

# GENERAL PRACTICE IN PRIMARY CARE: RESPONDING TO PATIENT NEEDS



An AMA blueprint for the delivery of primary health care services in Australia



**AMA**



## FOREWORD



International studies prove what general practitioners have known for generations – a strong GP-led primary health care system keeps people well and saves lives.

The studies also show that a strong GP-based system not only improves the health of our patients, but is

also a very efficient means of utilising scarce health dollars. It delivers substantial bang for the health buck.

Still further studies show that the high quality of general practice in Australia also serves to reduce health inequalities across the system.

Despite the proven case that GP-based primary health care improves health and delivers care efficiently and equitably, the community is not always well informed about the important role that general practice plays in primary health care.

This AMA blueprint *General Practice in Primary Care: Responding to Patient Needs* is designed to help the community, policy makers and health care professionals better understand the power of a GP-led primary health care system.

It outlines a number of important facts and also counters a number of myths that have been encouraged to bloom in the health debate.

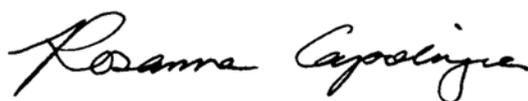
Salient facts include that:

- GPs provide all the care needed for 90% of the problems they encounter,
- GPs account for less than one tenth of per capita expenditure on health,
- GPs champion a team-based approach to patient care, routinely utilising the skills and knowledge of colleagues in the allied health professions. More than 60% of GPs have a practice nurse,

- the current GP shortage is a direct result of deliberate government policy. Australians should not be forced to accept a lower standard of care because of bad policy compounding bad policy,
- many years of intensive study, specific training and experience underpins the breadth of skills and knowledge that give to patients the holistic care that general practice provides. There are no short cuts,
- government red tape now forces GPs to spend up to 25% of their time completing paperwork,
- GPs fully support a system that provides patient rebates to reflect the longer consultations that patients require, as well as supporting acute care. The system must always allow doctors to deliver quality care based on the needs of the patient, not on limits, rationing or caps to care imposed by government.

Importantly, the blueprint also outlines steps that need to be taken to maintain and improve access to high quality primary health care for all Australians. The policy rejects the contention that we must accept lower standards of health care to make them affordable. It embraces reform and recognises the need for sustainable levels of health care funding, but puts patients' needs ahead of cost cutting.

This fundamental focus on our patients lies at the heart of this blueprint and at the heart of every GP practice.



**Dr Rosanna Capolingua**  
AMA President  
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# GENERAL PRACTICE IN PRIMARY CARE: RESPONDING TO PATIENT NEEDS

AN AMA BLUEPRINT FOR THE DELIVERY OF  
PRIMARY HEALTH CARE SERVICES IN AUSTRALIA



## Primary health care is very important for the health of our communities

International studies show that the strength of a country's primary health care system is directly associated with improved population health outcomes for all-cause mortality, all-cause premature mortality and cause-specific premature mortality from major respiratory and cardiovascular diseases <sup>1</sup>.

Increased availability of primary health care is associated with higher patient satisfaction and reduced aggregate health care spending <sup>2</sup>.

There is evidence for an association between health care systems that are organised around a strong

primary care sector and reduced health inequalities<sup>3</sup>. Because it reaches so much of the population, general practice has an opportunity to address health inequities by improving access to quality care.

The AMA has prepared this blueprint to help inform the community of the steps that need to be taken to improve access to high quality primary health care services for all Australians. It outlines proposals that are viable, cost-effective and safe. It also attempts to dispel some of the myths about the state of the Australian primary health care system.

## Australia has a world-class health care system

According to World Health Organization (WHO) data published in 2007 in respect of the year 2005, Australian males enjoyed a life expectancy of 79.0 years, the second highest of all the OECD countries, and females 83.7 years, the fourth highest of all the OECD countries<sup>4</sup>.

In relation to age-specific death rates in Australia, the death rate for males in 2005 compared to 1961 has more than halved for every age from 40 to 79 and, in respect of females, it has halved for every age from 0 to 84 years. Deaths per 100,000 population from circulatory diseases among males in 2005 were 26.8% of the rate in 1961 and for females, they were 27.3%. For genitourinary diseases, the figures were 27.8% and 56.5% respectively<sup>5</sup>.

Australia has an excellent primary health care system that is the envy of many other countries. It is crucial for all Australians to value their own health and the importance of good health across the community. The key to the success of primary

health care delivery in Australia is provision of comprehensive, continuous and coordinated patient-centred care by general practitioners. According to a joint Australian Institute of Health and Welfare/University of Sydney report released in October 2008, general practice provides all the care needed for more than 90% of all health problems that GPs encounter<sup>6</sup>.

