

Towards a National Primary Health Care Strategy

Introduction

This submission in response to the discussion paper, *Towards a National Primary Health Care Strategy*, has been facilitated by Greater Green Triangle GP Education and Training, which is based in Warrnambool and serves a region embracing the South East of South Australia and South Western Victoria.

The Greater Green Triangle region extends from Geelong in Victoria, west across the border to Millicent in South Australia. The area includes the major centres of Warrnambool, Hamilton, Portland, Colac, Mount Gambier and Millicent and all communities in between. The economic base is provided through agriculture and tourism as well as some value-adding manufacturing. Producing just over one quarter of the total agricultural production of the States of Victoria and South Australia, the region predominantly produces dairy products and wool.

A large number of health services, general practice groups, universities and training organisations reside within the region, with the following groups having been involved in the process and development of this submission:

- Greater Green Triangle GP Education & Training (SA, VIC)
- Otway Division of General Practice (VIC)
- Limestone Coast Division of General Practice (SA)
- Portland District Health Service (VIC)
- South East Health Service (SA)
- Colac Area Health (VIC)
- South West Healthcare (VIC)
- Greater Green Triangle University Department of Rural Health (SA, VIC)
- Flinders University (SA)
- Deakin University (VIC)

There is broad support throughout the submissions for the overall intent of the Discussion Paper and recognition that there has been a longstanding need to develop a national primary health care strategy. The region welcomes the opportunity to ensure the interests of rural communities are adequately represented and reflected in any national primary health care strategy.

It is evident that there has been an under investment in rural health and that rural patients are receiving less care and almost certainly less access to care. As a consequence, rural populations and people of this region in particular, have poor health outcomes relative to urban populations arising from CVD, diabetes, obesity, blood pressure control, premature death rate, and occupational accidents. Rectification of the issue is a matter of public health and equity.

Summary of the Principal Responses to the Discussion Paper

The disjunction between Federal and State funding systems and limited access to MBS items results in fragmentation of services, inadequate and poorly supervised care plans, inequity between patients, lack of continuity and confusion for patients and staff.

There is a structural divide between the GP clinics, some of which may include allied health and nursing specialists on a full time, or more commonly, part time basis, and the community health/primary care divisions of State funded regional and sub-regional healthcare services that are the employers of significant allied health and nursing resources.

As with other aspects of primary health care funding, the way funds are allocated and acquitted will fundamentally influence the outcome of the strategy. The single principled decision to change the focus of primary health care funding models to one of prevention, is the action that will reduce the cost of health care, that may otherwise have been incurred as a result of hospitalisation.

A comprehensive patient controlled Individual Electronic Health Care Record (IEHD) should be introduced as the best means of ensuring continuity of patient centred care and the measurement of evidenced based outcomes.

Workforce shortages and difficulties of recruitment and retention adversely affect patient access in all rural and sub-regional communities. Workforce strategies are required to ensure appropriate services for all geographical areas and population groups. All professions directly employed in healthcare are affected including General Practitioners, Nurse Practitioners, Nurses and Allied Health professionals.

There is an opportunity to increase workforce numbers by increasing training positions to allow young health professionals to develop roots and become established in areas of workforce shortage. The task is often complicated by the need to find employment opportunities for the partners of staff in rural settings.

Consideration should be given to the re-alignment of the Practice Nurse role to that of a case manager. While the Practice Nurse time can be cross subsidised by reimbursement for a GP Care Plan Item, it is suggested that Practice Nurses should be able to claim a MBS Item that adequately compensates them for the time involved in such a role.

Key Elements of Discussion Paper

1. Accessible, clinically and culturally appropriate, timely and affordable

Improving Access

There are a number of challenges to improving access. The national planning agenda is fragmented and we lack a comprehensive planning system to identify and address community needs at the local/regional level. This is exacerbated by a number of barriers; eg the absence of uniform data collection by service providers and the absence of effective meso level bodies mandated to undertake planning across both public (state, Commonwealth, LGA) and private services.

Experience in the Greater Green Triangle region has demonstrated that the principal barriers to ensuring appropriate access for all population groups are:

