largest medical college fellowship examinations. In 2005 over 1,000 members of the RACGP will sit examinations for Fellowship of the RACGP (FRACGP).

Those who pass the FRACGP examination are competent for unsupervised general practice anywhere in Australia, rural or urban. For those who wish to undertake further training in procedural aspects of general practice, for example in obstetrics or anaesthetics, the RACGP offers the RACGP Graduate Diploma in Rural General

Practice, in addition to the FRACGP. The RACGP continuing professional development (CPD) program supports nearly 22,000 general practitioners. The RACGP CPD program is the largest professional development program of any specialist medical college in Australia. *Australian Family Physician*, the RACGP's peer-reviewed medical journal reaches 33,000 doctors – all general practitioners in Australia and now also all physicians, through a joint initiative with the Royal Australasian College of Physicians.

This work demonstrates the central importance of the RACGP, as a specialist medical college, in the overall strategy to ensure an effective and efficient health workforce in Australia.

Terms of reference of the Productivity Commission Health Workforce Review

Following, is a summary of the Terms of Reference and scope of the Health Workforce Review (the Review) to be undertaken by the Productivity Commission as announced by the Federal Treasurer, the Hon Peter Costello MP, on 15th March 2005:

The Productivity Commission will undertake a study into the issues impacting on the Australian health workforce and make recommendations for the forward 10-year period to ensure ongoing provision of quality health care.

The Review is to have regard to the National Health Workforce Strategic Framework and other relevant research. It is also to be cognisant of changes to the health care environment such as demographic and technological changes over this 10-year period.

In essence, the Terms of Reference for the Review are to:

1. Consider the institutional, regulatory and other factors across both the health and education sectors affecting the supply of health workforce professionals, such as their entry, mobility and retention.
2. Consider the Structure and distribution of the health workforce and its consequential efficiency and effectiveness.
3. Consider the factors affecting demand for services provided by health workforce professionals.
4. Provide advice on the identification of, and planning for, Australian healthcare priorities and services in the short, medium and long-term.
5. Provide advice on the issue of general practitioners in or near hospitals on weekends and after hours, including the relationship of services provided by general practitioners and acute care.
6. Consult widely, including with peak industry, representatives and community organisations, and relevant government agencies and public authorities.
7. The Commission is to produce an issues paper by 31 May 2005, provide a draft report, and produce a final report by 28 February 2006.

The National Health Workforce Strategic Framework

As noted, the Terms of Reference require the Review to have regard for the National Health Workforce Strategic Framework endorsed by the Australian Health Ministers' Advisory Council in 2004.

The National Health Workforce Strategic Framework enunciates seven characteristics that it considers the Australia health workforce ought to have. The characteristics are that the workforce is:

- Population and health consumer focused,
- Sustainable,
- Distributed to achieve equitable health outcomes,
- Suitably trained and competent,
- Flexible and integrated,
- Employable, and
- Valued.

The RACGP supports these characteristics and this submission will consider them in the context of the terms of reference of the Review in the areas of general practice and primary health care.

Strong general practice is central to effective and cost efficient health care

Primary care provided through general practice is important to achieving improved health and workforce outcomes. Overcoming the current constraints to the provision of primary care will allow it to reach its full potential in supporting the health of Australians.

Starfield[1] suggests that between 75% and 85% of people in the general population require only primary care services within a period of a year. Australians see their GP on average 5 times a year[2].

In Australia, this equates to a substantial reliance on general practice. This reliance on general practice is likely to increase as the population ages and the burden of illness from chronic conditions increases. The other scenario – a reduction in overall morbidity, due to effective preventive health and health promotion strategies is also likely to increase demands on general practice. Thus, in either scenario, the demand for the general practice workforce is likely to increase.

With over 80% of Australians consulting a GP at least annually[3] and general practice providing the first contact with the health care system, it is in a unique and influential position to effect this change. Indeed there are 100 million GP consultations each year.

Although the focus of discussion tends to be on these consultations, GPs have wide and varied roles, and thus the general practice workforce has an impact well beyond formal consultations and general practices directly. Amongst the areas in which GPs practice and contribute are:

- Clinical consultations both within practices and in the community through home visits and visits to patients in residential care facilities
- Population health activities

- Public health activities such as representation and consultancy to local government, legal authorities and the emergency services
- Education and training, both formally and informally including mentoring of GP registrars (including the lifelong learning that GPs undertake and assist colleagues to undertake)
- Research
- Clinical accreditation
- Professional representation

The skills GPs possess and utilise are influenced by the health needs of the community, particularly in rural and remote areas where the GP may be the sole provider of health services. GPs can be called upon to undertake a breadth of practice ranging from obstetrics and other procedural practice to sports medicine and mental health care.