It is widely acknowledged that Australia's GP-led model of primary health care services delivers affordable high quality health care outcomes. The Commonwealth Government spent \$250 per person on general practice in 2005-06 through Medicare, non-Medicare funding, expenditure by the Department of Veterans' Affairs and other funding programs<sup>7</sup>.

In the same year, the AMA estimates that the total of Commonwealth and State/Territory Government per capita expenditure on health care was \$2,844. On any measure, general practice consumes a relatively small proportion of overall government expenditure on health care. There is evidence that improved investment in primary health care services will reap significant benefits for the Australian community.

The Australian community values the role GPs play in their health care. 80% of people visit a GP at least once per year and evidence shows that Australians spend more time with their GP than in most comparable countries. Australians report high trust in doctors, particularly general practitioners<sup>8</sup>. Patients also report high levels of satisfaction with, and access to, GP care<sup>9</sup>.

## Emerging pressures

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### Changing health care needs of the community

There is no doubt that the health care needs of the community are changing. The population is ageing and the burden of complex and chronic disease is growing. While GPs still play a key role in the management of acute conditions, more than one-third of problems now managed by GPs are classified as chronic. The most common of these are hypertension, diabetes, depressive illness, lipid disorders, osteoarthritis, oesophageal disease and

asthma<sup>10</sup>. In practice, this means that many patients of GPs have multiple illnesses. This has significant implications for the workload in general practice and how a patient's care is managed and delivered.

### Workforce

In 1993, 830 doctors entered the GP training program<sup>11</sup>. In 1996, the Commonwealth Government decided to limit the number of training places to 400 places per annum. This was a deliberate decision that was designed to keep health care expenditure down and address a perceived oversupply of GPs. The number of GP training places was subsequently increased to 450 places per annum in 2001 and 600 places per annum in 2004.

Australia is training fewer GPs than it did 15 years ago. It should come as no surprise to the community that patients in different parts of the country are having problems with access to GPs. The landmark 2002 report commissioned by the AMA, *GP Workforce: An Analysis of the Widening Gap between Community Need and the Availability of GP Services*, was instrumental in highlighting this issue and overturning the widely held belief that Australia had more GPs than it needed.

## Responding to change

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General practice is tackling key health issues such as complex and chronic disease. Between 1998-99 and 2006-07, there were statistically significant increases in the treatment rates by GPs of chronic disease including hypertension, diabetes, lipid disorders and oesophageal disease<sup>12</sup>.

In the face of workforce pressures and the growing burden of complex and chronic disease, GPs have embraced team-based care to give patients better access to other primary health care services after diagnosis and assessment and the consideration of an appropriate management plan. More than 60% of general practices have a practice nurse and GPs regularly refer patients to other primary health care services such as psychologists, specialised nurses, physiotherapists, dietitians and occupational therapists.

**Australia needs to build on these achievements.**

## GP-led primary care is the best model of patient-centred care

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GPs are the highest trained general health professional with a minimum of 10 to 15 years training. A GP's skills encompass: prevention, pre-symptomatic detection of disease, early diagnosis, diagnosis of established disease, management of disease, management of disease complications, rehabilitation, terminal care and counselling. GPs are specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom or health concern.

GPs are trained to manage patients with multiple illnesses, which is becoming more and more important as the population ages. 55% of people aged 65-84 years of age have 5 or more long-term conditions<sup>13</sup>.

Patient-centred care delivery considers the needs of the whole patient. True patient-centred care can only be delivered within a framework that enshrines a medical diagnosis and assessment. In the GP-led model of primary health care delivery a patient's care needs are fully assessed. A patient's care is then organised around these needs. The specialised training of GPs is vital to the evolving primary care system.

Other health professionals may be able to make a limited diagnosis of a specific illness or injury, but they are not trained in the total health care of the whole person. There is an increased risk of missed diagnosis and misdiagnosis, and delay in accessing appropriate treatment. Other health care professionals are trained in specific areas with specific levels of knowledge and experience and are not able to make a holistic assessment of the patient. Medical knowledge is growing at a furious rate and it is more important than ever to make sure that the primary health care system enshrines access to a holistic medical assessment and diagnosis.

The right assessment and diagnosis guide a patient's journey through the health system. Patient advocacy is a core role of the modern GP. GPs will open the right doors in the health system once they have

assessed and/or diagnosed a patient's condition. This ensures that the patients' journey is efficient for them, clinically effective and cost-efficient. GPs, based on their medical expertise and skill, will determine the clinical management of the patient, the investigations required and when to refer the patient to a specialist or another health provider. This is the key to patient centred primary health care.

