The Royal Australian College of General Practitioners

Response to
The Productivity Commission's
2005 Position Paper

Australia's Health Workforce.

November 2005

Introduction

The Royal Australian College of General Practitioners (RACGP) is pleased to have the opportunity to respond to the preliminary assessments presented in the Productivity Commission's 2005 Position Paper, *Australia's Health Workforce*.

The RACGP acknowledges the difficult task undertaken by the Productivity Commission (the Commission) in developing an understanding of the Australian health workforce and providing its preliminary assessments in a short period of time.

As a consequence of these difficulties, the Position Paper contains factual inaccuracies. In a number/the majority of instances, these appear to mirror significant inaccuracies – as perceived by the RACGP, in a least one submission to the Commission. They may also reflect misunderstandings of the context and content of certain submissions.

The RACGP considers that the broad directions outlined in a number of the Commission's recommendations to the Council of Australian Governments (CoAG) may offer benefits. However, the complexity of the issues provides a warning that without careful exploration and analysis, a decision to proceed may well result in major, expensive and disruptive change which does not achieve the anticipated benefits, and may have unintended negative consequences.

The recommendations in question are that:

- the National Health Workforce Strategic Framework be endorsed – subject to broadening the self-sufficiency principle, and followed by regular independent, transparent reviews of progress;
- an advisory health workforce improvement agency be established to evaluate and facilitate major health workforce innovations;
- primary responsibility for the allocation of … funding available for university-based education and training .. be transferred from the Department of Education, Science and Training to the Department of Health and Ageing;
- an independent standing review body be established to advise the Minister for Health and Ageing on the coverage of the of the ..MBS …to evaluate the benefits and costs…of proposals for change… to report publicly on its recommendations and the reasoning behind them
- a cross-program evaluation exercise be initiated designed to ascertain which approaches or mix of approaches are likely to be most cost-effective in improving the sustainability, quality and accessibility of health workforce services *(but this should apply in all areas, not just rural and remote)*

However, the RACGP also has major concerns relating to other recommendations and questions the validity of the information which underpins some of the Report's conclusions and recommendations.

Major concerns relate to the inaccuracies, apparent imbalance of views in some important areas, and lack of understanding of certain complexities relating to the specialist medical workforce, (particularly education and training and existing workforce reform initiatives).

These inaccuracies are understandable in the context of the Commission's limited capacity to validate the information it was provided, and the complexity of health workforce and training arrangements. However, where conclusions are drawn which appear to be partly or largely based on these inaccuracies, the RACGP contends that the consequences may be the reverse of those intended by the Commission.

More important however, is the challenge of addressing the clear differences in opinion amongst the submissions, and dealing with the emotive and critical 'tone' of certain submissions, which appears to have been adopted in the Position Paper, in part by the quotation from those submissions – without testing the underlying assumptions.

The RACGP would suggest that the report requires correction and/or appropriate revisions and annotations, to reflect the absence of verification of the material reported. The RACGP is also concerned that some inaccuracies and misunderstandings (for example, the role of the RACGP in general practice vocational training) will be perpetuated when the Position Paper is used in any subsequent (formal or informal) research, without appropriate critical appraisal of its limitations.

By way of illustration, the Position Paper incorrectly reports that "GPET remains the only way in Australia of training to become a GP". This ignores:

- the RACGP programs to support those undertaking Fellowship by the *Practice Eligible* route (about 50% of examination candidates);
- the alternative pathway through the National Consortium for Education in Primary Medical Care (NCEPMC),
- programs offered by the RACGP to support international medical graduates preparing for Fellowship of the RACGP, many of which have been commended by the Australian Medical Council (AMC), and
- the Remote Vocational Training Scheme (an RACGP-ACRRM initiative).

The RACGP would suggest to the Commission that the report be appropriately corrected or annotated, to reflect the absence of verification of the material reported.

The RACGP's commentary begins with some general observations followed by specific comments. Where appropriate, the RACGP points out inaccuracies and differences in perspective to some submissions, particularly the submission made by General Practice Education and Training (GPET).

Included in these comments are some suggestions about the assessments made by the Commission.