Research has demonstrated that countries with strong general practice systems have higher levels of health and correspondingly lower health care costs. In particular it has been shown that higher levels of primary care provided through general practice are associated with:

- Lower health care costs,
- Higher levels of patient satisfaction with care, and
- Less use of medication.[4]

Other authors[5] have found that countries characterised by a strong primary care orientation have more equitable health outcomes; and that good primary care is expected to be associated with improved functioning of the health system at large because strong primary care means better prevention, referral, coordination and continuity of care.

There is strong empirical evidence to support the view that access to general practice medical care is important to the health of the nation. Shi, Starfield, Kennedy and Kawachi, for example, found that the ratio of GPs to population is an important correlate of health outcomes for a population.

One key determinant of effective access is the size of general practice workforce. It is a key concern of the RACGP to ensure that the Australian population has a general practice workforce that is sufficient for its needs.

The RACGP believes that the current review of the general practitioner workforce supply by the Australian Medical Workforce Advisory Committee (AMWAC) will identify that the supply of GPs is insufficient to meet the needs of the Australian population now and into the future.

The important role of research in the area of general practice and primary medical care will be limited considerably through an insufficient GP workforce as the role of GPs becomes increasingly constrained to providing only essential services. A study by Rosser and van Weel in 2004 notes that:

> *"Primary care research is the missing link in the development of high-quality, evidence-based health care for populations"*[6]

These researchers noted the financial, workforce and health benefits from such research, stating that knowledge derived from general practice research has the ability to be readily applied globally and result in improved health care and a reduction in utilisation of more expensive therapies.[7]

The benefits from such research, examples of which are found within this submission, can only be achieved if there are appropriate mechanisms to facilitate transfer of research findings to practice.

The RACGP actively supports and promotes research in general practice through a range of mechanisms including directly providing grant funding and publishing research in its journal, *Australian Family Physician*.

The structure and distribution of the health workforce needs to acknowledge the crucial role of and diversity of services provided by general practice if its consequential efficiency and effectiveness is to be maximised. Planning for Australian healthcare priorities and services in the short, medium and long-term must also acknowledge this.

Optimising the use of the general practice workforce enables better medical care and more efficient and equitable health spending

Not only does Australia need a sufficiently large general practice workforce in order to achieve the most effective and efficient outcomes possible, but also it is imperative that the current GP workforce is utilised optimally and equitably distributed.

The RACGP suggests that the following elements are central to this optimal utilisation:

- Financial structures that align effort with the most effective and efficient use of the workforce and which encourage and support the equitable distribution of both the health workforce and health care services
- Using known evidence on preventive health and health promotion activities to reduce demand
- Using chronic disease self-management in the broader effort to reduce demand
- Using information technology to improve the efficient and effective use of general practice
- Using point-of-care testing to improve the quality of care, and its cost-effectiveness
- Support for general practitioners through the use of multidisciplinary teams. It is important that the allied health providers in these teams have clearly defined roles and that a coordinated system of training and skill recognition is in place to strengthen the effectiveness of these teams. In addition, evidence-based development of appropriate roles for team members will lead to increased patient safety and team effectiveness and efficiency.
- Target health care and services through culturally appropriate and effective health service providers such as Aboriginal Health Workers.

Aligned financial structures

Although general practitioners recognise the benefits of, and aim to provide, high quality and responsive medical care for their patients there are common and strong financial incentives for them not to do so.

The RACGP is not aware of compelling empirical evidence that would support a departure from the existing, largely fee-for-service model. Indeed, there are economic and quality arguments that support a model grounded in consumer decision-making in the choice of their doctor.

The RACGP has identified a number of areas where optimisation of general practice can occur including in the area of financing to provide effective and positive incentives for efficient, equitable and best practice medical care.

In late 2002, the RACGP summarised the research literature on the relationship between length of consultation and outcome. This research supports the view that 'longer' consultations often provide better outcomes [8]. In Australia, there is demand for longer consultations. This bodes well for continuing high quality and therefore reduced health service demand and spending.