## Reforming primary health care in Australia

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The Commonwealth Government has announced that it will develop a national primary health care strategy. According to the Commonwealth Government's announcement, the strategy will give priority to:

- better rewarding prevention,
- promoting evidence-based management of chronic disease,
- supporting patients with chronic disease to manage their condition,
- supporting the role GPs play in the health care team,
- addressing the growing need for access to other health professionals, including practice nurses and allied health professionals such as physiotherapists and dietitians, and
- encouraging a greater focus on multidisciplinary team-based care.

The AMA supports these broad policy objectives and is committed to working with the Commonwealth and other stakeholders to ensure patients continue to have access to high quality primary health care services. Reforms must be measured against the following key criteria:

- the quality of care provided is of the highest possible standard and does not increase the risk of adverse health outcomes,
- coordinated and comprehensive health care is provided,



- the health system continues to be efficient and effective for patients, and
- the overall health system continues to be cost-effective for the community as a whole.

## Australia must retain the GP-led model of primary health care delivery

Research supporting the substitution of nurses and other health care professions for GPs is limited. Most studies have:

- included only small numbers of nurses,
- had patient samples that have generally been too small to detect rare but potentially serious health outcomes such as missed diagnosis, and
- rigorously evaluated only a narrow range of nursing roles<sup>14</sup>.

It is unlikely that the substitution of nurses and other health professionals for doctors will save the health system any money. Studies show that, while there may be potential savings with respect to salaries, this is often offset by longer consultations, higher patient recall rates and the increased use of tests and investigations<sup>15</sup>.

The substitution of nurses for doctors does not appear to give patients quicker access to primary care services. Research into the impact of NHS walk-in centres in the UK, which are primarily nurse-led, found no evidence that walk-in centres

shortened waiting times for access to primary care<sup>16</sup>.

In 2006, the House of Representatives Standing Committee on Health and Ageing published *The Blame Game – Report on the Inquiry into Health Funding*. The Committee noted that there was broad support for a move towards a wellness model in service delivery – which is often used to promote the substitution of nurses and other health care professionals for GPs.

The Committee deliberated on the role of other health care professionals and concluded that, while it supported the move towards a health system based on a wellness model, decisions about the appropriateness of different types of health care were best made by medical practitioners and their patients<sup>17</sup>.

The Commonwealth Government would be doing the community an enormous disservice if, after having pursued a deliberate policy to suppress the intake in the GP training program, it then decided that Australia must move away from a GP-led model of primary health care because of GP shortages that were a product of the Government's own making. The community deserves better than that.

GPs leading teams that include nurses and allied health professionals will deliver the best outcome for patients. There is no substantive evidence that shows that nurses and allied health professionals working independently of GPs can deliver the same quality health care outcomes as the team-based model of primary health care delivery that is supported by the AMA and is currently established in Australia.

## General practice as the foundation of comprehensive and coordinated primary health care services

Evidence exists to show that improved access to primary care physicians (ie, GPs) and their expertise in clinical assessment and coordination has significant benefits. According to the World Health Organization, these benefits include less hospitalisation, less utilisation of specialist and emergency centres and less chance of being exposed to inappropriate health outcomes<sup>18</sup>.

In Australia, general practice is the foundation of primary care, providing continuing, comprehensive and coordinated primary health care to the vast majority of Australians. In contrast, the fragmentation of care can result in inefficiencies and higher costs, and can pose other risks. Task substitution in Australian general practice needs to be discussed in the context of supporting the core attributes of general practice, including its continuity, comprehensiveness and its role in coordination<sup>19</sup>. Otherwise, changes involving task substitution may deprive patients of the valuable contribution of general practice to their care.

## Strengthening the primary health care workforce

It is clear that, to improve access to primary health care services, the GP workforce needs to keep pace with the growth in demand for primary care services. In 2005, the former Australian Medical Workforce Advisory Committee recommended the number of GP workforce entrants should be in the range of 1,105 to 1,200 per year from 2007 onwards. Clearly, more training places in general practice are needed for medical students, prevocational doctors and GP registrars. The Commonwealth will need to invest significant resources into GP teaching incentives, the Prevocational GP Placements Program and the Australian General Practice Training Program.