- The disjunction between Federal and State funding systems and limited access to MBS items results in fragmentation of services, inadequate and poorly supervised care plans, inequity between patients, lack of continuity and confusion for patients and staff.
- MBS items in practice have added pressure to Allied Health services in the public sector. This had come about because there are no private providers, doctors are referring under the care plans, and patients expect to get this service for nothing. Whilst funded under Community Health, the application of the Department of Human Services (DHS) Fees and Charges Policy sees patients incur a cost of approximately \$8.00 per visit.
- The scheduled fee for some services under MBS does not cover the cost of the service. These clients are seen over and above publically funded targets, thus must be at full cost. Eg: the MBS schedule fee per visit for a podiatrist does not cover the cost of the podiatrist to see the client and then allow time for the paper work to do the claim.
- Allied Health services tend to work a typical 9–5 workday. This does not make services accessible for all in rural and regional areas, and there is little alternative as funding models do not support flexible hours for service delivery.
- Transport remains a major issue for people to be able to access services in rural areas, the necessary infrastructure, especially with an ageing population is not available or feasible in these areas.
- Workforce shortages and difficulties of recruitment and retention adversely affect patient access in all rural and sub-regional communities. Workforce strategies are required to ensure appropriate services for all geographical areas and population groups. All professions directly employed in healthcare are affected including General Practitioners, Nurse Practitioners, Nurses and Allied Health professionals.
- There is an opportunity to increase workforce numbers by increasing training positions to allow young health professionals to develop roots and become established in areas of workforce shortage. The task is often complicated by the need to find employment opportunities for the partners of staff in rural settings;
- There is a structural divide between the GP clinics, some of which may include allied health and nursing specialists on a full time, or more commonly, part time basis, and the community health/primary care divisions of State funded regional and sub-regional healthcare services that are the employers of significant allied health and nursing resources.

- For staff, the choice may be between working part time across a number of different GP practices, working in private practice in isolation from other disciplines, or taking advantage of the collegiality and support of a larger team.
- For patients, the fragmentation of the system may mean being directed to a number of different locations, lack of continuity, confusion and a propensity to drop-out, resulting in poorer care.
- Access for disadvantage groups is limited by the number of GP clinics that bulk-bill in rural and regional areas; the low cost, but perceived discomfort in attending emergency departments; lack of transport and child care support; and, failure or inability to attend follow-up appointments;
- For Aboriginal and Torres Strait Islander people, rigid time structures don't suit, little to no after hours services are available and no priority is given to address their concerns even though their health indicators are significantly worse. The inflexibility of the system results in poorer care.

More Appropriate and Accessible Services

The process initiated by the Discussion Paper has shown that the creation of an accessible, appropriate, timely and affordable national primary healthcare strategy must be predicated on resolution of the MBS funding issue. At the regional and local level effort should be directed to maximising the effectiveness of the available workforce, bridging the structural divide between the various modes of professional practice and addressing the organisational and training needs that will be required as part of any solution. Issues to be addressed and recommendations include:

- Attempts to improve local service coordination are traditionally focussed on physical or re-structuring efforts. However, this approach creates defensiveness between organisations. The solution many lie in local/regional approach based on functions and shared patient vision; this can be articulated in **clinical network development** traditionally, service level planning is ad hoc and incremental and rarely takes account of different funding streams
- Taking account of the growth of demand for medical services (as a result of ageing and prevalence of chronic disease) and the undersupply of trained GPs, one approach to improving access to primary health care services could be workforce substitution. While nurses are increasingly being located in general practice, they tend to operate in traditional roles (wound care, vaccinations, taking bloods etc). The GGT UDRH funded by Beyond Blue, are implementing a study of the impact of using a collaborative model of care (GP and Practice Nurse) for the management of chronic disease and co-morbid depression. This involves the re-alignment of the PN role to that of case manager¹. While the PN time can be cross subsidised by reimbursement for a GP Care Plan Item, it is suggested that Practice Nurses should be able to claim a MBS Item that adequately compensates them for the time involved in such a role.
- A large pool of Allied Health and Nursing specialities could be located within a central position (such as South West HealthCare) where clinicians travel to GP clinics under agreements but also patients are seen within South West HealthCare or other central locations if GP clinics have no specialist available at the time. This will ensure high priority patients can be seen at an appropriate time.
- Funding is via multiple sources including State government, Federal government, private insurers and other. A single dataset needs to be established with agreed indicators

streamlining the multiple data sets and results. This enables all specialist clinicians to be linked under 'one auspice' ensuring no 'cherry picking' of patients occurs and no gaps exist. It will remove gap payments and high cost delivery of care with large profit margins.

- Under this proposal priority patients can be seen immediately delivering the right care, in the right place at the right time. Referral pathways are a lot clearer as is data collection and history recording of patients. Clinical services are mostly evidence based and clinical governance is provided by a clinical manager overseeing that area.
- It was proposed that populations of 25,000 plus warrant a small bulk billing GP clinic open 7 days, although not needing to be 24 hour. This would reduce the load on the other GP clinics and the emergency department and allow these services to prioritise more appropriately. GP clinics would be focussed towards continuity of care, chronic disease prevention and management, and ED toward serious acute illness and urgent but less serious needs. It would increase equity of access and the richness of the care provided in the GP setting in particular.
- Practice nurses are common in the country of SA and are a valuable part of the GP team. This role could be further expanded and teams made larger to provide extended support to the management of chronic disease in particular. The community health nurse workforce could also be greatly increased, as they are a group that is well positioned to focus on prevention and early intervention, and also on the support of self-management. A strong network of practice and community health nurses has the potential to measurably improve health outcomes.
- Any funding model should support the use of multidisciplinary teams and increase the number of allied health referrals under Care Plans, so that the money follows the patient, not the provider.
- A regional model of education and training for health care professionals will take advantage of the collaborative overlay of organisations that already exist within this or other regions. A regional focus (already identified in GGT) needs to work within this framework to ensure the primary care focus of the local community is addressed. The GGT population of approximately 200,000+, is of sufficient size in which to locate a viable regional model of primary health care.
- The basic infrastructure of regional health services exist, but the personnel that are required to service this infrastructure remains an on-going concern, and would continue to be so even if a regional model of primary health care is adopted.
- Appropriate investment needs to be offered to up-skill regional professionals within regions to diversify their skills to cover gaps whilst being better equipped to work collaboratively with their regional partners.