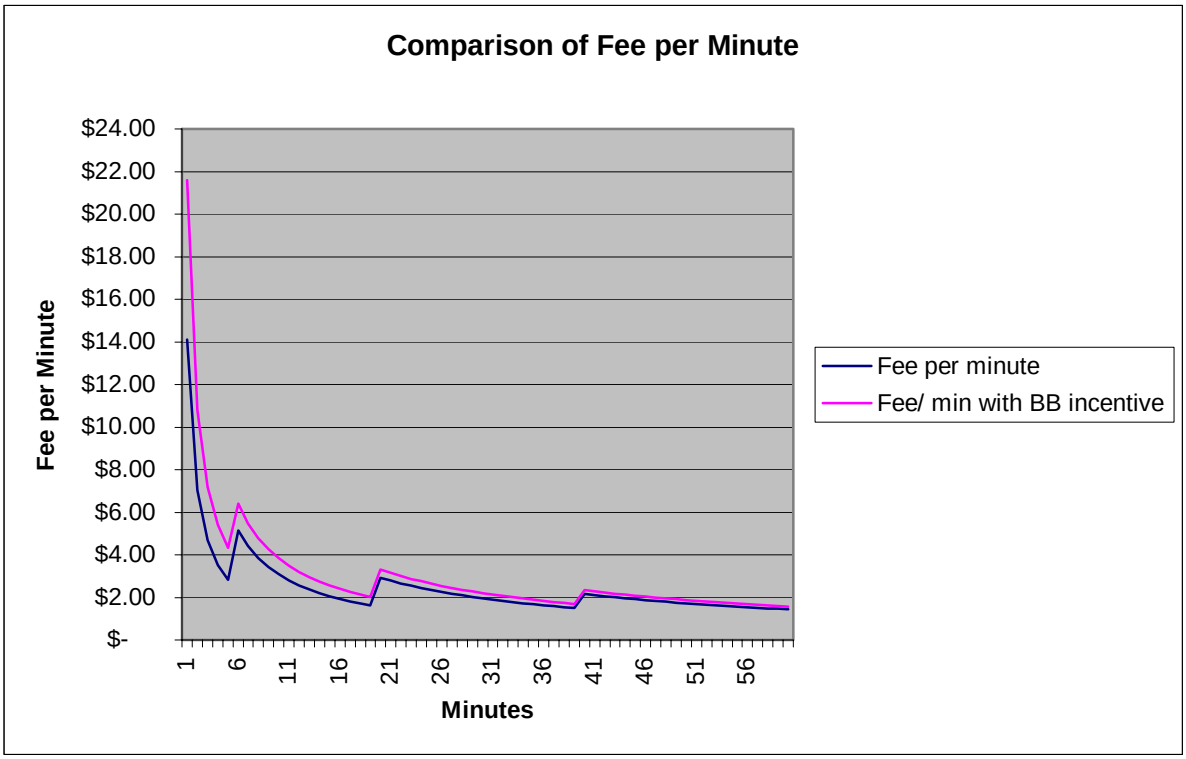
The capacity to provide these longer consultations is, however, adversely affected by financial disincentives for providing these consultations (and also constrained by workforce availability).

These disincentives are reflected in analysis undertaken by the Attendance Item Restructure Working Group[9]. The RACGP has recently re-calculated the fee-per-minute received when a general practitioner 'bulk bills' a patient. This shows a distinctive pattern that militates against longer consultations.

This has the effect of encouraging GPs to schedule shorter consultations to reduce the cost to patients and/or achieve appropriate income for service. This is of particular concern in areas of social inequality.

The graph below demonstrates this effect and highlights how shorter consultations, spiking around 6 minutes, can result in financial incentives for less efficient and effective health care and resource utilisation.

It also shows that recent Australian Government incentives to bulk-bill in general practice strengthen this inappropriate incentive.



(BB = Bulk Billing)

Stirling et al found that lower socioeconomic status is associated with shorter consultation times despite finding increased health care need in this group.[10]

Furler et al support this through their research finding that there was a significant increase in the rate of long and prolonged consultations with increasing socioeconomic status. Although people in disadvantaged areas visit GPs more often annually, they are less likely to have a long consultation, and thus may not be receiving the same high quality of care as people in areas of higher socioeconomic status.[11] Thus, the health care provided to these individuals is inverse to their health care need.

Additionally, Macinko, Starfield and Shi[12] make the point that there is evidence that access to certain types of care may be more beneficial than others in reducing a country's overall burden of disease. If this is the case, then the system of patient rebates needs to reflect this, and assist in shaping patient behaviour by providing rebates that encourage attendance at general practice.

Ensuring all people in Australia have equal access to the same high level of health care services and outcomes is of primary importance and requires appropriate funding mechanisms to attract and retain health care providers and appropriately resource services and infrastructure. Barriers to equitable health services include, but are not limited to, geographical location and cultural and linguistic diversity.

In this sense, to achieve equity, greater investment and different modes of funding may be required.

Robinson[13] reviews the empirical evidence on designing payment incentives for doctors, and concludes that there is a role for some non-fee-for-service payment.

The importance of funding modifications to support effective, efficient and equitable use of the health workforce can be seen in rural locations where the expectations of GPs are greater than in metropolitan areas and the GPs work in different contexts.[14] Funding for rural and regional general practice therefore needs to be structured and delivered in a way that recognises their contribution and encourages GPs to work in these locations to support equitable distribution of health services.

The RACGP supports the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework in its recommendations to improve and target health services for these communities.[15] Financial structures that encourage Aboriginal and Torres Strait Islanders to undertake training as health professionals and support them to provide services to these communities on completion of study will assist to better health outcomes for these communities. This strategy supports community control for service provision and builds capacity within communities.