General comments

The role and contribution of medical colleges

Australia's recognised specialist medical colleges exist to set and maintain standards for quality clinical care, and for education and training for our professional disciplines. Our medical colleges exist to ensure the safety and quality of health care in Australia, and to ensure that Australia's medical practitioners are well trained and supported in their life long education. Responsibility to our patients and to our society is paramount for this nation's medical colleges.

The role of the RACGP

The RACGP is concerned that, on page 59, the Productivity Commission Position Paper does not clearly reflect that the RACGP is a specialty medical college that provides educational and other services and supports to the specialty area of general practice. It would be more appropriate for the wording on page 59 to read:

> *Those seeking to specialise seek entry to a specialist training college program approved or accredited by the relevant professional college. In the case of those seeking to become general practitioners, they enter the Australian General Practice Training Program, which is administered by GPET (General Practice Education and Training). This training is delivered by regional training providers (RTPs) and provided largely by college Fellows, mainly in community-based GP practices. In the case of those seeking to specialise in other areas, the bulk of this training is provided in public teaching hospitals, largely by college fellows on a pro bono basis. However, as discussed below, the private sector is playing a greater role than in the past.*

Following this point on page 59 of the Position Paper the RACGP believes that the paper should recognise that many of the practising GPs are RACGP Fellows. A correction to the Position Paper also needs to be made to reflect that the training is under the Australian

General Practice Training Program and not the GPET program as stated. The RACGP therefore recommends that the paragraph following the above point on page 59 be amended to the following wording for accuracy:

> *The Australian General Practice Training Program is fully funded by the Australian Government, with funding allocated to RTPs through a competitive tender process. These RTPs in turn engage practising GPs, mainly RACGP Fellows, to provide education and supervision to trainees.*

Both Figure 6 in the Summary of the Position Paper and Figure B.5 at p.261 provide an "outline of medical training in Australia". Both state that Specialist Training is provided by Specialist Colleges, and that GP Training is provided by GPET. In fact, the Australian Medical Council (AMC) has confirmed that general practice is a recognised speciality, that the RACGP is the accredited college overseeing general practice training, and that RACGP does (and must continue to) carry out most of the roles of other specialist medical colleges.

The RACGP suggests that it is the *activities undertaken to uphold these roles of specialist medical colleges* that have been the focus of a substantial amount of the discussion and examination by interested stakeholders.

In this context, it is likely to be helpful to distinguish between the roles of:

- setting and monitoring standards for specialist medical education
- funding the training and training places;
- providing the setting for the training, and
- providing the training.

Although this is complex, it is the contrasting roles and obligations of the parties in these aspects of education that give rise to some of the differences in opinion and position. The tone of the GPET submission, for example, is to portray the RACGP as 'obstructive', when the RACGP's view is that it would be more appropriate to see these actions as a reflection of the important role that the RACGP plays as arbiter of our craft's standards.

The report consistently refers to the Australian General Practice Training Program, as the "GPET Program" and consistently omits reference to the essential role and fundamental contribution of the RACGP to the Australian General Practice Training Program.

At p.85, for example, there is a suggestion that the RACGP has (inappropriately) continued to exert tight control over the content and conduct of the training program. The RACGP's role has been to monitor and protect the standards for general practice vocational training which are required of GPET in its contract with the Australian Government. The current "independent national accreditation agency" for specialist medical colleges – the AMC – endorsed those roles when the RACGP's education and training programs were accredited. Similar quality assurance and improvement roles will be central in any future arrangements for accreditation.

Although specialist medical colleges are seen as having a conflict of interest in the Position Paper, the perceived nature of the conflict of interest and its impact is not made explicit.

Although it is partly to address such potential conflict of interest issues, that the Commission is proposing the staged introduction of an "independent national accreditation agency", it is not clear how better monitoring of the quality of training would occur than that already being provided by specialist medical colleges including the RACGP. The report does not explore the ramifications of training without the involvement of the RACGP and other specialist medical colleges.

A training model which is independent of specialist medical colleges is suggested in the submission of the Hunter Area Health Service to the ACCC. It should be noted that this submission also refers to the example of the RACGP where the college continues to play a vital role in monitoring the quality of training; and the submission (and the Commission's Position Paper) overlooks the critical fact that the efficiency and effectiveness of the

'contestable' model created in general practice has not been the subject of a publicly reported robust, comprehensive, independent evaluation.