Specific Rural Issues

Recent research undertaken by the GGT UDRH indicates that risk factors of the rural population are no different to metropolitan, but access to services does impact on health outcomes. The observations suggest that there has been an under investment in physical facilities in rural areas. This has resulted in space considerations that inhibit the adoption of improvements to General Practice by using Practice Nurses, co-located psychologists and other allied health professionals as part of multi disciplinary collaborative care teams.

Compared to urban areas, the data indicates that rural areas generally suffer from several key service access issues:

- Fewer pharmacies
- Supply of GPs and public dentists

- Availability of bulk billing GPs

These factors impact on the affordability of services for individuals, especially when the costs of the additional travel required, when 'hub and spoke' models are used. Unfortunately, while States have introduced a range of patient transport programs, these tend to be scoped for major visits to city hospitals (e.g. travel over 100 kms etc).

2. Patient-centred and supportive of health literacy, self-management and individual preference.

Supporting a patient-centred approach

The adoption of a patient centred approach is hindered by the absence of a culture of measurement of health outcome. Current data collection focuses on 'activity' and this forms the basis of current re-imburement systems based on activity (fee for service). Additionally, there are other barriers inhibiting a focus on patient health outcomes, they are:

- Workforce shortages in rural areas
- Short consultations as normal practice due to workloads
- Little time provided for a focus on chronic disease and patient education/self management.

While the up-take of electronic medical records in General Practice (over 88%) is commendable, the lack of connectivity between patient records and the lack of a unique patient identifier continues to create expensive and significant barriers in the patient journey. There are 'islands of information' creating information gaps or duplicated efforts between various settings such as GPs, hospitals, rehabilitation etc.

A unique identifier needs to be allocated at birth and constructed to provide information about gender, year of birth that can allow tracking for all patients across multiple systems.

The E-Health strategy to connect all through e-medical records, enabling patient access and selective access for health professionals should commence as soon as possible. If adopted it will be a significant contribution to the 'common good' and will by all connected with primary health care in this region.

Strategies to support consumer engagement and input

Within a general practice environment there is scope to improve the patient and family- centred focus of primary health care by funding time for longer consultations and follow up consultations, to address more than the immediate episode of care. Funded practice nurses could engage with patients to better understand their circumstances and health care needs in order to provide relevant services.

Tools such as the *Flinders Chronic Disease Care Planning* process and the 5As are being more widely utilised to maintain a more holistic view and approach to health improvement. They are however quite time consuming for both the client and the health professional and rely on ongoing review and motivation from both sides.

Implicit in these strategies is the notion of patients having a comprehensive health assessment at the point of contact with the health care system as a means of recording baseline data against which future health and episodes of care can be referenced.

Self management

There needs to be closer linkages, referral pathways and identification of people during acute episodes of sickness to ensure they are referred to and attend self-management intervention.

The techniques of self-management should be learnt by all health professionals to ensure they can be advocates for the benefits of patients taking a role in improving their own health.

Once self-management and its implications are better understood, it is important that all in-take, referral pathways and clinicians are structured around appropriate self management models of care. The health literacy of Australians may be improved in time by directing skills, tools, funding and health promotion programs in support of this strategy.

3. More focussed on preventative care, including support of healthy lifestyles

Better support for prevention activities and behavioural change

As with other aspects of primary health care funding, the way funds are allocated and acquitted will fundamentally influence the outcome of the strategy. The single principled decision to change the focus of primary health care funding models to one of prevention is the action that will reduce the cost of health care that may otherwise have been incurred as a result of hospitalization.

General Practitioners could/will be assisted in their task by:

- The digitization of the RACGP Red Book, enabling it to be linked to the Individual Electronic Health Record (IEHR) with appropriate decision support
- Encourage systems within practices to specifically target prevention activities, for example by funding practice nurse positions to conduct routine preventative activities and the measurement and recording of key indicators. (eg. height, weight, BP, lipid levels, BGLs,..).
- Promote preventions strategies direct to consumer, eg Immunisation, weight, BP, smoking status, waist circumference and other usual clinical measures.
- Address prevention measures for specific population groups such as schools by providing education in all schools on diet and exercise, and by removing unhealthy food from school tuck shops, as evidenced in the Colac model.

Improved integration between different primary health care organisations

Greater evidence of effective interventions is required, including more rigorous evaluation of public marketing campaigns such as the “Life! and QUIT” initiatives in Victoria. Alliances such as QUIT seem to be doing similar programs without looking at new alternative interventions such as Smoking Cessation Clinics.

