Australia's primary health care workforce — research informing policy

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ABSTRACT

- In 2008, the Australian Primary Health Care Research Institute (APHCRI) held a Primary Health Care Workforce Roundtable with practising clinicians, policymakers and researchers, which drew on Australian evidence in health care policy, systematic reviews, and expertise and experience of participants.
- Key recommendations for an adequate, sustainable and effective primary health care workforce that arose from the meeting included:
  - ➢ simplifying the Medicare Benefits Schedule, which is unnecessarily complex and inflexible;
  - ➢ effectively funding undergraduate and prevocational medical and nursing education and training in primary health care;
  - ➢ developing career structure and training pathways for general practitioners and primary health care nurses;
  - ➢ developing of functional primary health care teams; and
  - ➢ using a blended funding model, comprising fee-for-service as well as capitation for patients with chronic or complex needs.
- A report from the meeting, detailing these policy options, was submitted to the National Health and Hospitals Reform Commission for inclusion in their deliberations.

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A strong primary health care system has been shown to improve patient health outcomes, reduce costs, reduce health inequities and increase patient satisfaction regarding their care.[1] To achieve these goals in Australia, the primary health care workforce will need to be adequate, sustainable and effective. Currently, however, Australia's primary health care workforce is facing significant challenges in supply, distribution, changing demands and role delineation.[1-4] In 2008, the Australian Minister for Health and Ageing established the National Health and Hospitals Reform Commission (NHHRC) to report on how best to approach long-term reform for the Australian health care system to effectively meet these challenges.[5] During NHHRC consultations, the need for a synthesis of Australian evidence relating to primary health care workforce and its implications for policy options became apparent. In this article, we discuss policy options suggested to the NHHRC by the Australian Primary Health Care Research Institute (APHCRI),[6] based on the Primary Health Care Workforce Roundtable held in Canberra on 29 August 2008.

The APHCRI was established in 2003 to provide national leadership in improving the quality and effectiveness of primary health care through the conduct of high-quality, priority-driven research, and in supporting and promoting best practice. It has an explicit commitment to improving the translation of research into policy.

1 Primary health care workforce projects commissioned by the Australian Primary Health Care Research Institute in 2006*

The number of workers

- Attracting health professionals into primary health care: strategies for recruitment
- Review of primary and community care nursing
- Improving primary health care workforce retention in small rural and remote communities — how important is ongoing education and training?

Optimising the workforce

- Optimising skill mix in the primary health care workforce for the care of older Australians: a systematic review
- Optimising the primary mental health care workforce: how can effective psychological treatments for common mental disorders best be delivered in primary health care?
- The contribution of approaches to organisational change in optimising the primary care workforce

The place of generalism

- The expanding role of generalists in rural and remote health: a systematic review
- What is the place of generalism in the 2020 primary health care team?
- What is the place of generalism in mental health care in Australia? A systematic review of the literature

* Final reports and author lists are available at <http://www.anu.edu.au/aphcri/Domain/Workforce/index.php>. ◆

In 2006, the APHCRI Research Advisory Board commissioned work to examine Australian and overseas evidence related to increasing numbers of general practitioners, optimising the existing primary health care workforce, and understanding the place of generalism in primary health care. Funding for research grants was allocated via a competitive peer-reviewed process. All projects were required to demonstrate their relevance and value to current and emerging issues in Australian health policy, and articulate potential policy options arising from the research in the final reports. The nine successful projects (Box 1) were systematic reviews that used a narrative approach.[7]

In 2008, the APHCRI was asked by the NHHRC Commissioners for policy options drawn from a synthesis of available evidence on the primary health care workforce. The 2006 findings from the APHCRI projects were presented to Australian primary health care experts at the 2008 Primary Health Care Workforce Roundtable. Participants were encouraged to draw on their individual expertise and practical experience, as well as recent APHCRI and overseas research, to build a vision for the future of the primary health care workforce in Australia.