Funding models may need to be flexible to enable appropriate and effective use of health providers in these environments.[16] The capacity for individuals in rural, remote and Aboriginal and Torres Strait Islander communities to make payments towards their health care may prove difficult and create a barrier to their access to services and therefore compromise equitable health outcomes. The relatively recent Federal Government inclusion under Medicare funding of services provided by Aboriginal Health Workers as part of a health care plan is a positive step forward. This approach both uses the valuable skills of Aboriginal Health Workers and makes health care more accessible.

The view of the RACGP is that the relative value of general practice rebates for patients does not reflect the value that general practice brings to the health system, nor the relative cost of the real inputs for patient care. As a result, the rebate system does little to encourage appropriate (efficient and effective) use of the medical workforce. Addressing the problem of inappropriate relativities would assist by sending a signal to patients about the value of general practice, and may also have an impact on the attractiveness of general practice as a career choice (an issue taken up later in this paper).

The costs to general practice and GPs through administrative red tape is also a significant issue when considering optimisation of the GP workforce. An example of this is the implementation of Medicare items enabling GPs to undertake multi-disciplinary care. The use of these opportunities has been restricted by unnecessary levels of administrative burden resulting in a slower uptake and reduced use of these items by GPs. The outcome from this is reduced health outcomes, greater use of less efficient items and thus increased health expenditure.

The net result of perverse financial incentives is poorer overall health care for the community, increased and inefficient use of health services, and less effective health spending than may otherwise occur.

Maximisation of benefit for health spending is achieved where funding incentives are structured to facilitate and encourage strong general practice and efficient and effective general practice services. This links strongly to the National Health Workforce Strategic Framework characteristics that health services be population and health consumer focused and distributed to achieve equitable health outcomes.

The current Commonwealth and State funding split impacts on the health workforce through reducing the face-to-face time GPs have with their patients through administrative requirements and time required to liaise with others in the health workforce. The split also leads to duplication of some work, for example the re-ordering of pathology tests once a patient is discharged from hospital. These outcomes lead to inefficient utilisation of the general practice workforce.

Optimising chronic disease management will reduce demand on health services and increase financial and workforce efficiency

Ensuring the appropriate supply of the general practice workforce is not the only strategy required to make the most effective and efficient use of the Australian health workforce.

In addition to the important impact that preventive health care provided by general practice can have on the demand for health services (and thus, its impact on workforce demand), the effective management of chronic disease (CDM) and, particularly chronic disease self-management (CDSM) are important aspects of the required approach.

The management of chronic disease is an expanding area of health care need and creates increasing spending at all levels of health system. As a result, it provides an opportunity to achieve significant workforce and financing improvements.

Substantial research effort has been undertaken in this area with much of the pre-eminent research being conducted by Lorig of Stanford University.[17] The benefits of improved CDM have been identified as being readily and successfully adaptable for diverse groups within the community.[18] This provides promise for improving health

outcomes for socioeconomically disadvantaged groups whose health care needs have been identified previously in this submission as being the greatest.

Financial benefits, due to improved health outcomes and reduced health care utilisation, from improved CDM have been shown to be up to five times the cost of providing a CDM program.[19]

This has significant implications for the design of health services and the workforce to provide them. Most management of chronic disease occurs through general practice, and the creation of appropriate structures and incentives to self-management, particularly, will be a necessary element of ensuring the most efficient and effective use of the health workforce.

General Practitioners and General Practice have an essential role in the education, delivery and ongoing care of patients with chronic illnesses which aligns with the National Health Workforce Framework directive that health care is health consumer focused, sustainable, distributed to achieve equitable health outcomes and flexible.

IT/IM in general practice assist optimisation of the GP workforce and improves health and financial outcomes

As a support to the efficient utilisation of the GP workforce, information technology (IT) provides the opportunity to increase health outcomes and reduce health expenditure.

The use of information technology to support clinical decision-making creates safer health care.[20] Iatrogenic harm to patients is a major cost and makes significant demands on the workforce. Improving patient safety will have a direct impact on improving workforce utilisation.

Electronic health records in the general practice environment improve health outcomes through reducing potential for error relating to illegibility of handwriting and lack of access to records where multiple members of the general practice team provide services to a patient.[21] Electronic records were also found in the study by Hippisley-Cox et al to contain more extensive information about consultations, diagnoses and treatments which would assist medical care through increased information. [22]

There is empirical evidence supporting the use of electronic correspondence to improve health outcomes. Lorig et al in a study of patients with a chronic condition revealed that where communication between patients is increased through email communication health outcomes were increased leading to reduced health care utilisation and spending.[23]

Point-of-care testing and other technological advances will also assist to optimise the use of the workforce

The optimal use of the health workforce also requires that structural arrangements encourage the safe use of new technologies that improve health outcomes and maximise the appropriate use of the workforce.

An example of a deficit in this area is the use of point-of-care testing (PoCT) in general practice.