Further evidence and ‘pathways of evidence’ should be developed in multiple areas to ensure targeting of money into successful health promotion interventions. Change is costly and should be limited to situations where there is a genuine evidence based reason to do so.

All patients should have an end of decade health review as part of the normal course of life. It would also maintain a link with the health system and allow for ongoing communication in regard to lifestyle choices at particular stages and by encouraging clients to take responsibility for their own health. The data from such longitudinal studies, if linked to IEHRs, would be a useful addition to the primary health care evidence base.

However, there are frustrations at the inability to show results in the short or even medium term for primary care strategies such as prevention, or for ‘trials’ and “demonstration projects” that take considerable resources and time, but result in no long-term program due to specific issues:

- Results of health promotion programs are very long term, but often fail to win support from funding bodies. Funders usually want short term outcomes to show what they are getting for their investment

- Health promotion is not always supported by management because again the results are long term
- Despite these frustrations, there needs to be more resources, increased focus and a shift in health professionals' thinking on health promotion.

4. Well integrated, coordinated and providing continuity of care, particularly for those with multiple, ongoing and complex conditions.

Co-ordinating the clinical and service aspects of care

People with long-term illnesses and complex issues represent a large proportion of people seen in health settings. Experience has highlighted some potential solutions:

- There is a need for a unified care plan for patients with complex conditions that flow across all settings. Currently, multiple care plans are resulting in greater fragmentation.
- Rural Community Health Centres in small towns, such as Macarthur and Lismore have visiting GP services where care is well connected with nursing, allied health, health promotion and other services based in these centres. However, a divide is created between referrals for health promotion and primary care nursing and who pays for this. That said, the services provided from these facilities are extremely well connected and co-ordinated. Whilst small scale, they provide many insights into achieving a lot of care and efficiencies with minimal resourcing.
- A lot is expected of GP's, especially in regional and rural areas where they have admitting rights to the hospital. GP's are often not aware of services, or how to access help to reduce demand on them. As many services sit separately to the GP clinic, many GP's arrange additional patient services themselves. A more effective arrangement for supporting GP's, their referrals and follow up of their patients is required.

The HARP model in Victoria has demonstrated how an effective approach to client management can impact favourably on people's lives. The HARP model ensures:

- The client undergoes self-management training.
- HARP team manage the 'total client', not just aspects of their medical care or issues affecting their care.
- Understand the range of services available to ensure connection of all services thus preventing duplication.
- Remove unnecessary co-ordination tasks from the GP, further releasing GP's to focus on other issues.
- Move across all health settings including GP clinics thus removing communication, referral and co-ordination barriers that exist.
- Are funded to provide this task and can actively and objectively demonstrate (through data) the impact this has on improving patient's quality of life, decreasing unnecessary visits to GP's and reducing presentations, admissions and length of stay in hospitals.

It is important to note that the above model has worked exceptionally well in the regional town of Warrnambool, with the HARP team not being located with GP's but providing the hub and spoke model described earlier. The HARP team moves through all healthcare settings.

Changes to improve integration between different primary care organisations

One of the key issues effecting primary care service delivery is the state of Information Technology and Communication (ITC) solutions and infrastructure in rural and regional areas. Multiple and varying systems result in huge disconnection across services. Ownership of data and confidentiality is also a major issue for the various service providers. In Victoria, the region is fortunate to be linked through the South West Alliance of Rural Health (Vic) (SWARH), which has provided the model for the extension of ITC to all Victorian health care regions.

The resolution of issues concerning the choice of software systems to be deployed across the sector, the effectiveness and viability of Victorian State Government mandated suppliers under the Healthsmart program and the compatibility of other systems already in use are awaited. The “Medical Director” software is used extensively by GP clinics throughout the South West of Victoria. An effective interface with that system is needed to better integrate the primary care role of GPs with the health care system as a whole.

As noted in the Discussion Paper, the Individual Electronic Health Record (IEHR) must be at the core of a National primary health care strategy as the best means of monitoring patient health, encouraging self management, co-ordinating care and encouraging information sharing between providers, gathering population based health data, and enabling the propagation of evidence based models of care. The IEHR adopted must be capable of being used with all existing clinical software packages, both public and private.

Other changes that need to occur are:

- Funding that supports the connection of care and change directed toward outcome based, rather than spasmodic episode care.
- Centralised pools of staff that meet the needs of GP practices but are linked to a broader Primary Healthcare Workforce
- A centralised nursing and allied health team working across the entire primary and community health system using a single referral method lead by strong clinical support, governance and succession plans
- A single agreed care plan for all service providers
- A team that manage complex clients with multiple co-morbidities to prevent under or over-servicing
- Promote preventative care through voluntary enrolment of patients, targeting groups, eg chronic disease, mental health, or segmentation of the market, say by stage of life.