Broader issues, such as funding and models of care, were discussed only with respect to their potential impact on primary health care workforce profile and capacity. The recommendations that arose focus mainly on the general practice component of the wider primary health care workforce (GPs and primary health care nurses), as this was where most of the evidence lay. The submis-

2 Methods used by the APHCRI to produce a submission to the NHHRC on policy options for the primary health care workforce from the 2008 Primary Health Care Workforce Roundtable

Participants of the meeting

Participants included primary health care researchers, policymakers, practising clinicians (general practitioners and nurses) and students. All were invited as individual experts, rather than as representatives of peak workforce organisations.

Background articles

Participants were provided with two papers summarising major findings of APHCRI-commissioned projects[8,9] and links to the final reports from each project.

Meeting structure

The meeting was structured around three questions:

- What are the problems and trends in the primary health care workforce, including problems and trends in workforce numbers, distribution, changing demands, and role delineation and teamwork?
- What are the different models that Australia could explore to make the best use of the workforce, both now and into the future?
- What kind of recruitment and retention measures does Australia need to attract people to, and keep them in, the primary health care workforce?

Three brief presentations summarised the APHCRI evidence, described what will be different in health in 2020, and provided information on the current general practice workforce. Participants were asked to consider what the key features of a functional primary health care workforce would be in 2020 and, given that vision, how it could be achieved via currently available or newly created mechanisms.

Throughout a facilitated discussion, participants were encouraged to develop practical policy options by considering the evidence and the context in which the policy would apply. Potential policies were discussed in terms of effectiveness (will it work?), appropriateness (should we do it?) and implementation (how would we make it work?).[10]

The discussion was recorded, and notes were taken by two staff members.

Formulation of submission to NHHRC

After the meeting, we summarised the debate, discussion and policy options that arose at the meeting, drafted a submission to the NHHRC, and circulated the draft to all participants for amendments and comments. Suggestions were adopted and the final document was distributed to participants before being sent to the NHHRC. All participants were acknowledged in the final document.

APHCRI = Australian Primary Health Care Research Institute.
NHHRC = National Health and Hospitals Reform Commission. ◆

sion to the NHHRC was formulated from the debate, discussion and policy options that arose at the meeting (Box 2).

Expanding the primary health care workforce

Increasing primary health care workforce numbers in Australia requires a broad range of strategies. Nurses in general practice have received much attention as a potential, or necessary, part of the primary health care workforce solution. There are particular roles that primary health care nurses can successfully adopt — proactive patient follow-up, general patient consultation and support, and care planning and goal setting.[11] Research on community nursing affirms that nurses working in primary health care can "help address workforce shortages, improve access to health care and contribute to the management of chronic conditions and illness prevention", leading to suggestions that the role of practice nurses should be expanded and that this profession should be given a clear career pathway and clear training.[12] Delineating the role of the primary health care nurse (or general practice nurse) may help attract nurses to the sector in the face of declining overall workforce numbers.

The number of general practice nurses in Australia increased by 59% during the period 2005–2007.[13] Most practice nurses join the profession via hospital work, and their training in the tertiary environment is not always compatible with work in the primary health care sector. Despite this, there is no nationally agreed set of competencies required to enter primary health care nursing, no formalised postgraduate training or accreditation in primary health care nursing, and minimal exposure to primary health care nursing in undergraduate courses. These issues need to be addressed.

The research evidence around potentially broader roles for nurses in primary health care and chronic disease management was uncontested by participants of the Roundtable. However, they concluded that the Medicare Benefits Schedule (MBS) is too complex and rigid to allow the best use of nurses' skills. Nurses in general practice are funded for particular actions only, thereby significantly limiting the ability of practices to maximise and individualise their various talents. The participants noted that, even with targeted incentive payments, the fee-for-service system has difficulty supporting GPs and other team members to: allocate time for comprehensive management of chronic and complex conditions, conduct health promotion and illness prevention activities, use team care approaches in specific patient groups, and allow cross-sectoral planning for a local population. A systematic review and international comparison of the impact of different funding initiatives on access to multidisciplinary primary health care concluded that alternative funding arrangements, such as capitation and contracting, could be more widely adopted in Australia to enhance access to care for vulnerable population groups without fundamentally changing the overall fee-for-service financial arrangements.[14]

Recommendations for a sustainable primary health care workforce

Following discussion of these and other issues, several key recommendations for a sustainable primary health care workforce emerged around the themes of funding and financial arrangements, workforce education and training, and interprofessional organisation and teamwork.