Research has demonstrated that PoCT is accurate, practical and a community-appropriate way of monitoring chronic conditions including diabetes.[24]

The RACGP has been frustrated at the slow progress towards a research trial on the use of PoCT in the Australian general practice context. This slow progress contrasts with a trial undertaken under the auspices of the Third Guild Government Agreement between the Pharmacy Guild and the Australian Government. It is also at odds with the increasing availability of PoCT outside the Medicare Benefits Schedule.

The use of PoCT is likely to enable a reduction in repeat appointments currently required to provide results and make changes to treatment. Empirical evidence also suggests that it may result in more efficient workforce utilisation through reduced need to refer testing to other service providers and the administration involved in this process. [25]

An effective national workforce strategy will reduce inappropriate barriers to the introduction of such technologies.

Supporting GPs through multi-disciplinary general practice teams improves health and workforce outcomes

Benefits from optimised GP efficiency, an increased GP workforce and improved efficiency, efficacy and equity of medical care can all be enhanced through the well-considered and structured addition of non-GP staff to a general practice team. This position aligns with that of the National Health Workforce Strategic Framework which states that the health workforce needs to be flexible and integrated.

Arguably, in some general practices, General Practitioner time could be used more effectively. The RACGP believes that change management capabilities will be important to general practice, and supports the Federal Government initiatives to develop the 'collaborative' methodology in Australia, a strategy that is aimed at developing these capabilities.

The RACGP strongly supports the role of nurses in general practice, and has undertaken a project with the Royal College of Nursing Australia (RCNA), to investigate the educational needs of General Practitioners and nurses in general practice. [37]

It is not appropriate or effective for health outcomes or workforce utilisation to use nurses in general practice in place of providing the community with effective access to general practitioners. Nor is it acceptable to use general practice nurses to stream patient care where this has the effect of reducing health care access or outcomes.

The opportunities to improve patient care and workforce and financial outcomes through the increased use of nurses and non-GP staff can be best achieved where they support and enhance the role of GPs. The NSW Health Department has considered the role of the GP and allied health staff in multi-disciplinary teams and supports the position that the role of GPs as the leaders and coordinators of general practice care needs to be maintained.[26] The NSW General Practice Policy states:

> *"General practitioners' daily work gives them a good understanding of the patterns of illness in the community, the networks of care, and weaknesses in community support systems. General practitioners are also in an ideal position to act as advocates and coordinators of care and to contribute to population health outcomes."*[27]

Cheek, et al, showed in their study that consumers also do not wish to have direct access to GPs limited, unless the patient chooses this.[28] These authors also report that consumers do not want nurses to be responsible for diagnosing 'life threatening

or serious conditions'. They report that consumers, although having misconceptions and gaps in their knowledge around the actual and potential roles of nurses in General Practice, see nurses as adding value to General Practice by carrying out a limited number of roles. Cheek et al report that:

> *"For follow up nursing after a doctor's visit, e.g. dressings or removal of stitches, (consumers) want this to be an MBS item or incorporated into the cost of the initial doctor's visit."*[29]

In a systematic review of research on changing the skill-mix of the health care workforce, Sibbald, Shen and McBride[30] conclude that some outcomes of care provided by nurses in primary care may be good and that satisfaction with nurses was generally high. However they also concluded that:

> *"Compared with doctors, nurses had longer consultation times, carried out more investigations and often recalled patients at a higher rate so eliminating net savings in salary costs. From the perspective of the health economy as a whole, it was generally cheaper to train nurses than it was to train doctors; but savings were again eroded because nurses tended to have lower lifetime workforce participation rates than doctors."*

Additionally, Horrocks, Anderson and Salisbury, in their review of the research on nurse practitioners in primary care indicate that none of the studies reviewed was adequately powered to detect rare but serious adverse outcomes, and there are a number of methodological limitations in the studies reviewed.[31]

Nurses in general practice can be distinguished from nurse practitioners. The research around the role of nurses and nurse practitioners is conflicting and requires critical analysis in the Australian context. Any extension of the role of general practice nurses or nurse practitioners must follow the results of robust Australian research.

As a result, the RACGP takes the position that workforce substitution proposals need to be very carefully analysed, as they may not bring the patient-care or economic benefits often proposed.

In addressing the challenges of providing universal access, the RACGP adheres strongly to its longstanding position on the safety and quality of general practice care; and the integrity of the craft of general practice. Reliance on overseas-trained doctors and nurse practitioners is not acceptable to the RACGP.

The benefits of well structured and selected general practice teams can also be achieved through increasing the contribution of practice managers to general practice and thereby decreasing the time GPs would otherwise spend in managing finances, supplies and human resources. Through this role, practice managers can free up GP time enabling increased time for GPs to do general practice work more focused on clinical care, education and research, thus making better use of this workforce.