5. Safe high quality care, which is continually improving through relevant research and innovation

Developing performance frameworks

"... time constraints, and a lack of financial incentives, have limited the potential for primary health care professionals to be involved in research and CQI (continuous quality improvement) activities".
Discussion Paper p.27

The primary care divisions of health services across the GGT region have exemplified these characteristics. The difficulty is a product of the Victorian DHS funding model requiring service hours to be met, and reported on a monthly basis. Whilst the 'funding model' purports to have flexibility to achieve this function, in reality, it doesn't. The issue is compounded in regional and rural areas where small amounts of funding results in many part-time positions, from multiple funding sources.

This results in no flexibility due to many staff only being funded part-time. When leave is factored in, clinical staff are committed to reaching their target delivery hours and find it difficult to do quality activities within this time. Under the same guidelines, travel time between sites cannot be recorded as claimable time, thus threatening the continuation of services to rural and remote towns. Research is important, but for small rural services it is not possible. Funding models do not allow for research, staff skills are not there and staff are not encouraged to do research.

Potential solutions for these issues that could be explored include:

- A methodology that allowed the gathering of data from all health services to inform practice at a regional and national level would allow health professionals to have involvement and input without having to take full responsibility. Many health professionals might be keen to be involved in this way but they are less willing to be taken away from their service provision work to do so and thereby neglect their clients
- The existing partnerships and cooperative endeavours between universities, health services, training providers and divisions of general practice within this region clearly provide a viable basis for applied research, training, and continuous improvement in the provision of primary care
- Funding needs to be better connected helping to form a pool. Results need to become more outcome based resulting in distinct advantages
- The onerous reporting against target hours should be further simplified and less bureaucratic to decrease administrative duties on agencies and clinical staff, the need is recognised that
- CQI must be imbedded in every day practice – with adequate resources for clinician to learn and implement the process.

Creating an Evidence Base

Evidence around many primary care interventions is minimal or non-existent. Due to the relatively small budget afforded most primary and community health facilities, the resultant small numbers of staff will not be able to provide this evidence base, such as has occurred in large tertiary hospitals in the last 20 years.

Therefore, more focussed money to universities or larger primary care agencies, could enable comprehensive studies that begin to shape the care provided, however, they need to consider the whole ambulatory service system, including GP's, Community Health, NGO's and outpatients.

Data sets need to be more clinically focussed where clinicians can interpret it as meaningful data thus leading to improvements in clinical care based on objective data.

Linking patient health outcomes and quality of care provided to incentives for health professionals

Principles of research and the reality of innovation and QI needs to be “embedded” in our clinical systems and clinical approaches. We need QI in General Practice to be part of the RACGP Curriculum, as if it is not on the curriculum, it won't be taught.

It is suggested that the submission of data be tied to care plans and that reporting can be made against chosen “robust and proven” measures. This has been done in the UK as a way of linking patient outcomes to incentives;

However, like other primary health care professionals, participation in research activities by GPs comes at a cost to participants and data gatherers, especially in terms of time. Appropriate incentives should be available to encourage participation by practitioners in truly engaged and collaborative research in which they become involved partners in all stages of the programs – from planning through data collection and finally dissemination of findings. The incentives should thus include financial ones as well as opportunities for publication and conference attendance.

Options for making a clinical academic career more attractive.

Academic medicine will never match clinical medicine in income. However, the rewards of academia include intellectual freedom, status, and contribution to shaping the future from research and teaching outputs are strong motivators. If clinical academic positions are made available in general practice through partnerships with education organisations such as universities and regional training providers, there could be a greater uptake. KPIs for these positions could be developed and tied to ongoing practice funding. This may also be a way to combat those GPs who are considering ‘slowing down’ but wish to remain involved, their experience is not lost yet provides a new challenge

6. Better management of health information underpinned by efficient and effective use of eHealth.

The role of eHealth in supporting quality primary health care

The electronic environment leads to huge innovation in clinical care and time efficiencies. As previously mentioned, the IT based applications across health are disconnected and do not flow between funding streams resulting in fragmentation and the loss of the vision of an electronic health record. The following requirements to address this issue are expressed below:

- Implementation of a nationally compatible secure electronic messaging system which should include development of an integrated system for electronic transfer of patient information between hospitals, specialists and GP clinics which can import/export clinical information to all standard clinical software packages
- Establish the necessary infrastructure to support eHealth network, particularly in rural communities where there is lack of access to high speed broadband
- Investment in development of clinical computer systems, eg recall & reminder, data extraction, etc
- Patients should be at the centre of the system. Patients should have access to their own electronic record, and should be aware of who has access to it and why. The overwhelming benefit to the community and the individual of a well designed IEHR and appropriate eHealth infrastructure and systems should not allow privacy issues to be an excuse for not delivering improved care or communicating properly.

South West HealthCare specifically noted that a lot of work has been undertaken by the DHS and PCP's in relation to the SCTT tools and reducing the duplication of information gathered. However, the submission cautioned that a major flaw is that it has primarily focused on DHS funded agencies instead of taking a more holistic view and formulating a response across all care providers. They also commented that the Healthsmart experience should not be followed and a global solution is required that encompasses GP's, Community Health, NGO's and be actively connected with hospitals and health services with two way information flow.