- Simplify the MBS, which is unnecessarily complex and inflexible, by:
  - changing general practice nurse item numbers to payment for patient attendance, rather than limiting payments to specific activities. This would allow greater autonomy and flexibility for practice nurses to carry out different activities depending on their skill mix, and team and patient needs;
  - resisting the temptation to expand the complexity of the Medicare item numbers for Enhanced Primary Care Services; and
  - developing descriptive, rather than prescriptive, performance indicators.

- Effectively fund medical and nursing education and training in the primary health care sector by:
  - increasing the focus on primary health care in undergraduate, pre-internship and prevocational medical and nursing education. This should include the provision of support for infrastructure, and for the teaching commitments required to effectively educate doctors and nurses in the community. Promising programs such as the Pre-vocational General Practice Placements Program for medical graduates should continue to attract support, and similar programs in primary care nursing should be introduced; and
  - adequately funding community-based placements in primary health care for nurses and medical students (to shift training from the hospital system to the community, funding will need to be shifted to cover the costs of training by primary health care staff).
- Develop career structures and training pathways for GPs and primary health care nurses that enable career development in the primary health care setting, by developing a nationally agreed-upon set of competencies linked to postgraduate training programs for primary health care nurses.
- Facilitate the development of functional primary health care teams by:
  - increasing interprofessional health care education and clinical placements at all levels;
  - supporting interprofessional primary health care organisations, with one possibility being that the Divisions of General Practice Network evolves into larger interprofessional organisations;
  - learning from existing functional multidisciplinary team models (such as those applied to Aboriginal medical services) to build scalable models of primary health care teams. These models need to be flexible and variable to take account of local needs and resources. Examples could include collocated teams (eg, GP Super Clinics) or locally supported networks of providers funded on performance and clinical outcomes; and
  - instituting a quality assurance framework to provide the framework for funding.
- Introduce a blended funding model for primary health care, consisting of a mix of fee-for-service and capitation for patients with chronic or complex needs, by:
  - allowing patients to register voluntarily with a primary health care practice that would then receive capitation funding;
  - allocating responsibility to the practice for providing the registered patient with an agreed program of care with measurable outcomes. The funding stream would pay the practice (rather than an individual team member of the practice) for the clinical outcome. Who provides the service would not be mandated — it would be flexible depending on available skills and resources within the accredited practice or local area;
  - including a loading component in the level of capitation funding that reflects complexity of activity, age of patient, degree of rurality (based on an agreed measure such as the Australian Standard Geographical Classification or the Rural, Remote and Metropolitan Areas classification system), social disadvantage (using a socioeconomic index) and, possibly, workforce need and difficulty of recruitment and retention;
  - continuing the fee-for-service model for transactions outside the agreed program of care; and
  - enabling choice for practices and individuals to opt out and continue to use fee-for-service for all care.

Summary

The APHCRI's recommendations highlight the key aspects of the primary health care workforce that require significant systemic change and reform, to ensure the provision of appropriate, equitable, accessible and high-quality health care for all Australians, regardless of where they live or their economic or cultural backgrounds.

In making these specific recommendations to the NHHRC, the APHCRI is cognisant of the timetable for action that is required. Simplifying the MBS could be achieved quickly, and would have an immediate effect. Other recommendations — namely those relating to the funding of medical and nursing education in the primary health care sector, the development of career structure and training pathways, and the development of functional primary health care teams — need to be initiated quickly, even though their full benefit will not be realised for several years. A clear implementation strategy is important to ensure that action is taken, monitored, and evaluated using appropriate performance indicators. Also, the implementation strategy should include constant "feedback loops" from the evaluation to inform progressive policy improvement.