The RACGP suggests that it is likely that members of other non-medical disciplines such as nursing and allied health, through their professional bodies, will also want a key role in the monitoring of any training arrangements for their profession to ensure that the quality of clinical care is maintained.

Gains in General Practice training pre-GPET

The GPET submission suggests that the establishment of the Australian General Practice Training Program in 2001 saw a major shift in direction, achievement and accountability. The RACGP would strongly dispute this.

The Commonwealth has always decided entry quotas for general practice training. Prior to 1996, the RACGP was required to provide training for "all comers" on a fixed budget. As numbers were therefore unpredictable, planning, budgeting and quality control were extremely challenging.

In 1996, the Commonwealth limited the number of places available for general practice training – at that time, to 400 per annum. This enabled the RACGP to exert considerably tighter control over the delivery of a consistent program that met both education and workforce objectives.

In 1996, two major policy decisions were made – the first relating to the pursuit of regionalisation as a priority objective, the second, to a requirement for all trainees (as registrars were then called) to undertake a rural term.

During this period, the College approached the Commonwealth more than once for financial assistance in developing regional infrastructure. This was declined on the basis that the Commonwealth would not contemplate additional costs. The current cost of the regionalised training arrangements are now significantly higher than in 2000, with a substantially higher proportion going to infrastructure as opposed to training costs.

Despite the many changes, the RACGP, as reflected in its accreditation by the AMC, has maintained the vast majority of roles of all other Australian specialist medical colleges.

The importance of ensuring the safety and quality of the health system

The RACGP would recommend that further attention be paid to the need to maintain the safety and quality of the health system while pursuing workforce initiatives.

The college is concerned that the Position Paper pays insufficient attention to strategies that will monitor the safety and quality of health service provision, and that would trigger a re-assessment of the strategies should safety and quality be compromised. Unless these safeguards can be clearly enunciated, it is difficult for the RACGP to support the reforms without significant reservation.

The RACGP assessment processes have been clearly linked with high quality care and outcomes and increased efficiency of effectiveness in utilising resources such as pathology testing (see Miller, Britt, Pan and Knox, 2005). The Position Paper in its current form does not recognise this important link for quality in care in the primary care setting.

The importance of tackling the State/Commonwealth divide

The RACGP is concerned that little attention is paid to strategies that will address the fundamental challenges of Australia's federated system.

The barriers created by this system are well-known and pervasive. Their fundamental impact on the efficiency of the health system has been the subject of ongoing analysis, and the RACGP would recommend that further consideration be given to ways in which the adverse impact of the Commonwealth/State 'divide' can be addressed.

Workforce retention and re-entry

The Position Paper gives little focus to workforce retention and re-entry mechanisms. In the context of the 'baby boomers' leaving the workforce, and the high level of part-time employment, it is essential that attention be paid to mechanisms that will encourage health professionals to remain in the workforce, or to re-enter it.

Further, the Position Paper acknowledges there are unfilled training places in general practice, however, no examination of the reasons for this has been undertaken in the paper. The RACGP considers it important that the Productivity Commission examine in the paper the factors that have and continue to effect uptake of training places in general practice as these factors impact substantially on recruitment of registrars to the general practice workforce.

The decision by the Federal Government to place vocation training under the Australian General Practice Training Program resulted in a substantial change in the profession and a loss of confidence of prospective registrars in the training program. This confidence has taken four years to regain. In the interim, there have been a substantial number of unfilled training positions.

It is imperative that the Productivity Commission appreciates the impact significant changes to the education and training process for medical practitioners has on Australia's capacity to supply and maintain an adequate medical workforce.

Specific comments:

Facilitating workplace change and job innovation

Table 8.2 lists Areas of Potential or Current Task Substitutions. It ignores that general practitioners are the traditional professional, along with obstetricians, in maternity care; that general practitioners are the traditional professional, along with anaesthetists, in anaesthesia, especially in rural locations; that general practitioners undertake plain x-rays (along with medical imaging technologists), and that general practitioners report x-rays (along with radiologists).

This misunderstanding of the existing role and capacity of general practice is of concern. The RACGP strongly supports the diverse role of general practice, and the extension of the role of general practice research and technology (e.g. point of care testing) to support this.