Now is the ideal time to start this process. The number of medical school places in Australia is expanding rapidly and by 2012 there will be almost 3,000 domestic medical school graduates each year. This will be a fertile recruiting ground for general practice - provided the Government demonstrates its ongoing commitment and delivers the resources and infrastructure needed to expand and enhance training opportunities in general practice.

The delivery of general practice services in Australia is also heavily reliant on the contribution made by international medical graduates, particularly in outer-metropolitan, regional, rural and remote Australia. Despite their valuable contribution, many of these doctors do not receive any induction to the Australian health care system and are given little community support. They often work in challenging

environments where access to professional support and up-skilling is very limited. Providing these doctors with more support will enhance their contribution to patient care and will also encourage many of them to seek a permanent place in the Australian general practice workforce.

Workforce shortages are not limited to general practice. Shortages in other health professions are in some cases even more acute. The Australian Health Workforce Advisory Committee has estimated there will be a shortfall of between 10,000 and 13,000 nurses in 2010<sup>20</sup>. The former Department of Employment and Workplace Relations identified shortages in a number of occupations, including occupational therapists, physiotherapists, pharmacists and podiatrists<sup>21</sup>.

While reform has an important role to play, Australia cannot lose sight of the need to build the capacity of the primary health care system. If Australia does not train enough doctors, nurses and other health professionals, then reform will fail.

## Helping address the burden of complex and chronic disease, multiple illnesses and supporting preventative health care

### Reforming the Medicare Benefits Schedule

Patients will get the best quality care when decisions about their health care are made according to their clinical need. To effectively tackle chronic disease, GP items in the Medicare Benefits Schedule (MBS) need to be simplified and designed to encourage longer consultations and better support GPs to engage in preventative health care. Unless patients with complex and chronic disease are given a rebate that allows them to spend time with their GP, they may not be able to afford the treatment they need.

The Commonwealth MBS now resembles a patchwork quilt. Since 1999 the number of GP consultation items in the MBS has grown from 41 to 188. This has been the result of identifying patient rebates for specific descriptors of care. The structure of GP consultation items in the MBS is



crying out for genuine reform.

Various attempts have been made to introduce new items that are intended to direct a patient rebate for chronic disease or preventative health care, (eg, a health check). The evidence shows that, if GPs are able to spend more time with each patient, they keep people healthier and reduce the burden on other parts of the health system. Patients need to be able to obtain a rebate that enables them to spend more time in their general practice consultation.

The policy direction towards chronic disease management and preventative care is welcome, but the changes in the MBS that reflect this have been burdened with additional paperwork requirements as well as extraordinarily tight rules regarding the use of relevant consultation items.

Reforms must enable GPs to deliver the best possible care for their patients and release them from unnecessary protocols and paperwork. The

recent initiative to streamline the authority system of prescriptions is a good example of how government can trust GPs to make the right decisions about a patient's health care without risk to the government's fiscal position. Restructuring the MBS can deliver efficiencies that will benefit government and patients and enable delivery of more face to face care by doctors.

Reform of the MBS must address the need for patient rebates to be properly indexed so that they keep up with the rising costs of health care. Failure to properly index patient rebates simply means that over time the costs of health care are transferred from the Commonwealth to the patient. The Commonwealth must also continue to support patients through the maintenance of a strong Medicare Safety Net. The Safety Net helps to alleviate the financial pressures faced by many Australians in accessing medical services. The Safety Net has been a very positive initiative for patient access to medical services and has been warmly embraced by the population.

### Supporting the involvement of GP practice nurses and allied health professionals in delivering enhanced, GP-coordinated team-based patient care

The AMA supports an overarching model of primary health care delivery where GPs diagnose, assess and determine a patient's care needs and subsequently coordinate the delivery of care. This model works effectively in relation to acute or short-term medical care, complex and chronic disease and preventative medicine.

GP practice nurses and allied health professionals are a vital component of the care of patients, working as part of a primary health care team with overarching clinical management responsibility and coordination of care led by the GP. They have specific skills that can enhance patient care. The AMA believes that training places for nurses should be expanded and a number of specific measures taken to further support the involvement of nurses and allied health professionals in the care of patients.

GP practice nurse incentives should be extended to all practices. Currently, these can be accessed by general practices in a limited number of urban areas as well as in rural and remote Australia. Many metropolitan areas are ineligible for these incentives – even though they can help improve access to care. Any review of this Practice Incentive Payment should retain appropriate loadings for rural and remote practices while expanding support for all metropolitan practices to engage GP practice nurses.