In the area of Aboriginal and Torres Strait Islander health the utilisation of non-medical health providers including allied health providers such as dentists and optometrists and in particular Aboriginal Health Workers can contribute to the effective and efficient structuring of the health workforce for these communities. The establishment of Aboriginal Community-Controlled Health Services has been demonstrated to be appropriate and encourages equitable access to and outcomes from services. This is consistent with the recommendations from the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework discussed previously in relation to funding. The RACGP strongly supports community-controlled

models, and strongly recommends that the report of the Productivity Commission give detailed consideration to strategies that will make a difference in this area of health care.

In this area, particularly, health workforce planning needs to be informed by discussions about the role and demand for a workforce which is not traditionally seen as 'health', but is central to the effective functioning of the core 'health' workforce.

General Practice must be an attractive career option for Australia's brightest and best medical graduates if the value of the health workforce is to be optimised

The RACGP's position is that Australia must continue to focus efforts on generating and maintaining its own GP workforce. The National Health Workforce Strategic Framework reflects this need for the workforce to be sustainable.

The RACGP is keen to ensure that being a General Practitioner is an attractive career. An inefficient use of the health workforce would result from the most capable doctors differentially choosing to practice in better-remunerated crafts, rather than to pursue general practice. Currently, the RACGP would argue that appropriate recognition and reward for high quality general practice care is *not* reflected in the relative value of general practice services. This provides a disincentive to pursue this important medical discipline, and needs to be addressed if the workforce is to be used optimally. This disincentive also applies to other primary care disciplines and needs to be considered and addressed to overcome barriers to recruitment and retention.

General practice can and should be a viable career choice for recent medical graduates. If workforce policy undermines this, then there is a real likelihood that the net effect will be a decrease in new General Practitioners, rather than an increase in new Australian-trained General Practitioners. The National Health Workforce Strategic Framework has acknowledged this as vital. The Framework identifies that health and medical professionals need to be feel valued for the workforce to be sustainable.

Research into prevocational doctors considering general practice indicates that a number of factors attracts them to general practice including an interest in helping people, domestic circumstances, flexibility of hours, exposure to general practice and the number of years required to complete the program.[32] Any strategy to attract more GPs should attend to these factors.

The very real reasons why recent medical graduates are reluctant to take on careers in disadvantaged areas include professional isolation, partner career, children's education needs, high on-call burden, and difficulty gaining access to local hospitals. In a survey of former general practice registrars 79% of respondents identified family/domestic circumstances as the most influential factor in their decision-making.[33] It is also the RACGP's position that the solutions to achieving appropriate access to general practice for patients in Australia cannot rely heavily on overseas doctors, whether or not they train in Australia. Australia has an ethical obligation to contribute to the overall supply of doctors, proportionate to its demand for doctors. Policies that would create strong

incentives for GPs in poorly serviced countries to migrate to Australia are not acceptable.

The RACGP acknowledges that whilst many international medical graduates arrive in Australia with excellent and highly regarded medical knowledge and skills there are some who require assistance and support to attain the level of knowledge and skills required for safe and effective general practice.

Doctors who have not yet met the equivalent of the Fellowship of the RACGP must be assessed for entry to general practice, be supervised, mentored and supported in their education to the national standards of the RACGP. Adequate professional and personal support for the doctors entering general practice is critically important and a high priority for Government funding. Workforce recruitment measures must protect against any shift of workforce away from areas of greatest medical workforce need. Any additional funding should be coordinated with the current recruitment and support structures and the endeavour not be duplicated.

As a result the RACGP actively supports medical practitioners who have come to Australia. The RACGP has worked with the Australian Government to identify international medical graduates in Australia who are not in the medical workforce. Assistance has been provided to those doctors, where they chose to, to complete education and training to enable them to undertake the AMC Examination to practice in Australia. In addition to this support, the WA Faculty of the RACGP has established a mentor network to pair international medical graduates with Australian GPs to enable them to come together, share ideas and learn from each other's experiences.

The RACGP notes that the Australian Medical Workforce Advisory Committee (AMWAC) is currently undertaking a survey of doctors working in rural and remote locations under Australia's five year overseas trained doctor recruitment scheme.

General practice vocational training must also an attractive option for doctors. Educational needs must take precedence over workforce policy in decision-making concerning registrar positions.

To apply geographic requirements to general practice vocational training makes this training less attractive. It also makes it more difficult to fill training positions. The RACGP's position is that appropriate incentives will result in sufficient number of general practice vocational trainees in rural placements.

The role of medical colleges in socialisation of medical practitioners into the profession and in the areas of ethical professional behaviour, identity, motivation, altruism and attributes of the craft translates into improved service and workforce efficiency. Robinson[34] has noted that these non-price mechanisms in the health system support effective use of health dollars.

Quality education, training and registration systems enable high quality of care and maximise health workforce utilisation

It is the position of the RACGP that the most appropriate model on which to base considerations regarding health profession education and training is one focused on primary care. This reflects the position of the RACGP that primary care is pivotal in improving quality and efficiency of health care.