The RACGP is incorrectly portrayed in some parts of the Position Paper as amongst the forces standing in the way of workforce innovation. This is inaccurate and unfortunate given:

- the RACGP's role in regionalization of training since 1996 and the gains which are described previously
- its central role (with the Royal College of Nursing Australia) in the major initiative to have the Australian Government to provide funding for general practice nursing (which is not mentioned in examples of workforce changes)
- the RACGP support for the provision of allied health services for general practice teams
- the RACGP's role as the principal architect of the new care planning items, which enhance the capacity of general practitioners to delegate elements of the care planning process to other health workers with appropriate skills
- Its work with other medical colleges to enable the development of flexible career paths linking general practice with academic research, public health, anaesthetic, surgery, emergency medicine, mental health, geriatrics and palliative care
- the RACGP's support for, and active involvement in, the development of a medical assisting role in general practice (led by the Brisbane North Division of General Practice)
- the work being undertaken by the RACGP's National Rural Faculty with Services to Australian Rural and Remote Allied Health over the past 3 years to model the

sustainability benefits to rural and remote primary health care of the better integration of allied health and general practice services.

In this context, the Commission needs to be aware that the RACGP does not oppose nurse practitioners per se. Rather the RACGP opposes *independent* nurse practitioners who undertake roles separate to general practice teams, potentially undermining the continuity of GP-patient care and leaving the nurse practitioner in an isolated and vulnerable position.

The RACGP also opposes the establishment of roles for which the personnel are insufficiently trained, or for which there are insufficient safeguards for patient safety. In particular, compromises to systems safeguards where the practitioner is isolated from other professionals are of concern to and are opposed by the RACGP.

Statements and omissions such as some of those in the Position Paper that related to this issue tend to imply that the RACGP is against workplace reforms. This is incorrect. The RACGP has been and will remain an active supporter of appropriate reform. The RACGP continues to review and support new models of general practice that provide high quality outcomes for the Australian community while building on the valuable role of general practice and the knowledge and skills of the members of the general practice team.

The RACGP would suggest that the Commission give further attention to the implications for medical indemnity insurance and liability, particularly vicarious liability, when considering its recommendations. The RACGP has had ongoing discussions with medical indemnity insurers about the importance of effective, predictable insurance cover prior to significant changes in work role in general practice (e.g. significant increases in the role of general practice nurses).

The implications of effective coverage are, in the final analysis, a protection for patients as well as providers. Recent experience suggests that unanticipated consequences can occur when the implications of medical indemnity insurance are inadequately analysed (e.g. the perverse incentives created in the indemnity subsidy arrangements).

The RACGP contests any suggestion that general practitioners are over-trained for 80% of the day-to-day work they do. This is nonsense. The RACGP is very concerned that this erroneous fact is relied upon as the basis for decisions in the Position Paper that suggest the concept of role substitution is worth exploring further. If changes in roles are valuable for the Australian community, it is not because general practitioners are over-trained, but because the current arrangements do not enable the best use of a highly skilled workforce in general practice.

Reforms to Primary Health Care infrastructure and funding arrangements are urgently required to enable general practitioners to work within and lead multi-disciplinary teams, to delegate a greater proportion of their work to team members, and to spend a higher proportion of their time with more complex clinical problems.

Making education and training more responsive to changing care needs

The Position Paper (at p.81) suggests that the RACGP's 'control' of training impedes the incorporation of a broader range of expert input into defining professional competence (as per the GPET submission). This assertion is at odds with the history of the RACGP's work, as demonstrated by:

- past and current review of the RACGP's education and training curriculum,
- recent review of the *Standards for General Practices – applicable to all Australian general practices;*,
- the development of curriculum for education in Aboriginal and Torres Strait Islander health, and other initiatives.

All reflect very inclusive approaches involving government, consumer and community organisations, other medical organisations and other stakeholders. The rationale for this inclusive approach has, in large part, been to ensure that the work of the RACGP is responsive to changing community and professional needs. This approach in fact provides a model for other disciplines.

The Commission should note that while an extensive consultation is underway in preparation for revisions of the RACGP's educational curriculum, to date, both the government and GPET have declined to provide any level of financial assistance to support wider consultation with consumer and community organisations.

Any suggestion that education and training will become more responsive through reducing the role of medical colleges in the development of education and training needs to be supported by evidence, rather than by rhetoric.