7. Flexibility to best respond to local community needs and circumstances through sustainable and efficient operational models.

Improving planning for primary health care at the local level

“A more comprehensive model could involve establishing regional level organisations that are responsible for activities ranging from planning, co-ordinating, to delivering health programs, and potentially, allocating some elements of funding at ‘the local level’. Discussion Paper p.34

The Victorian DHS and PCP's are designated to undertake this function; however, there has been a lack of resolve to plan in a manner that results in change. From a governance perspective, the strategic/coordinating body that makes decisions about who delivers services should not also be involved in delivering services. To do so would not only demonstrate a complete lack of objectivity, but also be a major conflict of interest.

South Australia is currently in a period of major health restructuring and planning. However, in order to implement a national primary health care strategy, Commonwealth control of all health funding and services with a commitment to one system with resources linked directly to population health needs and a consistent “basket of services” available to all is required.

A regional organisation could work in an environment where the whole health system is Commonwealth and characterised by national programs, plans and evidence; population based; fairly resourced and full of appropriate incentives for consumers and health workers. Regional bodies in this context would be the local means of managing a regulated system, rather than an opportunity to create a unique version that then drifts away from consistent services. In any case, a regional body should be as independent as possible of influence from any one group or interest. Flexibility would not be denied with this scenario. Varying regional responses would grow from hard data about population needs and behaviours rather than be the result of opinion or preference.

Health Care Training in a Community Setting

The GGT GPET has proposed the following initiatives in regard to training.

The national framework needs to be flexible to meet regional primary health care needs identified by the community. It needs to include the participation and education of GPs, medical students, post graduate doctors, GP registrars and training doctors on community placements, practice nurses, nurse practitioners, pharmacists and allied health professionals. Professional college standards need to be applied and there needs to be an agreed target of inter-professional levels of training. Regional Training Providers do not necessarily provide all the training directly but are well placed to coordinate all aspects of primary health care training in the community setting.

GGT GPET must meet a consistent quality of care across the whole of Australia and can deliver to the standards set by government, colleges, universities and other peak bodies responsible for the standard of care delivered in Australia.

In rural and regional Australia the GPs are the first and most significant contact for the community and primary health care. More emphasis needs to be placed on recruiting and training doctors to become rural GPs within the regional context.

Regional Training Providers have the closest link to the General Practices and practitioners, medical students, hospital based doctors and overseas trained doctors and are best placed to coordinate the

demands on these practitioners to ensure they meet community needs by providing appropriate levels of training and support.

Increased Collaboration Between Providers

Whilst relationships between various providers exist, there is no accountability from one service provider to another to ensure the next service provider has enough information, tools and expertise to provide the best quality of care.

Lack of comparison with data against outcomes for people providing services produces no real benefit.

In order to better align a person's care along a best practice pathway, funding lines need to be similar and common to all agencies.

An agreed service plan that defines, "which agencies do what", is then required to remove duplication and align services better.

GP Participation in Planning at the Local Level

The Otway Division of GPs proposed that:

- Divisions need to be resourced to ensure GP representation and participation in planning of local health services;
- If community ownership is to be achieved, community engagement strategies need to be developed which are more than simply public relations, promotion, marketing or communication. Community engagement must be a truly collaborative, partnership-based activity in which the community is involved in all aspects of planning, implementation and evaluation of health programs;
- Community engagement in rural and regional Australia seems better developed, but the efforts and costs imposed on primary health care providers are often poorly recognized, acknowledged or recompensed by Governments.

8. Working environments and conditions that attract support and retain workforce.

Recruiting and retaining health care workers in a rural setting

The primary care divisions of our regional health services have distilled the following elements from their experience. Often the geographical location and attractiveness of an area, such as a seaside town, can influence the ability to recruit significantly. However, other factors, particularly career support and progression, have a strong influence in retaining clinicians longer term, the following issues have been identified:

- In regional and rural areas the workforce is ageing, coupled with that natural progression of people moving towards metropolitan areas, a strategy to reverse this trend must be looked at in partnership with a Primary Care Strategy
- Primary and community services are still not fully understood, especially in the nursing and allied health workforce, therefore many younger people move into acute health
- Clinicians are more focussed on work/life balance and will opt for increasingly lower paying jobs that meet their needs rather than higher wages that don't
- Clinicians (allied health and nurses) prefer to be part of a larger team where there is a large variety of work, with strong clinical leadership
- It is very hard to recruit 'specialised' nursing and allied health staff into a sole practitioner role. More effort to connect our workforce is vital to provide better balance
- A mix of private and public is preferable to improve the experience for many clinicians
- The inability to claim MBS items whilst working for a state health service severely limits diverse models that could solve many issues
- Long-term clinical managers who don't follow evidence based guidelines or are not aware that new clinical techniques are making many positions unattractive, especially in regards to retention
- Staff are willing to move to other towns/cities if their professional and personal needs are not met
- The number of sole practitioners in the rural areas presents a challenge for succession planning, in-service and management training
- Many clinical roles also have a management component, but rarely come with the training for that role.