The AMA believes that GP practice nurses could be better utilised to assist in areas such as the effective management of obesity, blood pressure and diabetes, as well as assist in the management of complex and chronic disease and screening (using GP-developed protocols). While GPs already delegate a broad range of work to GP practice nurses, Medicare funding arrangements mean that patients do not receive a rebate for most of these services, even though they are delivered on behalf of the GP. Currently, a patient receives a rebate only for routine immunisation, wound care, pap smears and a limited number of preventative health activities provided by the practice nurse. The MBS needs to recognise the full scope of work that GPs can delegate to their practice nurses. Funding arrangements should support GPs to delegate work based on the GP's judgement of the skills and expertise of the practice nurse.

The utilisation of the GP practice nurse will enable GPs to see more patients and provide patients with greater access to care.

Medical practitioners, of course including GPs, have always worked with allied health providers in providing patients with the best care for their needs. This has been a team-based approach to patient care. Patients have always accessed allied health providers directly when they have felt the need.

The AMA acknowledges that patients with chronic disease who need ongoing care by allied health providers also need support when accessing that care. Ensuring that patients get access to appropriate care from other health providers following an assessment of their clinical needs by their GP is part of best practice management of chronic disease aimed at improving patient outcomes. The current arrangement for patients to access a Medicare rebate for care delivered by allied



health providers is consistent with this model and is based on this cost effective and clinically efficient principle.

The AMA supports the introduction of improved and streamlined GP referral arrangements for patients to enable them to access rebates for services by allied health providers. This would assist patients in accessing the skills of nurses and allied health professionals as part of appropriate care.

Referral to the necessary expertise of an allied health provider and the number of allied health services a patient receives should be based on the clinical need of the patient, rather than prescriptive government guidelines that are linked to specific conditions or types of illness and limit the potential occasions of service. For example, a patient with chronic diabetes will need ongoing foot care by a podiatrist for life. In contrast, a patient recovering from a stroke will need physiotherapy and occupational therapy for varying time periods depending on recovery. A child will need the expertise of a speech pathologist for a number of years. Clinical review by a doctor is essential to monitor disease processes, progress and holistic evaluation and identify any additional need of the patient for more allied health care.

To support the delivery of team-based primary health care services, the Commonwealth is looking at schemes that will help patients meet the costs of these services. There are a range of possible options that should be considered and discussed, including the provision of redeemable vouchers to patients and the development of GP coordinated chronic care packages (uncapped).

## Providing patients with the financial support they need to access GP-coordinated primary health care services

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The system of Medicare in Australia provides patients with a rebate for GP services. This has worked well (see previous references to health outcomes and access to GP care in Australia). This allows precious health funding to follow the patients. This gives patients the choice of doctor and location of service as well as flexibility in respect of the number of times they see their doctor. This is a truly patient-centred care model – which patients value. When funds follow the patients it means that they can access the care they require based on medical diagnosis and determination of clinical need.

Patients have a tendency to attend the same GP or the same practice for convenience and familiarity. Medical records shared across doctors in a practice enable continuity of care. In addition, under the current Medicare system, patients have the right to choose to attend another GP or another practice when they feel the need, and still have access to a patient rebate for that service.

Suggestions have been made that patients should be registered with a practice to enhance continuity of care.

Patient registration is not required for continuity of care and it would ultimately remove the patient's right of choice within the principle of universality of Medicare.

Patient registration would lead to waiting lists for patients to access their allocated general practice without the freedom to seek an episode of care elsewhere.

The AMA believes that patient registration also ultimately implies that funds would be allocated to the practice to provide service to patients. The money will no longer follow the patient but be determined by government and allocated to the fund holder. This interferes with the doctor-patient relationship. The GP can no longer make determinations for patients based on their clinical needs, but must take into account the funds that have been allocated. This

introduces rationing of care. Patients will not have access to the care they need, and/or have waiting lists for accessing services depending on fund availability. This has implications for patients and their health outcomes.

Other countries have adopted funding arrangements that place artificial caps on the funding of GP services – either in a general practice or a broader geographic area. These caps impact on patients because they potentially mean that GPs must make difficult decisions to ration access to care. The inevitable result is that patients must wait longer to access the treatment that they need.

The AMA does not support funding models that create rationing and limitations on access to care by patients.

Currently, there is much discussion about developing a health system that is centred around the patient. The Medicare patient rebate is funding which follows the patient and is patient-centred. Funding arrangements must ensure that patients can access the care they need in accordance with the clinical assessment made by their medical practitioner.