Facilitating change in health workforce education and training models

The RACGP supports change in health workforce education and training models that will ensure that they are more responsive to both community needs and to the needs of the people involved in the education and training.

It would, however, caution the Commission to consider carefully the risks and benefits of the changes. The RACGP would suggest, for example, that the new training arrangements in general practice lead to *more, rather than less* inflexibility in training. This is due, in part, to the precedence of workforce imperatives over training imperatives; and such over-shadowing of the critical issues surrounding the training quality is of profound concern to the RACGP.

The Position Paper, on page 62, states that the current absence of streamlined retraining pathways or appropriate recognition of prior learning exacerbate the difficulties of accommodating demands for additional workers or replacing those who exit the workforce. The RACGP notes that this statement does not acknowledge that the training program developed and delivered by the RACGP, and now adopted by the Australian General Practice Training Program, had well-established processes for recognition of prior learning, which addressed this concern.

The RACGP was the architect of regionalised general practice training, delivering training through 17 regional nodes under the RACGP training program prior to the establishment of the AGPT.

A more sustainable clinical training regime

Pro-bono professional contributions

General Practitioners, particularly members of the RACGP continue to make substantial pro-bono commitments to the work of the college, as do the members of other crafts to their relevant colleges. This is exemplified in our discipline's commitment to the review of the RACGP's *Standards for General Practices* and to the review of the RACGP's education and training curriculum, both of which have attracted substantial pro-bono commitments by General Practitioners and other stakeholders.

The Commission might explore whether the same level of involvement is likely to occur through organizations that do not have the same level of independence, sense of professional altruism and collegiate involvement.

Contestability

The proposition that general practice vocational training is a model for contestable arrangements needs consideration. Any comprehensive evaluation of the model is yet to be reported. There appear to be significant transition and transaction costs, including any potential costs of changing the configuration of the RTPs should subsequent tenders result in different contracting arrangements. The need for stability in training arrangements was demonstrated during the transition to this model. This mitigates against truly contestable arrangements.

The Australian General Practice Training Program (AGPTP) is not a contestable model, and nor should it be

- effective regional function demands a pooling of functions, resources and effort. There is simply no functional or financial capacity for one stakeholder to compete against other essential stakeholders – as so it will be for other disciplines;

- integration of clinical service provision, education and training, and research remains a high order objective for all clinical disciples. This will never be achieved while core stakeholders are competing against one another. In fact there is a sound argument for a greater level of integration than currently exists;
- the playing field is not level: rural regions cannot compete with urban regions – therefore the system is heavily weighted financially to favour rural training. This is appropriate. A free market does not, and will not operate in circumstances where workforce objectives require an organised, collaborative and subsidised approach.

End points for general practice training

Registrars and their association, General Practice Registrars Australia (GPRA), have indicated their support for the maintenance of a single endpoint of general practice training, that being FRACGP, Fellowship of the RACGP.

The RACGP pioneered dedicated training for rural medicine in Australia in a way that serves as a model for other medical specialties. The RACGP Training Program's Rural Training Stream developed a range of educational support activities and schemes to:

- encourage interest in training in rural general practice contexts
- address the research that had identified that increased practitioner confidence in such contexts could be assisted by acquiring the specific skills and knowledge, and
- ensure that registrars were supported in acquiring the advanced rural skills to enable general practitioners to provide patient access to medical services normally provided by other (referral-based) specialties such as obstetrics, anaethetics, surgery, and adult internal medicine.

Registrars who completed all of the activities available through the Rural Training Stream were awarded a Graduate Diploma in Rural General Practice – a qualification accredited as a tertiary award within the Australian Qualifications Framework since 1996. A survey of all graduates of this graduate diploma in 2000 indicated that 70% of them were practicing in rural Australia – a workforce outcome second to none in this country.

Enrolments in the RACGP Training Program's voluntary Rural Training Stream (RTS) rose from 7% of registrars in 1996 to 36% in 2000 – just 3% short of the mandatory enrolment in GPET's Rural Pathway. In addition, between 1996 and 2001, the Rural Training Stream systematically regionalized training so that GP terms could be undertaken entirely in the rural context. By 2001, the RTS was delivering training through 17 regional nodes – the same number of rural or substantially rural Regional Training Providers under GPET.