Suggestions to combat and resolve many of these issues include:

- Strong clinical leaders, high quality clinical supervision and a strong cohort in the worker's own discipline help attract professionals
- Flexibility and a strong cross-disciplinary cohort add resilience to the team
- Access to high quality leadership and management
- Appropriate career advancement opportunities
- The ability for publicly based allied health and nursing professionals to access MBS items will create more attractive roles and allow care pathways to move through hospital, Community Health, GP's and people's homes
- Skilled Grade 4 and 5 clinicians should be allowed to refer to specialist doctors
- Nurse practitioner roles, could be expanded more widely and 'interdisciplinary roles' (not multidisciplinary) further expanded to provide more comprehensive care
- Specialist allied health and nursing should be allowed to have greater responsibility for complex clients and agreement to book high priority patients into GP clinics in a timely manner – this needs a lot of trust and respect between GP's and providers
- Fully define the competencies of allied health and nursing professionals
- A welcoming community of staff, and wider community, reasonable cost of living, access to services and activities that suit the individual and their family
- Recognition of achievement and effort.

With direct respect to GPs the following observations were offered:

- The specific changes needed in those regions and population centres where there is difficulty attracting and retaining staff include: increasing workforce numbers by making those positions more attractive - improving remuneration (as mining companies do to attract staff to isolated areas); improving supports (professional colleague numbers, CPD, locum availability); and, providing training positions from undergraduate to specialist training levels within the region
- Expansion of the Practice Nurse role and use of multi-disciplinary teams are already happening in some areas, but workforce shortages are impacting on all health disciplines
- Increasing number of medical graduates may be part of solution but investment in GP time & practice capacity to support and teach students is required
- Rural practices should receive financial recognition for greater involvement in community activities, eg rural loading.

Training of Medical Students in Rural Settings

There is now clear evidence in Australia and internationally that early, meaningful clinical training of medical students in rural areas affects their final career pathway, and geographical location. Flinders University students choosing to undertake their first clinical year in the PRCC (a year-long integrated community based program) have a tenfold increased chance of becoming a rural doctor. Currently 60% of the PRCC alumni end up with a career in rural Australia, with another 25% reporting that they would prefer a rural career but there are not rural pathways in their chosen area of speciality.

In the GGT region FURCS and collaborative partners (GGT GPET ACRRM etc) have been able to link training opportunities to develop an unbroken training pathway from senior medical student, to

intern with community-based rotations, to PGY2 with opportunities in community paediatrics, indigenous health and mental health (to name a few primary care priority areas), and onto GP registrar training.

The capacity for doctors in training to progress through a career pathway while establishing stable social networks has greatly increased the recruitment of doctors to primary care in this region. Support to connect the primary care training pipeline for rural areas across Australia is essential to ensure the increased numbers of students entering medicine provide the workforce redistribution (from specialties to generalists, and from areas of oversupply to areas of undersupply).

FURCS has demonstrated the value of connecting the training pipeline in medicine. This pipeline can also be mobilised to develop an allied health professional and nursing workforce essential for the multi-disciplinary workforce required to service the needs of Australia's community into the future. Only through rurally-based education can we attract and retain rural clinicians in primary health care.

9. High quality education and training arrangements for both new and existing workforce.

Steps to improving primary health care education and training

Some important points need to be raised in regards to education and training as they raise significant issues.

- Improvements required in primary health care education and training include providing physical infrastructure, improved teaching remuneration, fund GP registrars to provide teaching, increase the status of teaching with University appointments for in-practice teachers
- Trainees can be encouraged to settle in workforce shortage communities by supplying them with training positions from undergraduate level to specialist training within the area of workforce shortage. This would allow them to settle within that area during the period in which most of them will be forming families- finding partners locally, allowing partners & children to also settle within the region. Also, by involving those in training the following groups of trainees, involvement with local groups such as the Division, can provide them with a sense of belonging
- There has long been a push to train more graduates in areas of GP, allied health and nursing, **however**, although this is required, no re-designing of service provision has occurred, resulting in more people doing the same
- There has been no attempt to better connect disciplines, particularly allied health and better define their boundaries
- More effort should be concentrated on the 'Interdisciplinary' practitioner who is more relevant to complex and clients with co-morbidities than the numerous specialist disciplines
- The undergraduate courses in Australia were predominately established to cater for hospital and private environments. There needs to be more courses and options developed specifically around primary and community health with curriculum to match
- The undergraduate courses don't seem to have kept up with the changing needs and expectations of consumers.

The regional health services perspective

The perceived inequity between the resources provided for medical training and placement and those provided for other professions must be addressed. Allied health in particular runs on good will from both students and field placement supervisors, there is no money for travel and accommodation, and very limited university supervisor support.