## Giving GPs the support and infrastructure they need to deliver high quality patient care

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Top-down bureaucratic solutions to address problems in the delivery of health care are rarely effective. Good quality care is delivered when governments create a supportive environment that allows GPs and other primary health care providers to effectively meet the health care needs of local communities. To improve the overall delivery of primary care services, government policy must be directed towards:

- supporting GPs by giving them appropriate access to the best available diagnostic tests including the option to refer patients for a Medicare-funded MRI scan,
- support for the introduction of point-of-care pathology testing,
- supporting the adoption of information technology, including high speed broadband

- the development of information systems that support the coordination of care with other health professionals and the public hospital system, and
- infrastructure for training GPs in the community.

The AMA recognises that the expansion of existing models of multi-disciplinary practices may help improve access to health care services. General practice has undergone significant change over the last 20 years and there has been considerable amalgamation of GP practices during this time.

The Government can further assist this adjustment process by creating a framework that allows practices to invest in the delivery of services in response to local community needs. The AMA believes that a proportion of the Commonwealth's Health and Hospitals Fund should be specifically allocated to allow general practices to apply for funding grants that would support them to enhance the services they can offer to the local community.

## Ensuring equitable access to primary health care services

All Australians should have equitable access to primary health care services. A more equitable distribution of the primary health care workforce can only be achieved when the right incentives are in place and there is access to professional support as well as essential community services for the families of health professionals working in these areas.

The AMA has proposed, in conjunction with the Rural Doctors Association of Australia, a two-tier incentive program to recruit and retain doctors in regional, rural and remote Australia. The first tier is designed to encourage more doctors to work in rural areas, including GPs, other specialists and registrars. It takes into account the greater isolation involved with rural practice.

The second tier is aimed at boosting the number of doctors in rural areas with essential obstetrics, surgical, anaesthetic or emergency skills. Rural areas need doctors with strong skills in these areas to ensure that communities have access to appropriate local services including on-call emergency services.



The AMA also recognises that some rural and remote communities will be unable to sustain a local GP. Other health professionals working in these areas such as remote area nurses can deliver good quality care provided they are supported by IT and obligatory decision-making protocols are in place – including remote access to advice and support from a medical practitioner.

In some rural and remote communities it may not be possible for patients to access a GP in order to have a prescription written. In these circumstances, appropriate GP-supervised arrangements must be developed to allow patients to have access to the medications that they need in a reasonable clinical timeframe.

Geography is not the only influence on the community's access to primary health care services. Older people in residential aged care facilities (RACFs) need better support to access GP care. While previous investment in infrastructure is welcome, there has been insufficient policy attention paid to ensuring that aged care residents get access to medical services delivered by GPs and other medical practitioners.

Aged care accreditation standards need to include requirements that ensure residents of aged care facilities have appropriate access to medical care. This would ensure that RACFs worked closely with GPs and other medical practitioners to make sure that residents receive the quality of care that they need.

Australia must also work more effectively to close the gap in life expectancy between Indigenous and non-Indigenous Australians. We can make significant progress towards this goal by strengthening primary health care services. In relation to primary health care services, the AMA believes that there should be:

- an immediate investment of around \$500 million a year to expand primary health care services in indigenous communities,
- a commitment to increasing the number of health professionals from Indigenous backgrounds, and
- a requirement for mainstream services to focus current resources to improve health outcomes for Indigenous peoples including by expanding outreach and home visiting programs.

## Cutting paperwork so that GPs can spend more time with their patients

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By the time a doctors can practise independently as GPs it will have been around 10 to 15 years since they entered medical school.

Instead of maximising this investment by allowing GPs to devote most of their time to clinical practice, government programs and regulations often tie GPs up in paperwork. Some surveys have estimated that GPs can spend anywhere up to 25% of their time completing paperwork. This is a shameful waste of GPs' time and it denies patients access to care.

The Government should establish a benchmark for paperwork in relation to overall compliance with government programs and regulations – which should be set no higher than 5% of a GP's overall time. When the Government considers new regulations or program requirements, it should be required to review existing regulations and requirements so that a corresponding compliance burden is relieved.

## Taking the burden off our public hospital system

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A strong primary health care system can relieve pressure on hospitals in areas such as mental health and the treatment of complex and chronic disease. Hospitals can also work more closely with GPs to ensure that patients can return to the community as quickly as possible. Better discharge arrangements,

backed with the ongoing management of care by GPs, can get people back in their homes with a lower risk of readmission to hospital.

However, a stronger primary health care system is unlikely to make a significant difference to the workload in emergency departments, reduce patient waiting times or relieve the need for more hospital beds. GP-type presentations in emergency departments consume less than 1% of resources.