The RTS and its associated qualification, the Graduate Diploma in Rural General Practice, stand today as one of the most significant and successful innovations in general practice training. It is surprising this initiative does not appear in Box 10.2 of the Commission's report (p,172) on recent initiatives in rural and remote Australia, or in Box 10.3 (p.179) on College arrangements for rural and remote medical practice.

Quality Assurance and Continuing Professional Development (QA&CPD)

The RACGP's QA&CPD Program has been independently assessed and accredited by the AMC which made the following endorsement:

> The RACGP QA&CPD Program is a well developed and thought out program, backed up by clear documentation. There is a good range of activities, and an increased emphasis on activities that have demonstrated evidence of an influence on practitioner performance. The AMC team commended the RACGP QA&CPD Program and considered it a good model for other specialist medical colleges to consider as they analyse and modify their own programs

The RACGP has developed the web-based GPLearning education program which provides GP learners using the site with educational tools to assist them including short case studies through to intensive emergency medicine courses. The RACGP also delivers a range of

distance education tools including CD ROMs, videos, books clinical audits and modules relevant to rural GPs in areas such as emergency medicine, endoscopy, drug abuse and Aboriginal and Torres Strait Islander Health.

The RACGP's Library and Resource Centre has the most extensive general practice collection in the country and is fully accessible online for our members including those in rural and remote locations.

All of these strategies assist to ensure that high quality clinical training, through a lifelong learning model, is both efficient and effective in Australian general practice.

Integrated approach to the accreditation of training

The Position paper discusses a proposal to establish two new councils; an accreditation council and an advisory council (page XL). The RACGP notes that the paper does not fully describe the coordination and communication that would take place between these two councils. This is an important issue, which needs to be addressed before further development of this proposal is undertaken.

Further, the RACGP is concerned that the proposed councils would be comprised of and reflect the views solely of individuals rather than representatives from the key stakeholders, including medical colleges. The RACGP considers it essential that contribution to the councils needs to be on a representative basis rather than on an individual basis to ensure the appropriateness and relevance of the councils. The RACGP as a specialty medical college remains committed to ensuring and assisting to ensure national accreditation standards and approaches.

The proposal for a single national accreditation agency for health educational bodies and programs needs to first consider and then build on existing successes in the Australian context.

There is significant concern by the RACGP regarding the proposal on page 97 of the Position Paper which states that the proposed national accreditation body would:

> *exercise statutory powers across the full range of 'traditional' accreditation functions including…accrediting courses, facilities and institutions… However functions such as the selection of students and certification would generally remain with education and training providers themselves.*

The RACGP notes that in the case of the medical colleges, certification is the responsibility of the specialist medical college and the AMC, however the Position Paper argues for this to become the responsibility of the national accreditation body. In general practice this would result in the responsibility for certification being given to GPET. This would be strongly opposed by the RACGP as it would have the effect first of de-professionalising general practice accreditation, and second, of rendering the RACGP the only medical college without responsibility for its certification. As a flow on effect, the profession of general practice would be undermined.

The suggestion on page 85 of the Position Paper that the RACGP has exerted excessive control over the content and conduct of the Australian General Practice Training Program is not correct. The level of control the RACGP has applied is appropriate and is a direct reflection of the need for the RACGP, as an accrediting body, to ensure the standards for training. The paper appears to base the proposal for an independent national accreditation council on this incorrect premise.

The proposed accreditation council would still, presumably, need to establish and maintain standards for accreditation for training programs. This is an essential role to ensure a standard for training and outcomes. It is recommended that this suggestion in the Position Paper be reconsidered in light of the reliance placed on information provided from GPET.

The work of the Australian Medical Council (AMC) in accrediting medical schools, and the education and training of specialist medical colleges is a sound model, and needs to be incorporated into future developments.

Rather than wholesale dismantling and replacement, consideration should be given to the expansion of this model to education and training for nursing, allied health and health care providers in the areas of complementary and alternative medicine.