The RACGP is unique amongst Australian medical colleges in the degree to which GP education and training is provided across both the public and private health sectors. The result of this is to increase effective utilisation of the training opportunities available in the private sector. This model will be increasingly important as the number of university graduates in medicine grows, as there are significant constraints in the public system.

Research supports targeted education for rural GPs to improved GP retention in rural locations. A review of the RACGP Graduate Diploma in Rural General Practice has shown that 70% of graduates continued to practice in rural locations.

The RACGP believes that addressing the factors negatively affecting workforce recruitment and retention will assist substantially in achieving positive workforce productivity and health outcomes. A study into the career choices of medical graduates has demonstrated that a number of factors prove a disincentive to medical graduates to practice in rural and remote locations.[35] Measures addressing these disincentives hold the promise of improving workforce distribution, efficiency and health outcome equity in the short and long-term workforce.

Non-medical General Practice workforce education and training

As considered previously in this submission, there is a trend toward use of multi-disciplinary teams for health care delivery in the primary care setting. As also mentioned, a review of current research on changing skill mix in healthcare has not yet demonstrated sufficient evidence, reflective of the Australian health system, to support other health care providers taking on core GP activities. Given this, the RACGP strongly opposes any shift away from providing sufficient GPs. Australian research has also shown that patients strongly support the RACGP position and indicated they do not wish to have their care principally provided by other health providers or for nurses to limit direct access to GPs unless patients choose this[36].

The RACGP considers that there are important opportunities to increase the role of allied health and other staff in the general practice setting. In considering the health workforce the RACGP encourages the Productivity Commission to give consideration to the supply of General Practice staff more broadly. This includes practice managers, practice nurses and other staff where this can result in increased efficiency and quality of care provided by GPs.

The RACGP, in collaboration with the Royal College of Nursing, Australia (RCNA) completed a report in 2003 into General Practice Nursing in Australia. This report discussed, among other issues, the unique education needs of nurses working in general practice and provided recommendations for improved education and training.

The report found that the education currently available for nurses in general practice is in the main ad hoc, informal, poorly evaluated and inconsistent. It noted also that there are no systems currently in place to assess and ensure the quality of care provided by general practice nurses. General practice nurses and GPs both indicated, through the report, their strong support for improved education for practice nurses. [37]

In considering further specific education and training for nurses working in general practice the report identified the concomitant need for GPs working with practice nurses to receive additional education in relation to the practice nurse role.

As previously mentioned in this submission, the RACGP strongly supports the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework. This Framework recommends that the workforce providing services to Aboriginal and Torres Strait Islander communities be:

> "…transformed and consolidated to:
>
> > Increase the number of Aboriginal and Torres Strait Islander people working across all the health professions;
> >
> > Improve the clarity of roles, regulation and recognition of Aboriginal and Torres Strait Islander Health Workers as a key component of the health workforce, and improve vocational education and training sector support for training for Aboriginal and Torres Strait Islander Health Workers…"[38]

Education and training for non-medical general practice positions such as nurses, allied health professionals and Aboriginal Health Workers must be undertaken by an appropriate and registered training body with course content informed by the needs of general practice in a strengthened primary care environment. It is considered by the RACGP to be critical that all positions align the key elements of education, training, competence and registration[39]. The alignment and application of these elements for the role of Aboriginal Health Worker is supported by the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework.[40] These elements provide the basis for identifying high quality training and competence for practice and professional accountability.

From a productivity perspective the elements, when linked, provide an assurance of high quality and appropriate care and service and thus improved efficiency and equity of workforce utilisation and more effective health spending.

The RACGP urges caution in the consideration of common training, early specialisation, multi-skilling and exchangeable roles, and recommends that examination of these options be based on the best available evidence and take into account potential disadvantages and problems in these approaches.

The National Health Workforce Strategic Framework reflects this by stating that the health workforce must be suitably trained and competent. These requirements not only ensure high quality health care they also assist to prevent poor health outcomes and inefficient health spending.

The further Framework requirement that members of the health workforce be employable is also supported through these characteristics, as they are a standard against which professionals can identify themselves.

Expediency of education and training

It has been proposed that there are more efficient ways for medical practitioners to receive their training that would see them providing services earlier and thus enabling a more rapid increase in GP numbers.

The RACGP considers it critical that any discussion regarding education and training first and foremost consider quality and safety and ensure that these are not eroded through a more rapid education program. To do so has the very real potential of decreasing health outcomes and increasing health costs to address health problems created.

Currently training for general practice occurs across 18-24 months in general practice locations. Reducing the time for this training would result in insufficient time to appropriately cover the breadth of additional knowledge needed for safe, independent practice. It would also result in erosion to the perception of general practice as a defined skill and knowledge base amongst the medical workforce and the wider community.