The ultimate key to improving waiting times in public hospitals is the provision of more beds so that hospitals can achieve a bed occupancy rate of 85%. This includes the operational capacity to take care of the patients in those beds – doctors, nurses, support staff and equipment. This will improve patient safety and allow hospitals to operate with much greater efficiency.

Consideration also needs to be given to a greater role for GPs in the public hospital system. Creating more opportunities for GPs to work as visiting medical officers and in GP liaison roles could help improve the efficiency of the public hospital system as well as provide GPs with opportunities to maintain and enhance key skills.

## Major public health initiatives

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General practice plays a key role in the roll-out of specific public health programs. For example, childhood immunisation rates in Australia are at record levels. This has been achieved by ensuring that the right financial arrangements are in place to support the Government's objectives.

Taking immunisation as an example, general practice can play an even bigger role. The AMA would support the expansion of general practice immunisation incentives to encompass a broader range of vaccines and patient groups. By government support for GPs to undertake more of this work, the reach of programs would be expanded and more patients would benefit through having immunisations monitored by their GP.

GPs not only play a significant role in administering certain public health programs: they also have a strong role in raising awareness among patients about public health concerns and identifying those at

risk. There must be appropriate links between public health programs and general practice.

General practice delivers primary and secondary prevention. This means screening for disease risk, eg, cardio-vascular disease, diabetes, cancers, etc, and engaging patients in preventative strategies to reduce development of disease. In addition, the GP's close management of patients with disease and the practice of secondary prevention reduce complication rates, disability, morbidity and mortality.

Screening for a range of chronic and infectious disease is a major part of general practice. This includes major public health concerns such as sexually transmitted infections, cancers (eg, cervical, breast, colorectal and prostate), heart disease and mental illness.

Many of these conditions require sensitive handling and patients have confidence in the advice provided by their GP. This means there are substantial opportunities for GPs to further increase awareness among their patients about disease risks, the development and management of chronic conditions and the problems of substance use. Professional advice from a GP has been shown to be effective in motivating people to initiate appropriate behavioural and lifestyle changes.

It is important to effectively use GPs to tackle public health concerns. This can best be achieved by further strengthening the training and support provided to GPs to ensure that they can play their role in broader public health campaigns, and establishing appropriate referral pathways that can be used by GPs to refer their patients to relevant community services and other health providers with specific expertise in these areas.

## Research into best practice primary care delivery

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There are shortcomings in primary health care research nationally and internationally, in terms of both quality and quantity. A survey of public expenditure on primary care research in Australia, New Zealand, the United Kingdom and the Netherlands, found that the average was less than

\$1.50 per capita per annum, in contrast to the international average expenditure on health and medical research of \$28 per capita per annum<sup>22</sup>.

The National Health and Medical Research Council has often been the subject of criticism for its low level of funding for research into health services. Australia needs to lift its expenditure on primary health care research progressively over time. More research will help improve clinical practice and provide an evidence base to improve the delivery of primary care services.

Over time, through appropriate research, it may be possible to develop accountability benchmarks that could improve patient care – provided these benchmarks focus on getting the best outcome for the patient, not simply meeting certain targets for service delivery.

## Social support and infrastructure

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Delivering improved health care outcomes is not just about building a sustainable model of primary health care services. Though GPs provide world-class primary care services, social infrastructure and support are also vital to ensuring high quality health care outcomes – particularly for disadvantaged groups.

A fair safety net, accommodation, effective transport links, education and community support services all have a positive impact on people's health. Though the Government's focus on improving primary health care delivery is welcome, it must also acknowledge its responsibility to invest in the social determinants of health – in particular, education, housing, physical infrastructure and economic development.

## RECOMMENDATIONS

The AMA acknowledges that change and innovation in primary health care is important for the delivery of sustainable, high quality services to patients. GPs will continue to lead the way and this blueprint demonstrates the AMA's commitment to implementing appropriate reforms that deliver benefits for patients. In summary, this blueprint recommends that:

1. Primary care reforms must build on the existing GP led model of primary health care, which is a proven model that delivers high quality, cost-effective outcomes for patients.
2. Primary care reforms must ensure patients continue to have a right to a diagnosis by a medical practitioner.
3. While reform is important, it must not come at the expense of building the capacity of the general practice workforce. The Commonwealth must support additional training places in general practice for:
  - i. medical students,
  - ii. prevocational doctors, and
  - iii. general practice registrars.
4. International medical graduates should be provided with more professional support including access to relevant training programs and mentoring. They and their families should also be given access to basic services that are currently denied to them including Medicare and public education.
5. The Commonwealth should work with the medical profession to reform GP consultation items in Medicare Benefits Schedule so that:
  - i. it supports longer patient consultations and supports GPs to engage in more preventative health care activities,
  - ii. the paperwork associated with chronic disease and preventative health items is significantly reduced, and
  - iii. a more appropriate indexation formula is applied to patient rebates so that they keep up with the rising costs of health care delivery.
6. Within the GP coordinated model, reforms need to give support to the greater involvement of nurses and allied health professionals in the care of patients. This can be achieved by:
  - i. making GP practice nurse incentives available to all practices,
  - ii. expanding Medicare funding to support a broader range of work undertaken by GP practice nurses in areas such as the management of obesity, blood pressure, diabetes, complex and chronic disease and preventative screening,
  - iii. introducing streamlined arrangements that allow GPs to refer patients to other primary care services, based on an appropriate assessment of clinical need rather than prescriptive Government guidelines that currently limit access to such services,
  - iv. providing an appropriate funding mechanism to support patients to access GP-referred primary care services. Options could include redeemable vouchers for patients and the development of GP-coordinated chronic care packages (uncapped)', and
  - v. increasing the available number of nurse training places.
7. Government policy should be directed towards:
  - i. supporting GPs by giving them appropriate access to the best available diagnostic tests including the option to refer patients for a Medicare funded MRI scan,
  - ii. the introduction of point of care pathology testing,

- iii. supporting the adoption of information technology in primary care, including high speed broadband,
  - iv. developing information systems that support the coordination of care with other health professionals and the public hospital system, and
  - v. more infrastructure for training GPs in the community.
8. A proportion of the Commonwealth's Health and Hospitals Fund should be specifically allocated to allow general practices to apply for funding grants that would support them to enhance the services they can offer to the local community. This will support the further development of infrastructure and expansion of existing models of multi disciplinary practices, which may help improve access to primary health care services.
  9. The Commonwealth should fund a robust package of incentives to support the recruitment and retention of doctors in regional, rural and remote Australia – taking into account the isolation associated with practising in these areas as well as the need for doctors with relevant advanced skills.
  10. In areas where it is not possible to sustain a local GP, properly-funded and appropriate support must be in place to ensure that other health professionals working in these areas such as remote area nurses can deliver good quality care. This includes IT and obligatory decision-making protocols that ensure remote access to advice and support from a medical practitioner is available.
  11. In those rural and remote communities where it is not be possible for patients to access a GP in order to have a prescription written, properly funded, appropriate GP-supervised arrangements must be developed to allow patients to have access to the medications that they need in a reasonable clinical timeframe.
  12. Aged care accreditation standards need to include requirements that ensure residents of aged care facilities have appropriate access to medical care by GPs and other medical practitioners. This would ensure that RACFs worked closely with GPs to make sure that residents receive the quality of medical care that they need.
  13. Australia must work more effectively to close the gap in life expectancy between Indigenous and non-Indigenous Australians. We can make significant progress towards this goal by strengthening primary health care services. In relation to primary health care services, the AMA believes that there should be:
    - i. an immediate investment of around \$500 million a year towards building effective primary care services for Indigenous Australians,
    - ii. a commitment to increasing the number of health professionals from Indigenous backgrounds, and
    - iii. a requirement for mainstream services to focus current resources to improve health outcomes for Indigenous peoples.
  14. The Government should establish a benchmark for paperwork in relation to overall compliance with government programs and regulations – which should be set no higher than 5% of a GP's overall time. When the Government considers new regulations or program requirements, it should be required to review existing regulations and requirements so that a corresponding compliance burden is relieved to ensure that the majority of doctors' time is spent on face-to-face patient care.
  15. The role general practice can play in the roll-out of specific public health programs needs to be much better recognised. Professional advice from a GP has been shown to be effective in motivating people to initiate appropriate behavioural and lifestyle changes. To support

GPs to do more in this area, the following needs to be in place:

- i. appropriate funding arrangements that support the Government's objectives in areas such as immunisation,
  - ii. further strengthening the training and support provided to GPs,
  - iii. appropriate referral pathways that can be used by GPs to refer their patients to relevant community services and other health providers with specific expertise in these areas, and
  - iv. appropriate links between public health programs and general practice.
16. The Commonwealth needs to lift its expenditure on primary health care research progressively over time. More research will help improve clinical practice and provide an evidence base to improve the delivery of primary care services. Through appropriate research it may be possible to develop accountability benchmarks for primary health care services that could improve patient care – provided these benchmarks focus on getting the best outcome for the patient, not simply meeting certain targets for service delivery.

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