The proposal for a single body needs to be carefully evaluated, as a large body overseeing a broad range of initiatives may result in a reduction in the necessary discipline-specific elements of accreditation. There is an argument for consistency of requirements across disciplines and professions, and for some integration of the approach, to reduce unnecessary role delineation. This should not, however, occur at the cost of undermining the unique nature and contribution of the various disciplines currently present in Australia. In this area, the many professional bodies, such as specialist medical colleges, can play a valuable role, without impeding a nationally consistent approach.

It is perhaps useful to separate out here the educational value of encouraging students at the undergraduate level to engage in interprofessional learning, and undertake relevant learning in multidisciplinary teams. This may produce an approach to role delineation that will facilitate interprofessional cooperation and predispose health practitioners to the efficiencies and superior health outcomes to be gained from working in multidisciplinary teams. Similarly, it may have positive consequence for the quality of primary health care delivered to patients if qualified practitioners are supported in exploring greater inter-professional cooperation and multidisciplinary teamwork. A side effect of this activity may well be cost-efficiency that reduces the cost of health care. However, such improvements will never replace the cogency of the individual contribution each health discipline makes to the system. On the contrary, prudent articulation of role delineation is well known to be a vital characteristic of successful multidisciplinary teamwork in healthcare delivery.

Supporting changes to registration arrangements

The RACGP has been a consistent supporter of a national approach to medical registration, provided that appropriate safeguards, including the protection of personal privacy are incorporated. In this context, the RACGP would also support consideration of an appropriately configured national registration board for health professionals generally.

Were a national approach to be taken, however, the RACGP would need to be assured that high standards for the determination of appropriateness to practice in unsupervised environments, or the need for supervision and appropriate training were maintained. The RACGP's standards for entry into unsupervised practice need to apply to all doctors who enter general practice without the equivalent of Fellowship of the RACGP, as this is an important safeguard to the high quality of care provided to the Australian community.

The current lack of consistency in assessment of doctors seeking registration places members of the public at potential risk, and any introduction of a national approach that achieves consistency needs to ensure that this is achieved while maintaining a high level of vigilance about the standard of medical competence required.

Modifying payment and funding mechanisms to improve incentives

The RACGP, as outlined in its earlier submission to the Commission, supports improvements to the configuration of the Medicare Benefits Schedule (MBS). The RACGP has been an advocate for appropriate relativities in the MBS, and supports the introduction of appropriate mechanisms for the delegation of activities. The central role of general practice coordinating care needs to be incorporated in these arrangements, as this aspect of the health care system brings both benefits to patients, and is generally cost effective.

As identified in the RACGP's original submission to the Productivity Commission, there is a need for the MBS to support longer general practice consultations as such consultations have been demonstrated empirically to provide better health outcomes and more effective use of GP time. Despite this strong evidence supporting longer consultations, GPs are limited in their capacity to provide such consultations due to the strong financial disincentive for patients through the MBS.

Individuals from areas of social inequality are most disadvantaged by this perverse incentive as they experience higher levels of poor health and have less capacity to independently afford longer consultations. Details of this concern are expressed at page 9 of the RACGP's original submission.

Suggestions that alterations be made to the gatekeeping role of general practice need to be considered in light of the important role of continuity of care in improving health outcomes, and in light of the medico-legal obligations seen to exist for general practitioners in the role of providing continuous, coordinated care.

Improving outcomes in rural and remote areas

The National Rural Health Alliance and College of Medicine and Health Sciences ANU comments that "few, if any specialist medical colleges have structures adequate to support rural streams of training." This statement needs to be balanced by reference to the extensive work of the RACGP, the specialist college in Australia with the largest rural membership.

The RACGP has double the rural membership of the Australian College for Rural and Remote Medicine (ACRRM). Indeed, the RACGP has proportionally more rural than urban members. This indicates the value placed on high standards, quality education and the RACGP's support for rural doctors.

The support for the RACGP from the profession is extended to general practice registrars where well over 90% are members. Of these registrars almost 400 are members of the RACGP's National Rural Faculty.

It is on this basis that the RACGP feels able and compelled to speak on behalf of rural general practitioners.

The RACGP has supported the role of some non-fee-for-service arrangements, to complement fee-for-service arrangements that should remain the cornerstone of the payment system for general practice. Such non-fee-for-service payments can be necessary where it is difficult to attract and retain the appropriate workforce (and thus to provide appropriate and equitable access through the MBS).