This article focuses specifically on workforce issues, but it is clear that Australia's ability to ensure an adequate supply of an appropriately trained primary health care workforce requires broad systematic changes that tackle underlying issues of funding, financial arrangements, service organisation, role delineation and career pathways, and education and training paradigms. Introducing a blended funding model for primary health care may be politically challenging, but mounting evidence suggests that it is worth developing and trialling. In the absence of attention to broader issues, specific workforce reform alone may founder and not achieve intended goals.

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Competing interests

Kirsty Douglas is an employee of ACT Health on secondment to the APHCRI. Nicholas Glasgow was the Foundation Director of the APHCRI until January 2008. John Humphreys was recompensed for airfares to attend the Primary Health Care Workforce Roundtable by the APHCRI, and received a fee for preparing for and facilitating the meeting.

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References

1 Macinko J, Starfield B, Shi L. The contribution of primary care systems to health outcomes within Organization for Economic Co-operation and Development (OECD) countries, 1970–1998. *Health Serv Res* 2003; 38: 831-865.
2 Australian Government Productivity Commission. Australia's health workforce. Canberra: Commonwealth of Australia, 2005. http://www.pc.gov.au/__data/assets/pdf_file/0003/9480/healthworkforce.pdf (accessed Oct 2008).
3 Australian Government Department of Health and Ageing. Report on the audit of health workforce in rural and regional Australia, April 2008. Canberra: Commonwealth of Australia, 2008. http://www.health.gov.au/internet/main/publishing.nsf/Content/work-res-ruraud-toc (accessed Nov 2008).
4 Australian Medical Workforce Advisory Committee. The general practice workforce in Australia: supply and requirements to 2013. Sydney: AMWAC, 2005. (AMWAC Report 2005.2). http://www.nhwt.gov.au/documents/Publications/2005/The%20general%20practice%20workforce%20in%20Australia.pdf (accessed Nov 2008).
5 Australian Primary Health Care Research Institute. Submission to the National Health and Hospitals Reform Commission: primary health care workforce. Canberra: APHCR, 2008. http://www.anu.edu.au/aphcri/Hub_Research/APHCRI%20NHHRC%20Submission%20on%20workforce%20final.pdf (accessed Jun 2009).
6 National Health and Hospitals Reform Commission. A healthier future for all Australians — interim report December 2008. Canberra: Commonwealth of Australia, 2009. http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/interim-report-december-2008 (accessed Jun 2009).
7 Mays N, Pope C, Popay J. Systematically reviewing qualitative and quantitative evidence to inform management and policy-making in the health field. *J Health Serv Res Policy* 2005; 10 Suppl 1: 6-20.
8 Douglas K. Generalism and the primary health care workforce. *APCHRI Dialogue* 2008; 2: 1-2. http://www.anu.edu.au/aphcri/General/DialogueII_2008_26%20Aug.pdf (accessed Jun 2009).
9 Douglas K. (R)Evolution in the primary health care workforce. *APCHRI Dialogue* 2008; 1: 1-2. http://www.anu.edu.au/aphcri/General/DialogueI_2008_aug.pdf (accessed Jun 2009).
10 Dobrow MJ, Goel V, Lemieux-Charles L, Black N. The impact of context on evidence utilization: a framework for expert groups developing health policy recommendations. *Soc Sci Med* 2006; 63: 1811-1824.
11 Zwar N, Dennis S, Griffiths R, et al. Optimising skill mix in the primary health care workforce for the care of older Australians: a systematic review. Canberra: Australian Primary Health Care Research Institute, 2007. http://www.anu.edu.au/aphcri/Domain/Workforce/Zwar_1_final.pdf (accessed Jun 2009).
12 Keleher H, Parker R, Abdulwadud O, et al. Review of primary and community care nursing. Canberra: Australian Primary Health Care Research Institute, 2007. http://www.anu.edu.au/aphcri/Domain/Workforce/Keleher_1_final.pdf (accessed Jun 2009).
13 Australian General Practice Network. National practice nurse workforce survey report 2007. Canberra: AGPN, 2007.
14 McDonald J, Harris MF, Cumming J, et al. The implementation and impact of different funding initiatives on access to multidisciplinary primary health care and policy implications. *Med J Aust* 2008; 188 (8 Suppl): S69-S72.

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