Any consideration of any further changes to current training arrangements would need to be based upon sound evidence that the proposed changes will result in improvements.

Sufficient funding will enable multi-faceted benefits from strong general practice to be reaped.

The improvements to the structure of the health care system discussed in this submission will be fully achieved if they are adequately funded. When implemented these changes have been empirically demonstrated to result in significant returns including financial.

Reducing funding to improve cost effectiveness can have the opposite effect and result in significant decline in benefit.[41]

Not only do the changes themselves need to be appropriately funded to achieve success, members of the general practice team also need to be financially acknowledged for their efforts to implement the change. Sibbald et al explain:

> *"…successful implementation of change requires payment systems which reward staff for making the desired changes to their working practices*"[42]

Caution is urged by the RACGP where consideration is given to co-payments for medical care as research in the area of pharmaceuticals has shown this can result in significant reductions to usage of essential medications amongst socioeconomically disadvantaged populations.[43] The outcome of this extends beyond decreased health outcomes to increased morbidity and corresponding increased use of health services. These results are counter to the health, workforce and financial efficiencies gained through the approaches detailed in this submission.

General Practices in or near hospitals do not assist to reduce emergency department demand

This submission would now like to discuss item five of the Terms of Reference which considers the placement of general practices or general practitioners in or near hospitals.

Strong general practice services are those that are located within the community they service and are tailored to the needs of that community. This includes providing appropriate after hours services. Research in the Australian environment has not demonstrated health or financial benefits from the placement of general practice in or near hospitals.

The Australasian College of Emergency Medicine last year undertook a comprehensive review of the relationship between emergency department overcrowding and alternative after-hours general practice services.[44] Based on the

results, the study concluded that alternative after-hours GP services do not address the problems of access block and overcrowding in emergency departments.

The study found the number of patients visiting emergency departments who could be considered to be suitable to be seen in general practice was small and did not change significantly across the seasons. On average, the study found that emergency departments see less than 10 “GP-type” patients a day. At an operational level this means that emergency departments are seeing no more than 1 ”GP-type” patient an hour.

Planning of general practice services needs to be considered in the wider context of Primary Care planning rather than simply a band-aid measure where it has been shown to have no real benefit for the community or hospitals.

The RACGP has a long history of involvement in setting and maintaining quality and safety standards for general practices through the RACGP’s *Standards for General Practices*. It is important that general practices established in any location, including in or near hospitals, be accredited against these *Standards*. The *Standards* provide a mechanism by which to ensure practices provide their patients with comprehensive, appropriate and safe care delivered by doctors specifically trained in general practice.

Like any other general practice in Australia, practices in or near hospitals need to meet local needs and link with and be near other heath providers such as pharmacists and allied health professionals. A practice that is distanced from the intended patient population or which is difficult to access is unlikely to appropriately serve the community it is intended for.

As an integral component of meeting local community needs, general practices need to ensure they have in place arrangements to provide their patients with after-hours care.[45] This is required under the *RACGP Standards for General Practices*, the benchmark against which general practices in Australia are accredited.

As a result, the RACGP would suggest that the complete cost of providing general practice care in a facility collocated with a hospital be considered, should this option be canvassed; and that more limited forms of primary care which do not demonstrate the characteristics of comprehensive, coordinated and continuing care be distinguished from general practice. These forms of primary care that do not exhibit the characteristics of general practice care may bring other costs associated with the risks arising from fragmented, rather than comprehensive, continuous care.

Conclusion

The RACGP in this submission has demonstrated the substantial benefits to health outcomes and the health workforce and financing through implementing strengthened primary care principles within general practice. These benefits can be augmented through optimising GP time by reducing unnecessary administrative burden and substantially by reviewing financing arrangements so that they provide the positive incentives necessary for high quality, effective and cost efficient care.

An increase in GP workforce numbers is considered by the RACGP to be one of a number of approaches necessary to address the identified GP shortage. Appropriate and safe utilisation of non-GP staff as part of an integrated general practice team has been demonstrated empirically to provide opportunities for more efficient and equitable workforce utilisation.

Support structures for general practice such as IT have been discussed within this submission as having significant potential benefit for health outcomes and health workforce efficiency.

Against this the RACGP has asked that the Productivity Commission consider the significant issues of appropriate financing for these improvements as insufficient funding has been shown to result in significant reductions to effective implementation and thus reduced benefits. Co-payments systems have been discussed and were also noted to be of significant concern for the RACGP given research showing clearly the effect such payments can have on utilisation of essential medical services and medicines, leading to reduced health outcomes and increased utilisation of the health system for socioeconomically disadvantaged groups.

The RACGP, in accord with the characteristics identified in the National Health Workforce Strategic Framework, has identified in this submission a means for Australia to achieve a strong, efficient and equitable health system. The RACGP is pleased to have the opportunity to make this submission.

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