The RACGP does not support geographic provider numbers. The college's position is that such coercive mechanisms are likely to dissuade the brightest and best medical graduates from choosing general practice, and to act only as a short-term mechanism for achieving redistribution. In addition, the National Rural faculty of the RACGP conducted the first comprehensive assessment of the post-vocational quality assurance and continuing education (QA&CE) needs of rural GPs in 1998 – a national study that led to a national strategy to address rural GP needs in the continuing education environment. And while the RACGP acknowledges the disincentives to rural recruitment and retention listed under its statement on p.166 of the Commission's report that 'A variety of professional and lifestyle considerations can discourage practice in rural and remote locations', this research indicates that this very variety of medical practice and lifestyle considerations are extremely high on the reasons why GPs find rural and remote practice attractive.

In 2000, the RACGP commenced a 2-year program to train rural GP medical educators in emergency medicine education delivery at the vocational training level, to prepare for the regionalized implementation of the new GPET training regime.

Since 2000 the College has also undertaken 5 years of government-funded projects to support the development of educational programs and resources to support GPs working and training in Aboriginal and Torres Strait Islander Health, including 2 national conferences designed to network GPs with their fellow multidisciplinary team members.

Between 2000 and 2002 the RACGP's National Rural Faculty also offered GP registrars who had already undertaken advanced rural skills training a top-up subsidy, courtesy of the federal government, to enable them to pay the extra indemnity insurance premiums to allow them to practice procedurally in their GP training terms.

And more recently, since 2003, the National Rural Faculty has been working with Services to Australian Rural and Remote Allied Health to model the sustainability benefits to rural and remote primary health care of the better integration of allied health and general practice services.

Since 2004, the RACGP has, in collaboration with the Australian College of Rural and Remote Medicine and the Health Insurance Commission, been responsible for the disbursement of continuing professional development grants to rural and remote procedural GPs, to enable them to maintain skills vital to the health service needs of their communities.

The initial Position Paper appears to undervalue the prevalence of the rural GP in the workforce solutions it suggests. Whilst the report, for instance, tends to look to the possibilities of greater articulation between disparate services such as the general practice, the hospital and allied health services, it fails to recognise that the GP is the common link between these functions. The GP is often the doctor administering to cases that come into A&E at the local rural hospital, and is also the doctor admitting patients attending the local surgery to hospital for secondary care. Similarly, it is the local GP who is working with allied health professionals in the hospital setting to further secondary care and assist a patient in the journey to rehabilitation.

While there is much merit in the Commission's proposals to improve health services to rural and remote communities in cost-efficient ways – telemedicine, improved IT access to evidence-based diagnostic and prognostic support for practitioners to improve levels of quality, 'easy entry, gracious exit' models of general practice, further development of existing education initiatives in regional (rural) settings – the College is concerned at the focus on 'job redesign' as if someone other that the health professionals themselves are going to engage in this process. Given its centrality to primary health care in rural contexts, and the initiatives in which the RACGP is already engaged in terms of interprofessional quality improvements to patient access at the same time as increasing health service viability, the RACGP would expect to play a major role in any such project.

The College's experience through its rural initiatives certainly reinforces the Commission's finding that an incentives approach is far more likely to lead to positive regional workforce outcomes than coercion.

The RACGP believes that incentives are more likely to provide effective and sustainable mechanisms for workforce attraction and retention in rural and remote locations. These incentives need to recognize that there is a necessity to attract a full range of the health workforce, not only doctors.

The workforce requirements of people with special needs

The RACGP strongly support the draft proposal of the need to consider the workforce requirements of groups with special needs. There are, however, a broader range of groups than those mentioned in the Position Paper – Aboriginal and Torres Strait Islander people, people with mental health problems, people with disability and people requiring aged care services.

Other people living in Australia, such as those on low incomes, asylum seekers and refugees need to be included in these considerations. The RACGP has been a strong advocate and has provided specialised support for general practice in many of these areas. The college has recently been working on improvements to the structures of the MBS for people with an intellectual disability and Aboriginal and Torres Strait Islander people, but the MBS has a particularly adverse impact on many people with special needs.

References

Miller, G.; Britt, H.; Pan, Y., and Knox, S, (2004), "Relationship Between General Practitioner Certification and Characteristics of Care", Medical Care, 42(8), 770-778.