A hard look should be taken at the time it really takes to become an effective beginning health professional. A more competency based approach with more individualised progression may result. Medical practitioners have a paid internship year with explicit learning and supervision while filling a vital role in the health system. Nurses and midwives have a graduate year, which is not compulsory but often critical for future employment, but this may not be available to all as numbers increase.

If all health professionals had a well funded graduate/intern year or part year this would allow a more explicit period of learning to work in a multi or intra disciplinary environment.

Locating the training in the region

- More primary health care professionals are needed in rural areas. These professionals need to be trained within a regional context and the critical component of this is the interaction with the general practice community.
- Regional training providers (RTPs) are made up of local hospitals, universities, divisions of GP, professional colleges, trainees, and supervisors. RTPs exist to the degree that they have the imprimatur of all these stakeholders, all of whom either provide training facilities, training or training standards and deliverables. Regional Training Providers are intimately tied to the general practices in their region and are best placed to coordinate training in the community setting through a streamlined model of regional care.
- To achieve this Regional Training Providers will need primary health care settings to receive proper support and clinical opportunities as envisaged by the general practice super clinics model and a truly integrated primary health care setting.

Vertically and horizontally integrated teaching models

The concept of vertically integrated teaching assumes that a single teacher can simultaneously support learners at different stages. Although this is possible for a few skilled educators it is a demanding expectation for professionals whose primary role is patient care.

Another perspective is that of situated learning which defines learning as a social construct where novice clinicians work alongside their expert preceptors and gradually take on the attitudes, knowledge and skills required "to be" a member of their professional community of practice (Lave & Wenger). When students are provided with the opportunity to have continuity of supervision, they can develop a professional and personal relationship with their clinical supervisor who learns their capacity and weaknesses and provides them with agency of the doctor - patient relationship. This increases student learning, as reflected by their exam results and their usefulness in clinical practice.

This learning model is symbiotic with clinical patient care responsibilities and so is sustainable into the future. Longitudinal integrated learning opportunities for learners at different stages in their membership of a clinician community of practice, rather than vertical integration on block will provide sustainable education and professional development pathways in the primary care setting.

Finally, horizontal integration of teaching, under values the worth of interdisciplinary health professional education. Rather than teaching allied health professionals, doctors and nurses the same things at the same time, interprofessional education blends similar learning needs while recognising that these health team members complement each other in their care of patients by overlapping skills and valuing their own and each others' expertise. Inter-disciplinary education has been shown to improve communication between team members with overall improvement in health outcomes

10. Fiscally sustainable, efficient and cost-effective primary care system

It will be apparent from the foregoing that the attainment of a fiscally sustainable, efficient and cost effective primary care system will only be realised when the multiple issues associated with the funding of primary care in all its forms are resolved in accordance with a national strategy managed by the Commonwealth.

These issues are raised throughout this response paper. Some possible solutions are provided below:

- Whether we want to admit it or not, the funding methods, drive the way care is structured. If funding is directed to create a connection between service providers, the quality and connectedness of care will improve
- The Emergency Department, Community Health Centre and General Practitioner divide is the point at which State and Federal Government meet. A more collaborative and connected funding arrangement will result in more collaborative and connected service plans and provision. A Commonwealth funded and controlled health system with a minimum of levels between the funder and the service provider and consumer will eliminate much of the complexity, confusion and inefficiency evident in the system
- Activity based funding is a risk. Paying health services or professionals to do more, even though more of the same is not the best outcome, can result in too many people in hospital where other alternatives may exist. A health service struggling to stay in existence and keep its staff has no choice but to try to maximise what it does in terms of activity
- Health promotion and prevention do not show the immediate results that an acute intervention usually does. The community has trouble recognising that money put into health promotion is of benefit, and is often seen to be at the expense of direct services. Thus the funding of the system seems to drift always to the areas where results are more immediate
- There is a need for greater health investment in rural areas, rather than removing rural incentives or diverting to regional areas. Divisions of GPs already have experience in fund holding and effectively combining Federal, State & local funds to achieve agreed local outcomes. The ODGP submits that divisions need to be resourced to expand this role further
- A GP Super Clinic won't necessarily be the answer to the issues in a large regional area as there will still be multiple GP's providing services in other clinics. Thus similar, 'multiple-provider' issues to those already faced would persist. There would need to be an alternative service model for the clinics outside the super clinic. If adopted, the methodology should also be considered for towns with a population of 2,000 – 4,000 where all GP's could be included.

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- Greater Green Triangle GP Education & Training (SA, VIC)
- Otway Division of General Practice (VIC)
- Limestone Coast Division of General Practice (SA)
- Portland District Health Service (VIC)
- South East Health Service (SA)
- Colac Area Health (VIC)
- South West Healthcare (VIC)
- Greater Green Triangle University Department of Rural Health (SA, VIC)
- Flinders University (SA)
- Deakin University (VIC)

As such each of the individual statements made in this collaboration should not be viewed as being supported by each of the partner organisations involved.